Understanding the impact of self-harm on friendship: A qualitative approach

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Abstract

It has been well established that self-harm is a key healthcare issue facing young people (Health and Social Information Centre, 2015). Consequently, many self-harmers preferentially seek support from friends (Evans, Hawton, & Rodham, 2005). Despite their unique position, friends' experiences have been marginalised. Historically, friends have only been considered when they feature in the lives of the person who self-harms, when they are identified as “gatekeepers” to self-harming young people (Klingman & Hochdorf, 1993, p. 123), or when they themselves go on to self-harm (e.g. Hawton, Rodham, Evans, & Weatherall, 2002). Bearing in mind the friends’ unique, yet highly vulnerable status, there is a notable lack of research exploring how friends come to understand their experiences, and the subsequent impact this has on their friendships with the self-harmer. Through this qualitatively approached thesis I aimed to explore how the impact of self-harm on friendship is understood. Data was collected through a series of interviews and focus groups with friends of self-harmers, and those who supported them.

Using a qualitative methodology, I conducted three studies. In Study One, I explored how counsellors made sense of the impact of self-harm on friendship. Studies Two and Three focussed on how friends, whilst maintaining a friendship with a self-harmer, came to understand themselves, their friendship with the self-harmer, and their relationships with others. The results indicated that friends struggled to integrate self-harm into their friendships and their understanding of themselves, took on excessive responsibility for the self-harmer, and felt constrained by secret-keeping. Additionally, as the friends in Study Three felt that information available to them was either absent, or lacking, I developed a prototype support tool tailored specifically to the needs of the friends.
Chapter One

Introduction to self-harm

Self-harm is a key health issue. We know that in the year 2013-2014 there were over 216,000 admissions for self-harm in the UK, just over a quarter of which were 15-24 year olds (HSCIC1, 2015). From community-based studies, however, we know that the full extent of self-harm is thought to be much greater. Official statistics rely on hospital admissions data, yet community studies indicate that many of those who engage in self-harm do not seek medical help (e.g. Hawton, Rodham, Evans, & Weatherall, 2002), and only do so when they perceive the self-harm to be more extreme, or the motivation more dangerous (e.g. the wish to die) (Ystgaard et al., 2009). Rather, self-harmers preferentially seek support from their social network (Ystgaard et al., 2009).

In summary, self-harm is a concerning issue; one that is experienced by young people at an influential and developmentally significant time of life (Hawton, Saunders, & O’Connor, 2012) and is something for which they tend not to seek professional help.

In this chapter I provide an overview of the nature of self-harm as well as the impact that self-harm can have on health-care professionals, family, and friends. I also present some wider literature on supportive friendships and provide a rationale for why self-harm within friendship needs to be considered in more depth.

1.1. The nature of self-harm

Prior to defining what self-harm is, it is important to recognise that the term ‘self-harmer’ holds a controversial position within the research literature. For many, the use of this term would be considered to be pejorative as, in Braun and Clarke’s (2013) terms, doing so does not "put the person before the condition" (p. 300), rather it defines those who self-harm by their behaviour and as such opens them up to the stigmatisation of that condition. In an interview-based study, Walker (2009) explored the healthcare experiences of women who were diagnosed with borderline personality disorder and had a history of self-harm. The women felt that often their history of self-harm and their subsequent label of ‘self-harmer’ meant that they had been mistreated and felt that the label of ‘self-harmer’ had overridden their identities. It is thought that the resistance to using the term ‘self-harmer’ is derived from the popular understanding

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1 Health and Social Care Information Centre
of self-harm as being a manipulative, or attention seeking act (Allen, 2007; Rayner, Allen & Johnson, 2005).

However, the person-first approach, whereby the individual is not defined or identified by their condition, is not universally accepted. In a book exploring the impact of autism in childhood socialisation, Sainsbury (2009) (herself diagnosed with Autism Spectrum Disorder) suggested that merely being associated with a disorder, condition, or socially abnormal behaviour means that potential stigma is always present. Furthermore, she argued that ‘putting the person first’ merely makes the disorder an addition and enhances the ‘shame’ and stigma. Moreover, Braun and Clarke (2013) also encouraged researchers to use the terminology that “socially marginalised groups use to describe themselves” (original emphasis, p. 300). In a study exploring the motivations for posting on online self-harm support forums, Rodham et al. (2013) used the participant-defined term ‘self-harmers’ as a way to refer to the subjects of their investigation. Similarly, the participants within this thesis referred to their self-harming friends as ‘self-harmers’. Although I acknowledge the potential for this term to be considered a derogatory or stigmatising phrase, for the purposes of this thesis, those who self-harm will be referred to as self-harmers.

1.1.1. Definition

There are currently multiple terms for the act of self-harm, such as: self-mutilation, self-inflicted violence, self-injury, self-injurious behaviour, and non-suicidal self-injury. Clinically, self-harm has been identified as being an indicator of other disorders, specifically borderline personality disorder or a consequence of substance abuse (American Psychological Association [APA], 1994, 2000). In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) self-harm has been defined as ‘Non-Suicidal Self-Injury’ (NSSI), a stand-alone disorder in its own right (APA, 2013).

Under the DSM-V's classification, NSSI was conceptualised as being an intentional self-inflicted injury devoid of suicidal intent that falls outside of socially sanctioned behaviour (e.g. tattooing and piercing). The act must cause damage to the skin’s surface, such as; bleeding, bruising and pain. The injurious episodes need to have occurred on five or more days within the past year and to have been motivated by a need to: obtain relief from negative feelings, to attempt to resolve interpersonal problems, or to generate positive feelings. These acts need to have disrupted their ‘normal’ functioning (e.g. academically, professionally, and personally) and be associated with interpersonal issues (e.g. friend or family conflict), or intrapersonal issues (e.g. feeling depressed or anxious). There will also be a preoccupation with the act which seems out of their control. For NSSI to be diagnosed, the self-injurious episodes need to occur outside of
an altered state of mind (e.g. whilst not in a psychotic episode or whilst intoxicated) (APA, 2013). Although this classification is relatively new, In-Albon, Ruf and Schmidt (2013) assessed its validity, reporting that it does appear to be an appropriate clinical diagnostic tool.

The new DSM-V definition clearly demarcates self-harm from suicidal behaviour. In earlier understandings, self-harm was conceptualised as being a failed suicide attempt (Skegg, 2005). This is not without logic, it has been well established that previous self-harm is a strong predictor of later suicide (Hawton & Fagg, 1988), with some research indicating that those who present to hospital with self-inflicted injuries are up to 66 times more likely than the general public to commit suicide within the following year (Hawton, Zahl, & Weatherall, 2003). Despite this trend, research with those who self-harm has shown that for many, suicide was not the motivation, conversely it was reported that self-harm served the purpose of prolonging life (Harris, 2000). Therefore, later definitions were characterised by the act of self-harm being unmotivated by a “conscious suicidal intent” (e.g. Favazza, 1996, p. 253). Essentially, self-harm is done without the wish to die.

There are many ways by which people can engage in self-harm. The DSM-V only classifies NSSI behaviours as those which are “intentional injurious acts directed to the surface of the skin”, such as: “cutting, burning, stabbing, hitting, and excessive rubbing” (APA, 2013, p. 803). This is reflected in many community studies, with cutting, self-laceration, and injuries to the surface of the skin being the most commonly reported from of self-harm (Hawton, et al., 2002; Laye-Gindhu & Schonert-Reichl, 2005). However, the NSSI definition excludes other acts of self-harm. For example, looking at the hospital admissions for 2013 to 2014, self-laceration only accounted for 8% of 15 to 24 year olds admitted to hospital for self-inflicted injuries, compared to 89% of 14 to 24 year olds those who self-poisoned or overdosed (HSCIC, 2015). In their study, Hawton et al. (2002) focused predominantly on the motivation behind the self-harm episode, rather than the behaviour itself. Unlike the DSM-V definition, Hawton et al.’s (2002) definition included self-poisoning and overdose as long as the stated motivation was to cause harm without suicidal intent.

Furthermore, in many community studies self-poisoning or overdose is often reported as being the second most common self-harm method (e.g. Hawton et al., 2002). The predominance of self-poisoning and overdose in hospital admissions could be a consequence of self-harmers seeking help after believing it to be a more dangerous self-harm behaviour (Berger et al., 2013), and having an inadequate knowledge of the lethality of dosage (Harris & Myers, 1997, as cited in Fortune & Hawton, 2005). Unlike cutting, the injury caused by self-poisoning is not visible and not so easily controllable. This gap in knowledge may explain why more self-poisoners will
seek medical help. What this demonstrates is that the DSM-V category of NSSI fails to fully account for all self-inflicted injuries. As Kapur, Cooper, O'Connor and Hawton (2013) argue, the focus on injuries towards the skin within the DSM-V "leaves non-suicidal self-poisoning in the classificatory wilderness" (p. 326).

In excluding self-poisoning from the definition of NSSI, the DSM-V ignores the propensity for self-harmers to change their preferred method of self-harm. In their examination of accident and emergency admissions, Horrocks, Price, House and Owens (2003) found that of those who have self-cut, 57% went on to self-poison. The overlap in methods reported by self-harmers suggests that those who cut and those who self-poison are not mutually exclusive groups.

Under current clinical guidelines set out by the National Institute for Clinical Excellence (NICE) self-poisoning is included as a form of self-harm behaviour (NICE, 2004, 2011). Furthermore, self-poisoning has been identified by researchers as a self-harm behaviour (Butler & Longhitano, 2008; Evans, et al., 2005; Skegg, 2005). For example, Hawton et al. (2002) included the ingestion of prescribed substances, recreational or illegal drugs as well as substances or objects that should not normally be consumed (e.g. bleach) within their definition of self-harm. Taken together, this highlights a strong clinical and research precedence for the inclusion of overdose as a method of self-harm.

Although there is still debate surrounding the inclusion of self-poisoning within the definition of self-harm and criticism levied at the new DSM-V classification for its exclusion of poising (Kapur et al., 2013), there does appear to be agreement about certain characteristics of self-harm. Specifically, that self-harm is a self-inflicted injury, which is done without suicidal intent, and lies outside of socially sanctioned behaviour. For the purposes of this thesis, the definition of self-harm with a focus on motivation, as set out by Hawton et al. (2002) will be followed; self-poisoning and overdose will be included as forms of self-harm.

1.1.2. Population trends

The demographic profile of those who self-harm suggests that self-harm is more prevalent amongst females and young people. Although recently there has been an increase in the number of males reporting self-harm behaviours (Taylor, 2003), the bulk of research identifies self-harm as being a predominantly female-orientated behaviour (e.g. Hawton et al., 2002). The higher rates of female self-harm have been attributed to the higher propensity for females to develop mental health issues closely associated with self-harm, such as depression (Nolen-Hoeksema & Grgus, 1994). However, this female-orientated skew in reported self-harm could be a result of two other issues. First, many of the male-typical self-harm behaviours (e.g.
punching) have only recently been recognised in self-harm definitions (Laye-Gindhu & Schonert-Reichel, 2005); meaning that men who are now identified as self-harming were not previously recognised. Second, since self-harm is popularly considered as being a female-orientated behaviour, males who had self-harmed may not have felt comfortable in disclosing it (Taylor, 2003).

Although self-harm behaviours have been identified across the lifespan, young people in particular have been identified as those most prone to self-harm (HSCIC, 2015). It has been widely established that the age of onset is typically around mid-adolescence (Berger et al., 2013; Heath, Ross, Toste, Charlebois & Nedeccheva, 2009; Warm, Murray & Fox, 2002), and usually lasting until mid to late adolescence and early adulthood (HSCIC, 2015). Due to the high prevalence of self-harm between the ages of 15 to 24, and the tendency for young people to turn to friends for support (Hawton et al., 2002), it is important to consider the experiences of those who have supported a friend within this age bracket.

1.1.3. Self-harm as taboo

A key element when considering prevalence rates of self-harm is the position self-harm holds as a taboo subject within society. Self-harm has had an increased presence within the media, as well as educational and healthcare settings since the mid-1990s (Adler & Adler, 2007). Yet, it is still accepted as being a taboo subject within the general population (Adams, Rodham & Gavin, 2005). As self-harm has been popularly associated with suicide or a threat to life, it has been argued that the behaviour goes against the human instinct of self-preservation (McAllister, 2003). This in turn leads society to "hold negative attitudes, fears, myths, and repugnance [about self-harm and those who do it]", maintaining self-harm's taboo status (McAllister, 2003, p. 178).

Accompanying this taboo status is the common perception that self-harm is a form of attention seeking (Clarke & Whittaker, 1998), and is something which is done in order to manipulate others (Hadfield, Brown, Pembroke & Hayward, 2009). Many of those who do self-harm, however, report working hard to ensure the secrecy of their act, doing it in private and hiding it afterwards (Klonsky & Olino, 2008). The sense of secrecy is not only confined to the hiding of the self-harm itself, it has also been argued that those who self-harm tend to act in a more secretive fashion, with self-harm serving as a means by which to maintain physical and emotional distance (MacAniff-Zila & Kiselica, 2001). Secrecy is identified by many self-harmers as being a key element to the behaviour. An in-patient interview based study by Crouch and Wright (2004) found that self-harmers felt negatively about those who were open about their self-harm. If they believed someone to be self-harming openly they would question the
legitimacy of the self-harmer and the motivations behind it. Likewise, the conception of the ‘authentic’ self-harmer has been demonstrated within non-self-harming populations, who have been shown to conceptualise an ‘authentic’ self-harmer as someone who is motivated by distress and makes efforts to hide their injuries. In contrast, an inauthentic self-harmer was someone who self-harmed for socially manipulative reasons, such as to get attention (Scourfield, Roen & McDermott, 2008, 2011).

Whether or not self-harm serves as a method of attention-seeking has been well explored within the literature, with some researchers agreeing that self-harm serves a social function for those who do it. Nock and Prinstein (2004) argued that self-harm served two broad social functions; negative and positive social reinforcement. The terms negative and positive are conceptualised as either decreasing (negative) or increasing (positive) socialisation. Those who self-harm for a negative social function will report motivations such as wanting to avoid punishment by others (Nock, 2009). Those who self-harm for a positive social function will report being motivated to self-harm in order to gain something from those around them, such as attention or help (Nock, 2009). This proposed positive social function of self-harm as a method of communicating distress to others could go some way in explaining the stigmatising perceptions of self-harmers as attention seekers. Rather than self-harm being understood as a form of attention seeking behaviour, both medical professionals and the general public have conceptualised it as a “cry for help” (Anderson & Standen, 2007, p. 470). Moving away from the stigmatising connotations of ‘attention-seeking’, a ‘cry for help’ still implies that self-harm has a social function whereby the individual wants someone to acknowledge and respond to their feelings of distress (Klonsky, 2007; Scoliens et al., 2009).

If self-harm does serve a social function for some, its status as a taboo subject may affect how it is talked about within relationships. Those who self-harm may not wish to talk about their self-harm for fear that they would be considered to be either an inauthentic self-harmer or an attention seeker (Fortune et al., 2008).

1.2. Help-seeking behaviour

In 2005, Evans et al. explored the help-seeking behaviour of self-harmers. Firstly they identified a range of individuals that self-harmers sought help from, (friends, family, health professionals, impartial advisory services, such as telephone helplines, drop-in centres, teachers, social workers and ‘other sources’). Out of these, friends were the preferred choice, with 84.7% of self-harmers reporting preferentially seeking help from their friends. This pattern was also demonstrated in Canadian research conducted by DeLeo and Heller (2004)
who found that 80.9% of their sample identified friends as being the individuals that they favoured seeking help from.

Evans et al. (2005) compared the number of help-sources that self-harmers said they used compared to those who did not self-harm. They found that self-harmers reported a smaller number of people they felt that they could talk to. Self-harmers tended to identify only one or two ‘categories’ of people, compared to three to five identified by the non-self-harmers. Thus self-harmers have fewer outlets for support, and subsequently those who are supporting the self-harmer are likely to be providing the majority of support. The responsibility for providing support is therefore concentrated upon only one or two, with the likelihood that the friends will be the main group of people shouldering the burden of care. However, to date, although research indicates that friends are consistently identified as the preferred source of support (DeLeo & Heller, 2004; Evans et al., 2005), research that has documented the impact of self-harm on others has focussed predominantly upon health professionals and family members.

1.3. The “ripple effect”

Byrne et al. (2008, p. 495) argued that self-harm has a “ripple effect” through relationships, whereby the impact of self-harm is extensive and encompasses those around the self-harmer. Although Byrne’s research focussed upon the parents and carers of young people who self-harm, it is clear that others are affected by the actions of self-harmers. Two main populations have been studied: health professionals and parents.

1.3.1. Health professionals

The wealth of research looking at the beliefs and attitudes towards self-harm within the health profession indicates a generally negatively held attitude. For example, Hopkins (2002) conducted an ethnographic study whilst she worked voluntarily on a mental health ward. Over her time on the ward she reported that patients were objectified by staff, often being referred to as “stuff” (p. 150) and were talked about as a “blockage in the system” (p. 150). The extra care nurses believed self-harmers to need meant they thought care was getting taken away from the “really ill, poorly people” the people who had a “legitimate” need for care such as those with Alzheimers (p. 151). After spending further time on the ward she also became more aware of how nursing staff attitudes would change over time. As self-harming patients started to have repeat admissions, she noticed that attitudes towards the patients began to deteriorate with nurses reporting feeling frustrated and irritated. In some instances she reported how the care provided to the self-harming patients began to worsen as a result. The poor quality of care has been well documented within the health profession; with reports from medical professionals
indicating that colleagues would make pejorative comments about self-harming patients, such as “why didn’t he do it right this time and save us a lot of trouble” (McCann, Clark, McConnachie & Harvey, 2007, p. 1708). The lack of appropriate care has also been found in the physical treatment of self-harming patients, such as the withholding of anaesthetic whilst patients were being stitched (Jeffrey & Warm, 2002).

The lack of appropriate care provision for self-harming patients has also been reiterated in the accounts of self-harmers who have required medical assistance. Harris (2000) interviewed women who had been treated in accident and emergency wards as a result of their self-harm and found that all of them felt they had been treated inappropriately and insensitively by medical staff. There were instances where they had been told off in front of other patients or had received poorly executed treatment, designed to further humiliate them, such as being given injections in the buttocks.

It has been suggested that the humiliating or insensitive treatment of self-harming patients is a strategy adopted by health professionals who believe it to be an effective method to deter future episodes of self-harm (Hadfield et al., 2009; Law, Rostill-Brookes & Goodman, 2009). The belief in the ‘be cruel to be kind’ approach arguably stems from the interpretation of self-harm as an attention-seeking (Clarke & Whittaker, 1998; Sidley & Renton, 1996; Smith, 2002), and manipulative behaviour (Law et al., 2009). As a result of the association between self-harm and attention-seeking, medical professionals have reported that they often feel the treatment that they provide is futile; not only will the self-harmers repeat the behaviour, but their care perpetuates and endorses the self-harmers need for attention (Hadfield et al., 2009).

Alternatively, the cruel or cold treatment of self-harmers by some medical professionals has also been understood as a self-protective mechanism used to distance themselves from the self-harmer, and protect their own wellbeing (Wilstrand et al., 2007). Indeed, Hadfield et al. (2009) noted that health professions felt that, particularly with repeated self-harmers, their care was meaningless, they were powerless, and caused them to feel “disillusioned” with the care they provided (p. 760). Thus, in distancing themselves from the self-harmer, they were able to protect themselves from feeling powerless, and we able to maintain their “sanity” (Hadfield et al., 2009, p. 761).

In summary, those who provide formal care to self-harmers experience a considerable amount of personal distress. Not only are health professionals responsible for providing effective yet sensitive care, they are also expected to do so whilst maintaining a professional distance (Wilstrand et al., 2007). In order to maintain this distance many health professionals have reported treating self-harmers callously, particularly when interacting with them as well as
when administering treatment (Hopkins, 2002). It has been argued that this poor treatment is in response to feelings of powerlessness in failing to deter of future behaviours (Hadfield et al., 2009). As Hopkins (2002) stated, caring professionally for self-harmers is "submerged under the heavy burden of responsibility" (p. 151).

1.3.2. Parents

It is widely recognised that providing care to a child, parent, spouse or sibling can have a range of negative effects, including monetary and job stability (Raphael, Clarke & Kumar, 2006), mental and physical well-being (Sawatzky & Fowler-Kerry, 2003), and relationship quality (McDonald, O’Brien & Jackson, 2007). For example, a study looking at the parents of young self-harmers found that 86% of parents interviewed met the criteria for minor psychological distress (Morgan et al., 2013). Family members, and in particular the parents of self-harmers are a vulnerable group. They not only have the responsibility to care for their children, but also other children and spouses as well as juggling work commitments.

The general consensus within the literature on parents of self-harmers is that they are negatively affected. They are affected not only personally (e.g. feeling distressed) but also other relationships they hold can deteriorate or become strained. Commonly parents of self-harmers report feelings of anger, guilt, and grief (Raphael et al., 2006). McDonald et al. (2007) conducted seven interviews with the parents of self-harming children and found that participants initially reported feelings of guilt and shame. Guilt over feeling that they had failed their children for not noticing the signs of their child’s self-harm, and shame from the fear and embarrassment of how others would judge them. The fear and embarrassment experienced by the parents was not solely related to the stigma attached to their child’s behaviour, but was also linked to the notion that the self-harm of their child meant that they were inadequate parents. The fear and embarrassment often left the parents feeling unable to talk to anyone which lead to their social isolation, a risk-factor in itself for further emotional distress. The sense of fear was also directed towards the self-harming child, with many parents reporting fearing the potential for future self-injurious episodes (Raphael et al., 2006). Similarly, a parent in Oldershaw Richards, Simic, and Schmidt’s (2008) study stated they felt that they were “walking on egg shells” (p. 142), and began to question their parenting style.

Other researchers found that parents would manage fear for future self-harm episodes by increasing their surveillance of the self-harming child (Byrne et al., 2008). For example, the parents in McDonald et al.’s (2007) study reported increasing their supervision of their self-harming child by removing the privacy they normally afforded their child. The parents began to listen in to conversations or read their children’s diaries; essentially changing their routine
in order to observe their child’s behaviour as much as possible. As a result of these actions, the trust previously held between the parents and children began to break down, causing many relationships between parent and self-harming child to deteriorate (McDonald et al., 2007).

Many parents of self-harmers recognised that they prioritised the self-harming child above that of their other children, normally a result of hyper-vigilance over the self-harming child (McDonald et al., 2007). Some parents further talked about prioritising the self-harming child over other children as a further sign of their failure as parents (Oldershaw et al., 2008; Rissanen, Kylmä & Laukkanen, 2008). This impacted on relationships with their spouses. A parent in Raphael et al.’s (2006) study talked about their marital problems being fuelled by disagreements about how to manage medication in the home in a hope to deter potential self-harm episodes. Other parents reported that marriages had broken down as a result of adjusting to having a child who self-harmed (Sawatzky & Fowler-Kerry, 2003). This also had a wider impact in their lives. McDonald et al. (2007) interviewed parents of self-harmers and found that not only did their relationships with their children deteriorate, their involvement with their work also changed. Due to the focus of their attention being on the self-harming child, other areas of their life, such as work became less important; some parents even resigned from their jobs in order to care for their self-harming child (Raphael et al., 2006). Not only does resigning have financial implications, it reduces the social network of the parents, as well as the potential number of sources of support (Sawatzky & Fowler-Kerry, 2003).

In summary, the parental carers of those who self-harm are exposed to quite a serious amount of stress, emotional upheaval, and family conflict. Furthermore, due to the perception of stigma surrounding self-harm and the questioning of their own parenting ability, parents commonly cope with these experiences and emotions in isolation and without much social support (McDonald et al., 2007). As Byrne et al. (2008, p. 499) states: “Their child’s self-harming behaviour became the focal point of family life” and the shift to being caregiver to their self-harming child overrode all “other roles or relationships”. Essentially, self-harm within the family alters the functioning and the emotional well-being of all those within it.

1.3.3. What is missing from the research literature?

Whilst the self-harm literature has focussed predominantly on the experiences of health professionals (e.g. Hadfield et al., 2009) or parents (e.g. McDonald et al., 2007), it has been demonstrated that young people who self-harm preferentially seek support from their friends (e.g. Hawton et al., 2005). It is therefore likely that the friends of self-harmers play a pivotal role in the lives of those who self-harm, yet, to date very few studies have examined the friends’ experiences. The next section will outline what has been established about the friends of self-
harmers, and will demonstrate why the experiences of this population need to better understood.

### 1.4. Friends and self-harm

Within the self-harm literature friends have remained a relatively under-researched population. Despite this, it is clear that friends hold a unique position. Self-harm research that has considered friends has focussed on three key areas: friends as ‘triggers’ to self-harm episodes, friends’ therapeutic function, and friends’ potential for developing future self-harm behaviour. Yet, little research has explored the friend’s experiences of knowing and supporting a self-harmer.

#### 1.4.1. Triggers

Friends are most commonly talked about is as being ‘triggers’ to self-harm episodes. It has been found that those who self-harm will often report friend or peer conflict as a motivating factor to a self-harm episode (McMahon et al., 2010). To illustrate, Hawton, Fagg, Simkin, Bale and Bond (2000) conducted a monitoring study on self-harmers under the age of 20 who had required medical help. They found that 25.3% of the self-harmers identified friends as being a precipitating factor to a self-harm episode. Further, Hawton, Rodham, Evans and Harriss (2009) who conducted a community questionnaire study, found that 15.4% of those who had gone to hospital after a self-harm episode had reported friendship conflict as a triggering factor.

#### 1.4.2. Therapeutic value

The significant role that friends have in the lives of those who self-harm is demonstrated in the help-seeking behaviour of self-harmers. As discussed earlier, those who self-harm will seek help from friends, with some studies reporting over 80 per cent of self-harmers doing so (Evans et al., 2005). The help-seeking preferences of self-harmers demonstrate the unique position that the friends have; it appears that friends hold unrivalled experiential knowledge and insight into the lives of the self-harmers.

Due to their unique position in relation to the self-harmer, the friends have routinely been identified by researchers and clinicians as “gatekeepers” to distressed young people as they act as a “natural support system” (Klingman & Hochdorf, 1993, p. 123). As a consequence they have been included in the care provided to those who self-harm. Muehlenkamp, Walsh, and McDade (2010) developed a ‘Signs of Self-Injury’ programme, (developed from the ‘Signs of Suicide’ programme); this aimed to raise awareness about self-harm with high-school aged
children. The programme was comprised of sections aiming to educate the students about what self-harm was, including increasing awareness of the signs of self-harm, and training in how to react to it. It was hoped that as a result, those involved would feel more comfortable in knowing how to manage self-harmers who sought help from them. Overall the programme seemed to be effective as participants scored higher on scales assessing helping behaviour. Similar research has also been conducted by Klingman and Hochdorf (1993) for suicide and related behaviours, who found that the adolescents involved felt more knowledgeable, and reported feeling more comfortable talking about suicidal and related behaviours.

There have also been efforts to create information for the friends of self-harmers in the form of online guides or leaflets. They tend to include information about: what self-harm is, why people do it, and who is more likely to do it. Often a ‘dos and don’ts’ style guide for how best to support the self-harming friend in included (e.g. Harmless, 2008). Minimal attention is paid to the wellbeing of the friend providing support. Although these are helpful guides to knowing how to best support a friend who is self-harming, there is little provision for the friend themselves. There is an absence of information about experiences or feelings that they, as friends to self-harmers, may be going through. Furthermore, all of the therapeutic interventions that the friends are involved in are for the benefit, support and safeguarding of the self-harmers, very little attention is paid to the friends. The lack of consideration of the friends in the development of support tools is worrying considering that they are themselves a group at risk of developing self-harm behaviours (Hawton et al., 2002).

1.4.3. Predictor of own self-harm

Having a friend who self-harms is both a short and long term predictor of later self-harm behaviour (Berger et al., 2013; DeLeo & Heller, 2004). For example, in a cross-sectional questionnaire study, Hawton et al. (2002) found that nearly 50% of those who had self-harmed in the previous year had recently had a friend who was a self-harmer. In a cohort study Mars et al. (2014) found that nearly 80% of 16 year olds who had self-harmed had a friend who was a self-harmer. Further, Prinstein et al. (2010) conducted two studies on a community-based population as well as an inpatient population, and found that self-harm in friends was a long-term predictor for personal self-injury for the females in their sample. The lack of males reporting a socialized aspect to their self-harm could be a consequence of the under-reporting of self-harm common with males (Taylor, 2003). A similar gender difference was found in a study conducted on Irish adolescents, McMahon et al. (2010) who found that knowing a friend was one of the key factors influential in those with a lifetime history of self-harm, second only to low self-esteem for girls, and third to anxiety and impulsivity for boys. This has also been
described as a ‘contagion effect’, whereby self-harm is transmitted around friendship groups who interpret it as being either an appropriate coping mechanism, or effective in gaining some social outcome (De Leo & Heller, 2004; Heilbron & Prinstein, 2008; Prinstein et al., 2010). Thus, although it is evident that the friends are an at-risk population, their experiences are widely ignored until they themselves go on to self-harm.

1.4.4. The ancillary population

It is evident that friends of self-harmers hold a unique position, though this is one that has remained widely unconsidered. As previously noted, the friends of self-harmers tend to be considered only when they provide some insight into the lives, beliefs, or behaviours of self-harmers. If we are to imagine the “ripple effect” as argued by Byrne et al. (2008, p. 495) as a series of concentric circles with self-harmers as the central point; with each successive circle the ripple slightly changes. The friends of self-harmers would be one of these circles, with family members, and health professionals in others. Although all part of the same ripple, and coming from the same central point, the experiences of the friends and the impact upon them will be qualitatively different to that of family members or health professionals.

All of this research is unified by the categorisation of friends as being an ancillary population to those who self-harm, the friends’ experiences and understandings are only made meaningful when they provide information about the self-harmer. Although it has been well documented that friends are responsible for a surprising amount of support (e.g. Evans et al., 2005), and are a potential at-risk population for developing self-harm (e.g. Hawton et al., 2002), friends still remain a relatively under researched population. Currently, an insight into the experiences of friends of self-harmers and how they begin to understand these experiences is lacking. In order to better support and safeguard the friends of self-harmers, an understanding of what problems they face and how they come to understand these problems is needed.

1.5. Friends: Where have they been considered?

Although the experiences of friends remains a relatively under-researched area within the self-harm literature, friends’ experiences have been the focus of research in other literatures. Chiefly, how friends make sense of death by suicide, and how friends make sense of supporting those with HIV/AIDS, those who have been sexually assaulted, victims of domestic violence, and those with suicidal thoughts.
1.5.1. Friends and death by suicide

Friends bereaved through death by suicide are actively engaged in a sense-making process. For example, in their study of family, friends, and higher education staff who knew a young person who died through suicide at University, Bell, Stanley, Mallon and Manthorpe (2012) found that often those bereaved through suicide would blame themselves for the young person’s death. In trying to make sense of the death, they would try to understand why the young person had committed suicide. Consequently, many explored their role in the death; whether they were responsible, or could have done anything to prevent it. This process of evaluation has been further explored by Mallon and Stanley (2015) who explored the retrospective experiences of 12 people who had experienced the suicide death of a friend at University. They found that people would engage in their own “personal inquest” (Mallon & Stanley, 2015, p. 3). Meaning that, as they were making sense of their friends’ deaths, the participants would explore alternative explanations, such as the influence of alcohol, before concluding that suicide was the cause of death. What this research demonstrated is that, before accepting death by suicide (as classified by a coroner), the friends actively engaged in a complex process of trying to make sense of their friends’ death.

Similarly, Bartik, Maple, Edwards, and Kiernan (2013) interviewed ten people who had all experienced the suicide death of a friend and found that participants struggled to understand their friend’s death, and searched for a meaning in their friends’ actions. They found that the participants began to question their friendships, this was particularly evident when they queried why their friends had not asked for help. The participants also felt guilty; guilty for not being more involved, for not realising their friend was feeling suicidal, and for not knowing how to appropriately communicate their experiences. Furthermore, Bartik et al. (2013) also found that the participants felt uncomfortable in identifying themselves as bereaved when others had held closer relationships with the index person.

Taken together, this research highlights the importance of exploring the experiences of friends. Within the research it was clear that young people were affected by the death by suicide of a friend, and they were engaged in psychological processes to help them understand their friends’ actions, and the role that they played in their friend’s death. Indeed, the need to understand the experiences of the friends to a greater extent is highlighted by the high incidence of subsequent depression (Bridge, Day, Richardson, Birmaher, & Brent, 2003) and potential suicidal thinking or suicide attempt (Feigelman & Gorman, 2008) identified in friends bereaved through suicide. Whilst this research has demonstrated the importance of exploring the experiences of the friends, it is focussed predominantly on the specific experience of
bereavement in the context of a completed suicide. Although there may have been support provided prior to the death of their friend, the participants in these studies were focussed on exploring what the death of their friend meant to them, and how they came to understand that experience. As such, the next section focusses on the literature available concerning supportive friends.

1.5.2. Supportive friends

When friends as support providers have been studied, they have been identified as the "forgotten sufferer(s)" (Hill, Shepherd & Hardy, 1998, p. 616). Since there is minimal research focussing on the friends of self-harmers, literature relating to other supportive friendship research (e.g. HIV/AIDS, sexual assault, domestic violence, and suicide literature) was searched. Three broad issues were identified as being important to those who provide support to a friend; feelings of powerlessness, changes in relationships, and support seeking.

A key issue highlighted within the friendship-based support literature is that supportive friends have a sense of powerlessness. In their mixed methods study looking at the impact of sexual assault disclosure on friends, Ahrens and Campbell (2000) found that the participants felt helpless, and unable to fully support their friend. Around 68% of the 60 undergraduates interviewed felt uncertain that the support they provided was at all beneficial. This finding has been reiterated across the literature in a variety of different contexts, particularly within domestic violence literature (Weisz, Tolman, Callahan, Saunders & Black, 2007) and sexual assault literature (Banyard, Moynihan, Walsh, Cohn & Ward, 2010). What this research highlights is that friends struggle to cope with not only supporting a friend, but also knowing how to support a friend.

In not knowing how best to support someone, or by struggling to cope with the support they are providing, the friends described how their relationship changed from friend to carer. For example, Bor, du Plessis and Russell (2004) conducted qualitative interviews with those who had been diagnosed with HIV and their "self-identified family", including friends. From the accounts collected, it was clear that upon HIV being disclosed, the self-identified family took on the responsibilities of being a carer. The ability for individuals to cope with this role change differed. For some this change happened with little disruption, for others this meant that the friendship became strained as they took on too much responsibility. In contrast, some friends distanced themselves and the friendship deteriorated as a result.

Similarly, in their questionnaire-based study, Hill et al. (1998) found that participants supporting an individual with bipolar disorder were likely to report having difficulty in
negotiating the change in their relationships. The participants highlighted that caring was not simply an activity, or change in shared activities, but rather it changed their whole way of being with that person. This change was reported as not being a natural progression, and instead required a restructuring of their relationship into which they had to integrate caring. For some this was considered to be a positive step that brought them closer together, developed their caregiving skills, and made them feel useful. Others, however, found their new role to be burdensome.

Further, friends who provided support for a friend also reported contrasting changes in their relationships with other friends and family. For example, Bor et al. (2004) found that those who disclosed to others that they were providing support to a friend in turn felt more supported by those around them. Others, however, found that supporting their friend made them angry and distrustful of others. To illustrate, in their study Branch and Richards (2013) looked at the perceptions of people whose friends had been sexually assaulted. They found that friends of sexual assault victims were more likely to feel angry or distrustful of society, and that it had changed their “worldview” (p. 665), others reported feeling isolated. Similarly, Malone (2007) found that female adolescent friends of someone who had committed suicide reported feeling distanced and isolated from other peers; thereby decreasing their own opportunities for support.

Indeed, support, and who to seek support from was regularly raised by the friends as being an issue. For instance, support within the friendship was most commonly constructed as unidirectional. As demonstrated in Bor et al.’s (2004) study, friends often refused to seek help from their friend because they felt more comfortable giving than receiving support, and that their friend needed more support than they did. Alongside this, supportive friends were unwilling to seek help for themselves as they were not convinced it would be beneficial (Bor et al., 2004). Of those who did seek support, however, 75% reported feeling better able to cope with providing support to their friend (Bor et al., 2004). A key barrier to help-seeking identified by friends was feeling comfortable with the issue itself. In their study, Dunham (2004) found that American undergraduates were less likely to seek external support after finding out a peer was feeling suicidal if they had personal experience with suicidal thoughts, or had supported someone who had suicidal thoughts previously. Thus those who are potentially more vulnerable to suicidality may be more inclined to support in isolation.

In summary, the research that has focussed on how people make sense of providing support to a friend suggests that people experience considerable problems. Notably there appears to be a change in the relationships held with the index person, and other friends and family. However,
much of this research fails to adequately distinguish between friends and family, and is overwhelmingly focussed on older people. Consequently, little attention is paid to how young people make sense of supporting a friend. As self-harm is predominately a youth issue (HSCIC, 2015) more attention needs to be paid to how young people come to terms with providing support that exceeds the expectations of their place within that relationship.

1.6. Summary

Throughout this chapter it has been argued that friends of self-harmers are a currently under-researched group. Furthermore, it is argued that there is a need to understand this group in more depth. When taking into consideration the amount of care they may be providing (Evans et al., 2005) alongside their high risk status in developing self-harm themselves (Hawton et al., 2002), the friends of self-harmers appear to be a uniquely placed yet highly vulnerable population. Through placing the friends as the subjects of investigation, an understanding of their experiences of supporting a self-harmer, and the impact this has had upon their friendship can be developed.

In order to provide an insight into how young people make sense of providing support, the next chapter will consider the young carer literature. This next chapter will provide an understanding of how young people come to understand, and make sense of their experiences of providing support outside of the remits of their relationship.
Chapter Two

Young people: Friendship, support, and the relational being

In Chapter One I provided an overview of the literature on self-harm, and highlighted the “ripple effect” it has throughout relationships. I have shown that friends of self-harmers have been largely ignored unless they provided information about the self-harmer, or if they themselves went on to self-harm. As a consequence, there is a need to better understand the experiences of the friends of self-harmers, and how they come to make sense of supporting a self-harmer.

In order to address the absence of the friends of self-harmers from the research literature, and to explore the experiences of the friends, it is necessary to establish what is known about friendship, caregiving, and support. In this chapter I provide an overview of how friendship can be understood as a socially situated relationship within which individuals orientate themselves. I also review understandings of how young people make sense of providing support.

2.1 Friendship

Friendships have been described as being a relationship everyone experiences at some point within their life (Adams & Allan, 1998). It is a particularly important relationship for young people who use friendships for a range of functions, one being the provision and receipt of support (Buote et al., 2007). Indeed, it has been demonstrated that young people begin to shift much of their support needs away from the family towards friends (Frey & Röthlisberger, 1996). Given the importance of friendship to young people, it has been studied from a number of approaches.

2.1.1. Operationalization of friendship

Conceptualizations of friendship in social science research vary depending upon the field of enquiry. For example, developmental psychology, sociology, anthropology, critical gender studies, and research on delinquency and risk-taking all define friendship differently. These definitions range from a developmental milestone (e.g. Fehr, 2000), to a relationship that influences psychological wellbeing (e.g. Sakyi, Surkan, Fombonne, Chollet, & Melchoir, 2014), to a relationship that acts as a place to do social practices, such as gender (e.g. Hey, 1997).
In spite of the range of definitions, Digester (2013) argues that conceptualisations of friendships are based on a few key underpinning characteristics. Firstly, friendships are based on mutuality and affection (Cockling & Kennett, 1998). They are created out of choice, and are characterised by equality and reciprocacy (Allan, 1998). Although some researchers have suggested overlap between friendship and other relationships (e.g. family, or partners) (Allan, 2008), young people consider these types of relationships to be distinct, and qualitatively different to relationships to that held with a partner, or family member (Pahl & Pevalin, 2005).

Friendships are often organised and formed into hierarchies, with “best friends” being placed at the top indicating superiority and “exclusivity” (Branje, Frijns, Finkenaue, Engels & Meeus, 2007, p. 588). Usually, these closer friendships are identified by the sharing of secrets, and increased self-disclosure (Fehr, 2000). Consequently, friends mention trust and loyalty as being important qualities in their friendships (Azmitia, Ittel & Radmacher, 2005). Further, friendships also include expectations of emotional care-giving and receiving, and unlike family relationships, it has been noted that care within a friendship is often given voluntarily and without expectation or reciprocation (Bowlby, 2011).

Although these conceptualisations provide a general overview of what distinguishes a friend, they pay little attention to how people use friendships as a social relationship within which they come to understand themselves and others. Counter to this, Digester (2013) has argued that friendships are not inert relationships that exist between people, rather they are active social structures which help people construct their sense of identity. In other words; people “do friendships” (Green, 1998, p. 179). This means that individuals are active in the construction of their relationships and themselves within that relationship (Green & Singleton, 2009). For example, Digester (2013) argued that friendships are fluid, are influenced by the social world, and as such are culturally bound relationships.

"Friendship is composed of a set of social practices in which certain norms and expectations govern not only the actions, but also the motivations of the friends" (Digester, 2013, p. 35).

Here, it is argued that within the friendship, expectations of behaviour are negotiated. Digester (2013) uses the ideas of Oakeshott (1975) to understand friendship as a practice, as a relationship that is done, rather than a relationship that just exists. Thus, friendship expectations are created between the friends, and are influenced by prior understandings of friendship drawn from experience and society (Digester, 2013). Much research has looked at friendship as being a place for the (re)production of wider social understandings, particularly gender (e.g. Green, 1998). For example, Hey (1997) conducted ethnographic research with
girls from two inner city schools in the 1980s. She argued that adolescent female friendships were used for the (re)production of power, meaning that norms and ways of understandings were inculcated into young female’s lives through the development of group norms. It is through these relationships, she argued, that individuals came to embody norms of behaviour and in so doing these powerful discourses were reproduced and bound young people to ways of being within a social world. She further argued that friends acted as a form of social regulation to each other’s behaviour, acting as the “projected judges of each other” (p. 63). Within this practice, individuals also use social relationships, such as friendships, to explore and develop their own identity within these wider social understandings (Green, 1998; Green & Singleton, 2009). Although the focus of this research has largely been on class and gender, what this does demonstrate is that friendship, considered from a social constructionist perspective, is used as a place for reproducing social constructs and developing an identity within wider social frameworks.

What is less clear, however, is how to do these friendships. Digester (2013) notes that there are expected patterns of behaviour (such as providing support), yet, there are no “formalised ways of being a friend” (p. 38); such as how to provide that support, or what support should be. If there is no formalised way of knowing how to be a friend, then individuals must draw on wider understandings to help make sense of their experiences.

As the literature that has considered supportive friends either included family members, or was focussed on adult friendships, little is known about how young people provide support to friends. One such body of literature that does consider the experiences of young people providing support is that of young carer literature. Since this literature is focussed on a different social context, that of family, some of the experiences, and sense-making of the young carers may differ to that of friends. To illustrate, in integrating care into a parent-child relationship there are transgressions in social expectations of care provision between parent and child that are not present in friendship. Whilst this literature is focussed on a different social context, the young carer literature is well situated to provide an insight into how young people come to understand providing support. This literature is particularly useful as it focusses on young people whose support provision typically exceeds the expectations of the position they hold within the family. The next section provides an overview of the young carer literature, focussing on how young carers begin to construct their own identity.

2.2. Young Carers

How young people come to constitute their identity as a young carer is the predominant focus of this section. In order to explore how young people come to understand themselves and their
experiences through relationships and wider social constructions, I focus on how young people come to acquire the identity of carer, how they consolidate the dual roles of young person and carer, and how they use these two roles in order to build their sense of identity.

Before exploring this, however, a definition of what a young carer is needs to be established. The Edinburgh Young Carers’ Project (EYCP) (2015) defined young carers as someone aged between 5 to 20 years old who provides care to someone in their home. They may be helping their family cope with mental health problems, disability, chronic conditions, or alcohol or drugs misuse. Further, they may be struggling emotionally and physically to cope with the demands of being a carer in terms of their wellbeing, their social engagement, their educational attainment, and their financial stability.

2.2.1. Identifying as a carer

In exploring the experiences of young carers, researchers focussed on how the young carers came to understand their new place within the family. Often this has been identified as “parentification” (Boszormenyi-Nagy & Spark, 1984; Earley & Cushway, 2002), wherein the child takes on the role of the parent. Although this interpretation has been heavily criticised, particularly by Keith and Morris (1999), for over being overly focussed on the roles, rather than the responsibilities of young carers, it suggests that young carers move outside of their position as child and take on the responsibilities and characteristics of parents (Thomas, et al., 2003). Indeed, Aldridge (2006) conducted interviews with young carers, their parents, and support providers and found that although there was an element of “role adaptation” (p. 82) by the children, particularly at times where the parent was incapacitated, there was little evidence to suggest that the parents, support workers, or the young carers considered this to be indicative of a loss of parent-child relationship. What this does highlight, however, is that young carers do take on responsibilities that exceed what is expected of them as a child, as such, they have to try to understand their new position within the family.

How young people come to understand their role as carer varies. Some researchers found that the participants were unable to identify when they had become a carer (Bolas, Wersch, & Flynn, 2007). Others showed that young carers did not identify themselves as such due to the perceived everyday nature of their activities (Van Parys, Bonnewyn, Hooge, De Mol, & Robber, 2014). Indeed, in focus groups conducted with young carers, policy makers, and service providers, Smyth, Blaxland, and Cass (2011) argued that many young carers were unaware of their status due to caring being “embedded within a normative framework of familial obligations and responsibilities” (p. 149). This means that young carers often failed to identify themselves as such because their frame of reference was only their family setting.
Other researchers have explored how young carers came to understand how they acquired their new role. Hughes, Locock, and Ziebland (2013) conducted 40 interviews with carers of someone with Multiple Sclerosis (MS). They identified four key ways in which the carers came to understand their new role. Some participants discussed the new role as being “concordant” (p. 81) with their other role identities. Thus, the new role was in-keeping with their other roles with that person, such as child. Other participants talked about feeling tensions between their already existing roles and their new role. For some, they felt that this was a role they had to take on, as the MS sufferer needed a carer. There was little happiness in taking on this role and the acknowledgment that it often meant they were exhausted, or needed a carer themselves. The role was taken on out of obligation, or circumstance. Others felt their role as carer had “fluidity” (p. 82), and that rather than being either a child or a carer, for example, they were able to spend time in both roles and move between them when necessary. Some participants completely rejected the identity of carer. Instead, they considered their behaviour to be aligned with their pre-existing role, put simply; their new caregiving activities did not challenge their pre-existing roles. What is consistent across all of the accounts was how the participants used an understanding of what being a carer was, as a frame of reference which they used to help identify themselves.

How people have come to understand their position as carer has been considered elsewhere, with particular focus on those who are more resistant to the role. Researchers such as Watson and Fox (2014) found that young carers appeared to struggle more when they felt that they had been forced into caring for the family member, usually because others were unwilling to take on the responsibility. Similarly, Van Parys et al. (2014a) found that often those who were resistant to the role often took it on out of “a sense of moral obligation or to feelings of guilt” (p. 8).

This body of research suggests that how young carers acquire their status differs for each person. It appears that the relationship held with the person requiring care prior to taking on responsibilities, and how much control they felt they had over taking on the new role is important to how young carers make sense of their transition. More broadly, this research demonstrates that how people adopt social roles is fluid and changeable, and that they are active in the taking up of social positions. This reflects much of the work into positioning theory, whereby individuals use social roles which both ascribe and inhibit social behaviours, and understandings (Harré & van Langenhove, 2008). These social roles come with a set of linguistic patterns, or ways of speaking, that people use to make sense of their position within relationships (Davies & Harré, 1990). How people come to acquire these roles and take up these linguistic repertoires, Drewery (2005) argues, changes. In particular she argues that
people respond to “position calls” (p. 314), or opportunities to take up social roles. She proposed that people interact with how they take up their position, and that either they can accept, reject, or change it. Similar patterns can be seen in how young carers describe their role acquisition, some willingly took on the role, whereas others felt forced into it because of a sense of obligation (e.g. Van Parys, et al., 2014a). What this suggests is that taking on caring responsibilities is a difficult process to navigate, and one which draws on feelings of control and obligation. Once in the role, the young carers then have to make sense of their experiences through the lenses of both carer, and young person.

2.2.2. Navigating roles: The young person versus the carer

As young carers occupy the social space of both a carer and a young person they have the potential to draw from multiple constructs and linguistic repertoires in order to make sense of their experiences. In understanding their new role within the family, it has been argued that young carers use social understandings of what a carer is, and what a young person is, as tools to understand their experiences and status within the family and society generally (Bolas et al., 2007). It is within these two, arguably disparate, roles that the young carers begin to make sense of their experiences and consolidate challenges that arose.

In discussing their “status” as young carers, it was evident that the young carers drew on socially constructed understandings of what a carer is. Largely, it seemed that what constituted being a carer was based on gender, and unselfish support. In terms of gender, in their meta-synthesis of young carer literature, Rose and Cohen (2010) found that generally the elder female child was called upon to provide support. In their study Smyth et al. (2011) found that often males would not identify themselves as a carer, and would identify their female counterparts as being the most appropriate person. Further, they argued that males would only take on the role out of necessity, and if there was a lack of an appropriate female. The reluctance for males to identify themselves as a carer was considered to be a reflection of transgressions of expectations of masculinity (Smyth et al., 2011). Bolas et al. (2007) expanded on this stating that males may reject an identity of carer because in accepting it, their “identity, and masculinity, is under threat” from being identified as a “member of a low status group” (p. 837). Thus, for these male caregivers, the researchers felt there was a conflict between a gendered, masculine identity and a caring one. This was not consistent across all research, Earley, Cushway, and Cassidy (2002) found that some males reported being positively appraised by female friends because of their caring role, and there was little conflict between their conceptions of masculinity and care. What this may highlight is that constructions of
caregiving are a threat to a masculine identity, only when the male carers were around other non-carer males.

Turning to unselfish support, young carers talked about the all-encompassing nature of being a carer. In their interview-based study of adults looking back on their time as a young carer for a depressed parent, Van Parys et al. (2014a) found that their participants reported feeling constricted by the care they provided, with one participant stating “once I stepped into [a caring role], there was no way back” (p. 8). Indeed, the participants felt unable to fully reflect, make time for themselves, and step back from caring until they left home. This was reflected in their experiences of sharing their feelings within the family. Often young carers reported feeling uncomfortable in discussing the impact of caring with other family members, and would weigh up whether relieving the burden of talking was worth the impact it would have on those they cared for.

This research suggests that there are certain expectations surrounding what a carer is, and what this means for the young carer. In particular, it seems that young people construct, or consider, the carer as being someone whose responsibilities are stereotypically female, and all encompassing. In (re)producing these constructs, young carers were drawing on them as a form of comparison in order to make sense of their own experiences. Doing so allows them to come to terms with the extra support they provide to family members (Van Parys et al., 2014a). However, they also have other social constructions through which they can come to understand their experiences, and identify themselves within. Predominantly, the young carers drew on constructions of ‘youth’.

Unlike the carer identity which was used to help make sense of some of their experiences, the concept of youth was used as a marker for difference. For instance, the young carers felt like they were different because they were not able to socialise in the same way as other children could (Thomas et al., 2003) and had been “deprived” of part of their childhood (Heyman & Heyman, 2013, p. 569). Additionally, the young carers described peers as being “trivial and immature”, were more likely to engage in risky behaviours, and were less “competent” (Watson & Fox, 2014, p. 30). Thus, Watson and Fox (2014) argue, young carers were using pejorative constructions of peers in order to construct themselves as being “extraordinary” (p. 30), or “exceptional” (Smyth et al., 2011, p. 151), in order to generate meaning and see benefit in their experiences.

In having multiple, and sometimes competing, frameworks within which they could make sense of their experiences, the young carers seem to vacillate between the role/identity of carer, and that of young person. Watson and Fox (2014) argued that the young carers would
move between the two constructions when either favoured their point. For example, the authors argued that in constructing themselves as being “just a kid”, and highlighting their young age (p. 30), the participants were able to communicate the struggles they faced and their perceived lack of support. Further, Watson and Fox argued that by drawing on constructions of childhood, the young carers also gave themselves the “option to ‘opt out’ of caring” (p. 31). Thus by predominantly constructing themselves as “kids”, they could legitimately decrease the level of care they provided.

However, young carers would also draw on the identity of carer when it was appropriate. For instance, in their study Hughes et al. (2013), found that carers were more likely to identify themselves as such when they were talking with either those in positions of authority, or those who could not understand what they did. Further, it has also been suggested that young carers work within multiple constructs. Van Parys et al. (2014a) found that often young carers felt that one role allowed them to come to terms with their experiences more than the other. In their study they gave an example of a woman looking back on her experience of supporting her mother who had had depression. They stated that “Taking a caregiver position created distance from the painful emotions they would feel in a daughter position” (p. 10). Thus, the role of carer acted as a buffer, or an acceptable frame of reference within which young carers can find understanding.

This demonstrates that young carers drew on multiple constructs of identity in order to make sense of their experiences and themselves. In particular they focussed on constructs of youth in order to denote themselves as being different to others their age, as well as using it as a way to ‘opt out’ of caring. In drawing on constructs of care, however, the young carers came to cope with taking on the extra responsibilities they adopted, and made sense of their new role within the family. Thus, the competing constructs of youth and carer served different purposes, and were used for different audiences. In a broader sense this highlights that how people, particularly those that provide support, come to make sense of their experiences is not straightforward, and demonstrates that people will attempt to consolidate and renegotiate their sense of self within multiple, and sometimes disparate roles. As young carers took on and attempted to consolidate their roles it was also evident that they were active in the reimagining, or reconstructing of the role of carer.

**2.2.3. Reimagining the role**

Much of the research, and policy focussing on young carers has conceptualised them as being a vulnerable group whose educational, financial, and emotional wellbeing are in jeopardy (EYCP, 2015). However, across the research literature it was evident that young carers also
offered a counter-construction of the impact of being a young carer. Thus demonstrating that people are actively aware of the social constructions within which they come to understand themselves, and that these socially constructed identities and understandings are negotiated by the person using them; they are not necessarily pre-packed identities that are taken up passively. In particular, the research highlighted that young carers constructed caring as helping their *personal development, repaying their family, reinforcing family bonds, and being fluid.*

Policy makers have expressed concern that the educational attainment of young carers is negatively affected by their change in role (EYCP, 2015). This issue has been explored in depth, and the opposite viewpoint has been espoused by young carers who felt that they were able to succeed and that caring had actually provided them with the opportunity to develop skills (e.g. Bolas et al., 2007). These skills were not only useful for them to find future employment (Bolas et al., 2007; Heyman & Heyman, 2013); they also felt that they were more mature, and less likely to partake in risky behaviour than others their own age (Watson & Fox, 2014). This construction was further intensified by comparisons made between themselves, as “mature”, and the “normal teenager” who was “trivial and immature” (Watson & Fox, 2014, p. 30). In effect, the young carers constructed their experiences, rather than being a detriment, as helping them to be “extraordinary” (Watson & Fox, 2014, p. 30).

In line with constructions of what a carer is, and how far they identified with this construction, young carers also played down their involvement in the care. In their phenomenological study with six young carers, Watson and Fox (2014) found that participants framed their caregiving as being reciprocal, and that they were “repaying” their family member (p. 28).

Cumulatively, this research suggests that young carers actively reimagined the identity of carer, and challenged dominant discourses within society. Much research and policy has constructed young carers as being vulnerable, and victims of their situation (Keith & Morris, 1999). It is evident, however, that young carers also consider and negotiate the positive aspects of their experiences within this identity. It has been argued that young carers thinking positively about their caregiving experiences encouraged them to think positively about themselves. They further argued that often idealised perceptions of carers as being “brave and noble” were used to make the young carers feel more “useful and capable” (Bolas et al., 2007, p. 839).

Unlike the majority of research considering the sense-making of young carers, Van Parys et al. (2014a) and Van Parys, Smith, and Rober (2014b) have focussed on the retrospective sense-making of those who were young carers. Van Parys et al. (2014a) also explored how young
carers understood the transition out of the role of carer. The authors noted that this occurred most often when there was a change in living arrangements, such as moving out to go to University. The authors argued that the participants felt there was "no room left for the caring role" that they had previously had (p. 10). The move to University has been considered a key point of change in multiple relationships and identities (Oswald & Clark, 2003). Returning to conceptions of friendship, University is often considered to be a point of drift in friendships (Fehr, 2000) due to changes in geographical location and locus of activity (Feld & Carter, 1998). Universities provide young people with an opportunity to increase and diversify their friendship networks by facilitating encounters that would have traditionally fallen outside of the geographical and institutional homogeneity of previous friendships. The new friendships developed whilst at University provide a new context within which young people can explore their own identities and interests (Oswald & Clark, 2003).

Across the young carer literature it was evident that the young people reconceptualised some of the notions of young carers, with a particular focus on how successful they were expected to be, how vulnerable they were, and how they were unable to move from their caring role. Through actively engaging in the views surrounding young carers and challenging them, the young carers demonstrated that their identity was not something that they passively acquired, rather their identity and the constructs within which they came to understand themselves were actively engaged in. What this suggests is how young people take up roles and constructs is not always passive, people actively interact with, and (re)construct the roles that they have taken up. Young people who provide support used multiple constructs within which they orientated themselves. How these were taken up, understood, and integrated into a sense of self, however, differed. What this means is that identities are patchworks of social constructions that have been drawn together through experience. A lot of work goes into the production of an identity, and in the case of young carers, these identities were often a product of an attempt to make sense of a difficult situation (Smyth et al., 2011), as such, people tried to maintain their identity (Martin, 2006). How young carers managed and maintained their identity, whilst also struggling to provide support is outlined below.

2.2.4. Protecting the identity

A paradoxical issue identified by researchers was that young carers would report feeling distanced from others and unable to form social bonds. However, they were protective over, and secretive about, their role as carer, the role which was contributing to their isolation (Rose & Cohen, 2010). In Martin’s (2006) study looking at how Zimbabwean children understood caring for a parent with HIV and AIDS, the children begrudged being removed as carer and

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placed back as the child. Martin argued that the children had integrated caring as an aspect of their identity and in being removed, their social and familial identity was undermined.

Other researchers have explored how the young carers framed their protection over their role, and have identified three key reasons that participants gave. Firstly, many young carers felt that they had to protect their role in order to protect those they cared for from stigmatising views (Bolas et al., 2007), or felt that they would be stigmatised by identifying as a carer (Smyth et al., 2011). In their interview-based study with 20 young carers of parents with mental health problems, Fjone, Ytterhaus, and Alnvik (2009) understood young carers attempts at concealment as a form of impression management. The young carers felt that there was stigma attached to discussing their experiences, and would employ a range of strategies through which they could avoid revealing their caring behaviour. Secondly, young carers also discussed fears over family separation as a motivating factor to keeping their caring a secret, particularly from those who could involve social services (Thomas et al., 2003). Finally, some young carers reported feeling guilty about discussing their situation with others. In their study Van Parys et al. (2014a) identified that often young carers reported wanting to speak to others, yet felt guilty and "disloyal" if they did (p. 8).

Although the carers framed their secrecy in different ways, through keeping their level of involvement in the care of the family member private they were able to maintain and protect their role. The paradoxical relationship that young carers held between adjusting to, and maintaining their caring role, versus their desire to find affinity and feel a sense of belonging, highlights one of the challenges that they faced (Rose & Cohen, 2010).

Once the young carers were in the position of carer they became protective over their responsibilities. Whether this was intentional or accidental, the young carers tried to conceal the support they provided even if concealing their behaviour had a detrimental impact in other areas of their life. In a broader sense, this suggests that young people who do take on excessive responsibility for someone may struggle, yet be unwilling to seek out support for fear. Whether this is fear for loss of their role, stigmatisation, or the consequences it may have for the person they support, young people seem unwilling to take the risk of seeking out support. Thus, young people may struggle to cope with providing the support, but feel compelled to keep it a secret.

2.2.5. Summary

What is evident across the young carer literature is that (young) people who provide support to others draw on social constructs of roles, responsibilities, and associated expectations in order to make sense of their experiences. Social constructionist writers have explored the
integral role that language and social relationships play in the understanding of self. They have argued that through language, individuals are complicit in the (re)production of socially constructed understandings, such as that of a young person, a friend, or a carer. Indeed, Gergen and Gergen (2003) stated that “we are ‘relational beings’” (p. 120), and that the knowledge and understandings we have are informed by social constructions.

2.3. The relational being

The underlying argument of the self as a relational being is, rather than the self being fixed and a solely internal process, it is “embedded...within interpretive or communal traditions.” (Gergen, 2009a, p. 88). Gergen (2009b) proposes four main tenets that constitute the development of the relational being. Firstly, ways of speaking are developed within relationships. How language is understood and made intelligible is through “coordinated action” (p. 70). Gergen gives the example of a child learning to speak, with an adult providing the language for the child to make sense of their inner world. Thus, Gergen argues that language is something that is passed on, and developed, it is not something that is innate or universal. Secondly, language serves a social function, it is used as a “pragmatic” (p. 71) tool to communicate. Thus, in order to understand and appropriately function within the social world similar understandings of language and meaning are cultivated. Thirdly, language is part of a “culturally prescribed performance” (p. 75), meaning that language is embedded within the rituals and expectations of interaction. For example, saying “I like your scarf” whilst smiling is understood as a compliment; replace the smile with a sneer and the compliment turns into a criticism. Finally, there are expectations and “traditions” (p. 74) in the use of language. As language is social, the outcome of communication is not solely for the performer. The recipient or co-performer is constricted by conventions of what is expected within the interaction.

In other words, we come to understand ourselves and our experiences through interactions, those we hold relationships with provide us with the language we use to make sense of our experiences (Gergen, 2011). These relationships are locations for the (re)production of “shared versions of knowledge” (Burr, 2003, p. 5) which both inhibit and allow certain behaviours and ways of understanding experience (Burr, 2003). These relationships can be with those we interact with in daily life such as parents, partners, or friends (Burr, 2003). Also termed micro social constructionism (Burr, 2003), language and ways of understanding are developed within everyday interactions and relationships. Meanings can also be constructed through relationships with wider social engagement, such as society, institutions, and ideology (Cunliffe, 2008). These wider social constructions are historically and culturally situated
(Shotter, 1997), thus understandings of the social world are descendants of previous cultural, political, and social worlds (Martin, 2003).

In order to understand ourselves and our experiences, people draw on social understandings. These understandings are similar to groupings of types of behaviours which are assigned to a specific role within society. Thus, these roles and expected patterns of behaviour allow individuals to make sense of their own situation, as well as delineating how they should behave or interact with others. These roles can both co-exist and be situationally bound. These roles and constructs of behaviour allow people to develop a “self-narrative” within which the “individual attempts to establish coherent connections among life events” (Gergen & Gergen, 1988, p. 18). Meaning that, through drawing on social understandings, people are better placed to make sense of their own experiences and produce a coherent self-narrative.

2.3.1. Challenges to the self-narrative

In developing a coherent self-narrative, however, individuals will face challenges within which they have to consolidate new roles and responsibilities within their sense of self. For example, it is expected that friends will provide support, yet little is known about how to support (Digester, 2013). Therefore, when support is identified as exceeding normal expectations of friendship, individuals may draw on alternative ways of understanding their experiences.

In their work, Salgado and Hermans (2005) explored how the notion of multiple selves could be conceptually understood. They suggested that in each kind of social relationship there are different “relational and linguistic games” (p. 6). Thus, suggesting that meaning making and construction of the self differs across different types of relationships. This was evidenced in Watson and Fox’s (2011) research looking at young carers. One woman talked about providing care to her mother and struggling when she identified herself as a daughter, yet finding it easier to cope when she identified as a carer. She talked about the feelings of pain, or upset that she experienced when she felt mistreated by her mother as a daughter as being less problematic when she identified as a carer. Similarly, Smyth et al.’s (2011) participants felt relief and a sense of understanding once they found out about the identity of young carer. Smyth et al. argued that learning about the identity of a young carer provided them with the linguistic tools, and experiential similarity for them to help understand what they had been doing. Thus suggesting, like Salgado and Hermans (2005) argued, that different contexts require different linguistic and relational repertoires within which the individual can orientate themselves to make sense of their experiences.
Work by Pahl (2002), and Pahl and Spencer (2004), has also demonstrated that individuals will also try to integrate different roles, such as friend and sister. What Pahl (2002) argues is that people will regularly draw on different social roles in order to present something different about the relationship. In this case, he argued that, often friends would identify themselves as a family member in order to portray the friendship as being stronger and unlike other friendships. The research by Pahl and his colleagues suggests that identity construction and identification does not always have to occur at a point of crisis. Drawing on other social constructs also helps to make a pre-existing identity distinctive and superior to others who occupy the same social space.

What this highlights is that people will draw on social roles and constructions in order to communicate something about either themselves or the position they hold in relation to others. For example, the research suggests that friends will draw on constructs of family in order to denote closeness (e.g. Pahl, 2002), and that young carers will draw on constructs of youth in order to demarcate themselves as being different and superior to others (e.g. Watson & Fox, 2011). In thinking about the friends of self-harmers, this research suggests that they may draw on constructions and roles that lie outside of ‘friend’ in order to place themselves within an appropriate social understanding. In so doing, the friends may draw on constructs of friendship, family, or carers in order to make sense of providing support to a self-harming friend. It is how the friends come to understand themselves, and the role within their friendships which is the focus of this thesis.

2.4. Summary

Within this chapter I have provided an overview of how friendship can be understood as a socially situated relationship within which individuals orientate themselves. Due to the lack of research that focuses on young friends who provide support for self-harmers, attention has been paid to the young carer literature. This literature has highlighted that young people use a variety of social constructs, such as young person and care provider, in order to make sense of their experiences. Finally, I explored how people come to understand themselves in relation to others, and draw on linguistic tools and mechanisms in order to make sense of their experiences. This chapter provides a theoretical context to how I consider relationships, such as friendships, to be a social space which is actively used to construct an understanding of the self. As little is known about how friends come to understand their experiences of supporting a self-harming friend and the impact this has, taking a qualitative social constructionist approach allows for a deeper insight that engages directly with the friends.
2.5. Aims and Research Questions

Drawing the two chapters together it is clear that the friends of self-harmers have thus far been eclipsed from the self-harm research, only considered when they provide an insight into the life of the self-harmer. However, from the self-harm research it is evident that friends hold a unique position. Not only are they the main source of support for self-harmers (Evans et al., 2005), they are seen as "gatekeepers" and are used by therapists to help provide support to self-harmers (Klingman & Hochdorf, 1993, p. 123), further, it has been demonstrated that the biggest known predictor of own self-harm is the self-harm of a friend (Hawton et al., 2002). This research demonstrates the clear impact that self-harm can have on the friends, yet little is known about their experiences.

Looking at the self-harm research that has considered the impact of providing care, it is evident that health professionals and the parents of self-harmers have been well represented in the literature. This research has shown that those who provide support to a self-harmer struggle. Indeed, it has been well documented that the parents of a self-harmer will have decreased psychological and physical well-being (e.g. Sawatzky & Fowler-Kerry, 2003), as well as deterioration in relationships (e.g. McDonald et al., 2007). In looking to more general research that has explored how people cope with supporting a friend, it is evident that caring is not necessarily just an activity taken up, but rather something that changes the relationship held between the friends. As Hill et al. (1998) note; "caring is not simply an activity, but a relationship" (p. 618), and this change in relationship is not always an easy transition to make (e.g. Bor et al., 2004).

What is problematic about much of the research exploring how friends provide support is that it is predominantly looking at adults who provide support to a friend; there has been little focus on how young friends cope with providing support. Due to the scarcity of research on young people who provide support, attention has been paid to the young carer literature. Although this research is focussed on care within a familial relationship, it is the only body of literature that explores how young people come to understand providing support that exceeds ‘normal’ expectations. From this literature it is evident that young people find it difficult to support someone, particularly when they identify themselves as something other than a carer, such as a daughter or son (e.g. Van Parys et al., 2014a). Consequently, it is clear that young people will use a range of different socially constructed roles in order to make sense of their experiences (e.g. Van Parys et al., 2014b). It was particularly evident that often the young carers struggle between the role of care provider, and being a young person (e.g. Watons & Fox, 2011). These social roles and constructions, however, are not always taken up passively; throughout the
young carer literature it is also evident that people interact with roles, have understandings of the social constructs, and as such are able to affect how they take up these roles and how they then subsequently (re)produce them (e.g. Heyman & Heyman, 2013).

In looking to the more theoretical literature on how the self is constructed through social relationships, it is clear that people draw on what social understandings they have in order to generate a coherent understanding of themselves and their experiences (Gergen & Gergen, 1988). Indeed, this was well documented in the young carer literature with many stating that they felt comforted in being able to identify themselves as a young carer, as they were able to find similarity with others, and felt better able to communicate their experiences (Smyth et al., 2011).

In thinking about how young people come to understand providing support to a self-harming friend, focussing on how they construct themselves and others within social relationships is not only appropriate, but necessary. As noted previously, providing support is not just an activity, but something that young people are clearly using as a vehicle for understanding themselves and their role within relationships. Through exploring the experiences of the friends of self-harmers from this approach we are better placed to gain an understanding of the impact of self-harm on the friends, and what can be done to better support them. In making the friends and the experiences the focus of this research, I aim to address the inattention that has thus far been paid to them.

The overall aim of this thesis was to gain an insight into the impact of self-harm upon friendship and how those who support self-harmers make sense of, and understand this impact.

The overall research question was: *How is the impact of self-harm on friendship understood?* This was achieved through three sub-questions that were addressed in the studies within this thesis. These sub-questions are:

1. *What are the key issues facing the friends of self-harmers?*
2. *How do friends make sense of the experience of being a friend of a self-harmer?*
3. *How do friends make sense of the impact of self-harm on their friendship?*

In the following chapter I will provide an overview of, and justification for the methodology of this thesis. Each study will be outlined, and I will discuss the appropriateness of conducting this research from a critical qualitative perspective. I will justify my ontological and epistemological stance and explain how this informed the methodological direction of the project. There will also be a discussion about how the methodological decisions were made,
and why these were considered appropriate. There will also be an ethical consideration of the methods used and of conducting research into a sensitive issue.
Chapter Three

Methodology

The previous chapters provided an overview of the literature on self-harm, and friendship. It is clear that the experiences of the friends of self-harmers are often overlooked. We know that from studies which have taken a quantitative approach that friends are the preferred choice of support (e.g. Fortune, Sinclair & Hawton, 2008), are routinely identified by clinicians as being "natural support systems" for adolescents (Klingman & Hochdorf, 1993, p. 123), and are at-risk from developing self-injurious behaviour (e.g. McMahon et al., 2010). However, these studies fail to explore the experiences of the friends of self-harmers. This thesis aims to address this gap through exploring the experiences, understandings and sense-making of self-harm in friendship. In order to achieve this in a rigorous manner, it is essential to consider, and justify the methodological approach taken, and my theoretical orientation (Caldwell, 1997). Thus, in this chapter I will discuss my ontological and epistemological stance and how this has informed the methodological direction of this project. I will also explain how the methodological decisions were operationalised and offer a rationale for the design of the project. Finally, I will address relevant ethical issues.

3.1. Aim and Research Questions

The overall aim of this thesis was to gain an insight into the impact of self-harm upon friendship and how those who support self-harmers make sense of, and understand this impact.

The overall research question was: How is the impact of self-harm on friendship understood?

In order to address the aim and research questions, I used a range of qualitative data collection and analytic methods.

3.2. Overview of the Studies

Three studies were planned, each addressing a different aspect of the overall research question. In addition, a prototype support tool was also produced. In this section a brief overview of each of the three studies, and the prototype support tool, will be given. Fuller descriptions of the methods employed for each study can be found at the beginning of each of the results chapters.
3.2.1. Study One

In Study One I conducted one semi-structured focus group with those who provided a counselling role to University students. As counsellors had provided support to both the friends, and the self-harmer, through interviewing them I aimed to explore the bigger picture of self-harm within friendship, and identify key issues. This was done in order to answer the research question:

What are the key issues facing the friends of self-harmers?

This focus group was analysed with Thematic Analysis. A fuller description of the justifications for the use of focus groups, how they were conducted and analysed can be seen in Chapter Four.

3.2.2. Study Two

Study One had established that self-harm did affect the friendships of young people. In Study Two I conducted six in-depth semi-structured interviews with the friends of self-harmers in order to gain an understanding of the experiences of the friends over the life-course of their friendship, and to answer the research questions:

What are the key issues facing the friends of self-harmers?

How do the friends make sense of the experience of being a friend of a self-harmer?

How do friends make sense of the impact of self-harm on their friendship?

The interviews were initially analysed with IPA, but as the analysis progressed, positioning theory was further used as an interpretative lens. In Chapter Five there is a fuller description and justification for the use of interviews. I have additionally discussed how the analysis was conducted and positioning theory integrated as an interpretive tool.

3.2.3. Study Three

In Study Three I conducted five unstructured focus groups with the friends of self-harmers. As Study Two had focussed on the experiences of friends over the life-course of their friendships, I aimed to explore the collective understandings of those who had more recently had a friendship with a self-harmer. In so doing, I aimed to answer the research questions:

What are the key issues facing the friends of self-harmers?

How do the friends make sense of the experience of being a friend of a self-harmer?
How do friends make sense of the impact of self-harm on their friendship?

The focus groups were analysed using Thematic Analysis with positioning theory. In Chapter Five I have detailed the justifications the appropriateness of using focus groups when exploring sensitive topics, and how this was accounted for in this study.

3.2.4. Prototype Support Tool

In Chapter One I highlighted that existing support tools for the friends of self-harmers tended to exclude their experiences, or failed to acknowledge to a great extent the difficulties that they faced whilst supporting a self-harmer. Further, Studies One, Two, and Three, highlighted that friends often felt ill-equipped to support a self-harmer. In order to ensure that my research had both theoretical and practical application, I focussed on developing a prototype support tool designed specifically for the friends of self-harmers.

The support tool was developed across three phases. In the first phase the materials were developed from a combination of the key findings from Studies One to Three with a critical evaluation of pre-existing support tools. In phase two, five focus groups were conducted, one with the counsellors, one with a local support service, and three with friends of self-harmers; the draft support tool was further developed and refined. In phase three the draft support tool was presented in a focus group with local support providers, and three focus groups with friends. Having incorporated the groups’ suggestions the leaflet was finalised. A full description of this process can be found in Chapter Seven.

3.3. Appropriateness of critical qualitative research

Chapters One and Two established that the friends of self-harmers tend only to have been considered when they provide information about the self-harmer (Klingman & Hochdorf, 1993), or when they themselves self-harm (e.g. McMahon et al., 2010). Research that has included the friends has chiefly been conducted quantitatively. Consequently, the experiences of the friends, and how they come to understand this impact has gone largely ignored. In order to investigate the understandings of self-harm within friendship, a qualitative approach was necessary.

Much research has considered the (qualitative) experiences of those who self-harm, including how they make sense of their own self-harm (e.g. Harris, 2000), their experiences of healthcare (e.g. Lindgren, 2004), and how they discuss their self-harm online (e.g. Rodham, Gavin & Miles, 2007). Furthermore, in the friendship literature much of the research has been conducted from a positivist social approach, such as establishing how friendships are formed, the different
types of friendship (e.g. Branje et al., 2007), how they are maintained (e.g. Frijns et al., 2013) and how they are ended (e.g. Azmitia et al., 1999). The critical research that has considered friendships has normally done so from a gendered perspective, i.e. how men and women practice friendship (e.g. Hey, 1997); or a Foucauldian perspective, i.e. how friendships are a site for resistance (e.g. Kingston, 2009). What these approaches have in common is that there is an acknowledgement of friendships as being a constructed social relationship, meaning that friendships have purposes, meanings, and practices. Within these relationships, people come to understand themselves and their role in relation to another person. Friendships, therefore, are considered to be a social space through which young people draw on constructions of youth, friendship, and care in order to make sense of their experiences.

What has not been considered in depth is how friends understand supportive friendships. The research that has critically considered the impact of supporting friends is limited in terms of its nearly exclusive focus on adults (e.g. Hill et al., 1998), and the grouping of family and friends together (e.g. Bor, du Plessis & Russell, 2004). In focussing almost exclusively on adults, the experiences of young people, those more likely to seek support from friends (Frey & Röthlisberger, 1996), is overlooked. Further, in grouping friends and family together, the nuances in the friends’ experiences are lost. Thus, in order to gain insight into the impact of self-harm on young people’s friendship it was important to consider the lived experiences and consensual understandings of the friends, and those who support them.

3.4. Theorising the production of reality and knowledge

Due to the multiple, sometimes incompatible, approaches taken within qualitative psychology, discussions and consideration of ontology, epistemology, and methodology are integral in ensuring the production of rigorous, and ontologically and epistemologically compatible research (Chamberlain, Stephens & Lyon, 1997). Outlining how I approached this project is especially pertinent considering the multiple methods and analytic strategies I used (Caldwell, 1997).

I acknowledge that research is “value-saturated” (Bahm, 1971, p. 391) in that the topics we choose, how we approach it, and come to research it are based on our own philosophies and experiences. I wanted to produce rigorous and robust research that was sensitive to, and acknowledged, my theoretical and philosophical orientation (Smith, 1983). Further, since I was interested in exploring both experiential and consensual understandings of people’s social worlds, researching within a positivist paradigm would have restricted the opportunity for multiple accounts to gain equal weighting (Harré, 2001). Thus, it was important that the epistemological and ontological foundations of this project complemented my orientation as a
researcher, and the different types of knowledge I wanted to explore in order to answer the overall research question.

Specifically, I understand the production of reality (ontology), from a relativist perspective; and knowledge production, (epistemology), from a social constructionist perspective. Below I will outline and justify the ontological and epistemological approaches I took within this project.

3.4.1. Ontological approach: Relativism

"Ontology is concerned with the nature and form of reality and asks what there is that can be known" (Chamberlain et al., 1997, p. 694).

Psychological research tends to be conducted from a realist ontological position, that reality is tangible, universal to all, value- and "context-free" (Chamberlain et al., 1997, p. 694). Realist understandings of reality have three core tenets: universality, objectivism and foundationalism (Harré & Krausz, 1996). Those who orientate themselves within this understanding argue that:

- there are a set of universal beliefs, or understandings that hold true for all (Harré & Krausz, 1996),
- these beliefs are objective and held independently of the cultural and historical heritage of people (Harré & Krausz, 1996),
- there is one physical reality from which all other understandings are developed from (Harré & Krausz, 1996).

In contrast to this stands relativism, which takes the stance that reality is culturally and historically mediated (Krausz, 2010). Within relativist understandings of reality, “meaning, truth and value are relative to culture. Thus meaning that each culture has its own unique systems of meaning, repertoire of truths and criteria of value” (Harré & Krausz, 1996, p. 11). Relativism developed in response to “philosophical concerns” of realist, or absolutionist doctrine (Baghramian, 2010, p. 31), how people come to understand their world and the experiences they have within it are bound by their own cultures and prior experience (Zemach, 1989). Relativism rejects the absolutist view that there is “metaphysical realism” that exists independently of our understanding (Olssen, 1996, p. 277). Rather, there are multiple, and equally valid ways of interpreting experiences, objects and interactions, none offers a more “privileged” insight than the others (Harré & Krausz, 1996, p. 3). This is not to say that (social) objects do not exist, rather, relativists argue that there are tangible objects around which different meanings and interpretations are maintained and developed (Krausz, 2010). These
interpretations are not objective, and are not value-free (Macfarlane, 2010). Rather, they are inextricably linked to the persons who view and interpret them (Harré & Krausz, 1996). Thus, within the relativist approach, reality is produced, reproduced, and reconstructed through people’s experiential and socially constructed knowledge (Chamberlain et al., 1997).

Putting this in terms of my project, I suggest that the relationship (friendship) held between the friends and the self-harmers was a ‘social object’. It is how they came to understand their experiences within their friendships that I argue was formulated through, and informed by, their cultural and experiential frameworks. What the friendships did, or “exist[ed] as” (Harré & Krausz, 1996, p. 124) for them, and how they came to understand their experiences in the friendship, were both similar and dissimilar based on their prior cultural understandings and experiential knowledge, and it is this that I wanted to explore more.

3.4.2. Epistemological approach: Social constructionism

“Epistemology is concerned with how reality can be known, asking about the relationship between the knower and the knowable” (Chamberlain et al., 1997, p. 694).

Developed out of the movement away from positivist, experimental approaches to psychology (Kuhn, 2003), social constructionism aimed to provide a culturally contextualised approach to understanding people’s experiences of their world and themselves within it (Burr, 2003; Gergen, 2003). In positivist approaches within psychology, human experience was considered to be knowable, universal and objective (Burr, 2003). Social constructionism was seen as a paradigm shift away from research being a form of truth “excavation” (Mason, 2002, p. 62), to a critical approach that acknowledged, and was sensitive to, the interconnectedness of individual experiences and social understandings (Shotter, 1997). In general, social constructionists are encouraged not to accept “taken-for granted knowledge” (Burr, 2003, p. 2), and rather, to be critically engaged and sceptical about implicit assumptions (Burr, 2003).

Although there are variants of social constructionism, Burr (2003, p. 2) argues that there is a “family resemblance” of characteristics. Specifically that knowledge is a social product that is culturally and historically situated, and upheld through social processes.

Knowledge is Historically and Culturally Situated

Social constructionists argue that because knowledge is a social product, it is contingent upon the cultural and historical context within which it is produced (Shotter, 1997). Specifically, the
ways in which experiences, phenomena and social objects are understood and interpreted are underpinned by existing frameworks of knowledge. Some would argue that we inherit tacit knowledges, or "sleeping metaphors" (Martin, 2003, p. 30), that come to underpin subsequent understandings.

For example, in his book examining the Western historical understandings of suicide, Marsh (2010) discussed how at different times societies have had different repertoires, or ways of understanding, to draw on to make sense of suicide. He discusses four main stages in how society came to understand suicide. In the late fourth to early fifth century, when Christianity was a dominant ideology, suicide was understood within theological terms. Specifically that those who committed suicide had committed a sinful act and were sinners. In the thirteenth century, law was becoming more omnipresent and it was legality, rather than religion that demarcated the good and the bad. Thus, suicide was discussed in legal terms, that those who committed suicide had enacted a form of murder, and were discussed as being criminals. Post-enlightenment, the focus had shifted onto the use of science and scientifically-informed medicine as being the dominant discourses of the time. Within this new way of thinking, suicide was considered to be a consequence of mental ill-health, or insanity. In the late twentieth century, he argued that those who committed suicide were largely understood as being the victims of risk factors. Marsh concluded that currently, we understand suicide as an individual act, one divorced from wider social, political and cultural influences, and one that is considered ultimately to be a sad outcome to an individual pathology.

Other illustrations of the culturally and historically situated knowledge can be seen in the ways that homosexuality (e.g. Foucault, 1976), and female sexuality (e.g. Groneman, 1994), for example, have been discussed. What this highlights is how knowledge is a product of cultural and historical heritage. Social constructionists argue that new or alternative ways of understanding the same phenomena do not necessarily suggest a progression in thinking. Rather, each way of understanding is an "artefact" of that particular period (Burr, 2003, p. 4).

The Importance of Language

It is through social interactions, and the use of language, that knowledge is constructed, reconstructed, and "sustained" (Burr, 2003, p. 4). Often these practices and knowledge are built up within normal everyday interactions (Gergen, 2003). It is argued that the language that we use, and have access to, opens up different types of cultural knowledge and ways of understanding our experiences (Burr, 2003). As Billig (2003, p. 141) notes;
“Language is primary, it does not merely provide labels attached to our perceptual impressions. Language permits us to enter into the life of culture.”

Thus, what is ‘knowable’ and how we come to know it, is dependent on our linguistic heritage, integration, or exposure. Language both shapes, and is shaped by our knowledge, and comes to “constitute” or represent “the culture that generates them” (Bruffee, 1986, p. 777). Thus those who align themselves with social constructionism acknowledge that different cultures, at different times will have different ways of being able to understand their experiences, as their language permits them. Importantly, none are more ‘accurate’ or provide a more ‘truthful account’.

Drawing this together, how the participants in this thesis came to understand the impact of self-harm on friendship was a consequence of cultural tropes, social ways of understandings, and social interactions. Meaning that the accounts of the participants were not assumed to represent an accurate or universal insight into the reality of the impact that self-harm has on friendship. Rather, these accounts were assumed to represent the participants’ lived experiences, and the outcome of the active process of socially embedded sense-making. This process provided an understanding of how friends, and support providers made sense of self-harm within friendship.

3.4.3. Methodological operationalization

In order to produce a robust project, I had to ensure that the methods I used to generate and analyse the data were appropriate to my theoretical orientation (Willig, 2008). In this section I will detail why these collection and analytic choices were suitable in terms of their appropriateness to my orientation and the types of knowledge I considered. The details of how I carried out the collection and analysis of data can be found at the beginning of each results chapter.

Interviews

In-depth semi-structured interviews are arguably one of the most common data collection strategies within qualitative research (Willig, 2008). Within the interview setting the interviewer has an interview schedule, which will list a few pre-established questions (Bloor & Wood, 2006). Unlike structured interviews, within which the researcher will only follow the interview guide, or set of questions, semi-structured interviews allow for the participant and
researcher to explore other areas of interest raised within the interview itself (Braun & Clarke, 2013). In so doing, the interviews are shaped both by the researcher and the participant.

This data collection method was deemed to be appropriate due to several factors. Firstly, my ontological and epistemological position. Secondly, the appropriateness of the semi-structured interview to the research question. Finally, the importance placed in making the participants the experts and the opportunity to be a flexible and reflexive researcher (Mason, 2002).

As semi-structured interviews have traditionally been used within the social constructionist paradigm, and allow for the researcher and participant to explore constructed understandings, semi-structured interviews were considered to be an appropriate data collection method (Mason, 2002; Smith & Eatough, 2007). Semi-structured interviews allow for the consideration of how individuals construct their experiences and place the participants’ voice at the forefront of the research, arguing that they are the experts of their own experiences (Willig, 2008). Conducting a semi-structured interview allowed a focus on the participants’ experiences in creating an understanding of their experiences, rather than the “excavation” of a truth (Mason, 2002, p. 62).

The main advantage in using semi-structured interviews was the flexibility it afforded both myself and the participants (Braun & Clarke, 2013). Through using a non-standardised approach to interviewing, myself and interviewees were able to explore avenues of interest with more ease than with other, more structured forms of data collection (Braun & Clarke, 2013). In so doing, ways of talking about their experiences or issues that I may not have considered could be introduced and discussed (Willig, 2008). This also allowed for the idiosyncrasies of experiences to be explored, participants also influenced the direction of the interview, rather than them being researcher-led (Yeo, Legard, Keegan, Ward, McNaughton Nicholls & Lewis, 2013).

Furthermore, through using a semi-structured approach I was able to be more reflexive than in a more structured and standardised setting (DiCiccio-Bloom & Crabtree, 2006). On completion of each interview I reflected on, developed, refined, and diversified the interview schedule (DiCiccio-Bloom & Crabtree, 2006). Through being actively reflexive I was able to develop a more in-depth insight into participants’ understandings and remain open to alternative ways of thinking (Braun & Clarke, 2013).
Focus Groups

Focus groups are considered to be a focussed discussion within a group in the hope of producing rich qualitative data on a particular topic (Stewart, Shamdashi & Rook, 2007). Often they are considered to lie somewhere between observation and interviews (Barbour, 2007), representing a more ‘naturalistic’ environment than interviews, and a more structured focus than observation (Kitzinger, 1995).

Researchers have discussed at length the appropriateness of focus groups (e.g. Barbour, 2007). Broadly speaking, arguments for using focus groups have been identified in terms of their appropriateness for the research purpose (Fern, 2001) and the focus on accessing consensual understandings. Focus groups are particularly useful for considering collective understandings through contextualising sense-making (Barbour, 2007), and questioning tacit knowledge (Bloor, Frankland, Thomas & Robson, 2001). In other words, they are a means of exploring shared understandings.

In particular, focus groups have been identified as particularly useful in considering peoples’ shared understandings (Kitzinger & Barbour, 1999), as they encourage clarification between participants (Morgan & Krueger, 1993). Specifically, focus groups have been heralded as a means through which researchers can assess the constructions, and reconstructions of shared knowledge (Barbour, 2007).

As evidenced by the array of contexts within which focus groups have been used, they are considered to be a relatively flexible qualitative method (Kitzinger & Barbour, 1999). Indeed, Kid and Parshall (2000, p. 296) argue that, as focus groups have developed outside of the predominant qualitative methodologies, they are “relatively agnostic in terms of the methodologies attending them”. Therefore, it is important that researchers clearly understand their own position within the research, and focus group setting (Barbour, 1999). As my orientation was social constructionism I considered myself as playing an active role in the generation of knowledge (Barbour, 2007).

Interpretive Phenomenological Analysis

I analysed the interview data from Study Two using the principles of Interpretive Phenomenological Analysis (IPA) as outlined by Smith, Flowers and Larkin (2009). This was the most appropriate analytic tool to use as IPA is focussed upon exploring personal meaning-and sense-making of a person’s lived experiences, both personal and social (Smith et al., 2009;
Smith & Eutough, 2007). IPA is based upon three core components: phenomenology, the study of human experience; hermeneutics, the interpretation of human experience; and idiography, the focus away from the general onto the particulars of individual experiences (Smith et al., 2009).

Although normally considered a methodological approach in of itself (Donnison, Thompson & Turpin, 2009), I used IPA as a method, or tool for analysis. This decision was made as epistemologically I did not feel that I was able to form a coherent insight into the lives of my participants, nor did their accounts represent a form of inner truth (Smith & Eutough, 2007). Rather, I felt that the interviews provided me with an understanding of their experiential sense-making, from which they drew on social constructions of friendship and support. In order to remain faithful to my own approach to the research, yet sensitive to the experiential knowledge I wished to access, I “applied the principles IPA” (Storey, 2007, p. 51).

IPA involves interpretation as an enterprise including the researcher. The researcher attempts to make sense of the participants’ sense-making, commonly known as the “double hermeneutic” (Smith & Eatough, 2007, p. 36). Due to IPA’s use as an in-depth method it was considered to be particularly advantageous in Study Two as it allowed for a deeper insight into the experiences of the participants and opened up avenues for further consideration in the subsequent studies (Smith & Eatough, 2007; Smith et al., 2009).

Social constructionism is often more strongly associated with other modes of data analysis, particularly Discourse Analysis (Coyle, 2007). Discourse Analysis comes from the post-structuralism movement, and focusses on how people use cultural tropes, linguistic practices, and ways of understanding to construct their experiences (Frost et al., 2010; Potter & Wetherell, 1987). Discourse Analysis is based on the premise that discourses are infused with power and serve functions, thus ways of talking have an orientation and a social purpose (Potter, Wetherell, Gill & Edwards, 1990). It is within discourses that people construct their understandings and social realities (Potter & Wetherell, 1987). Due to the culturally-focussed approach to knowledge construction, Discourse Analysis was considered to be an inappropriate analytic strategy for this research. Since the key focus of this research was on personal meaning, and sense-making of experiences, rather than the examination of wider social discourses and knowledge construction within Discourse Analysis (Smith, 2011; Smith et al., 2009), IPA was deemed to be the more appropriate analytic framework.
Thematic Analysis

The focus groups were analysed with Thematic Analysis (Braun & Clarke, 2013). Due to Thematic Analysis' flexible approach to knowledge production, it has been used within a variety of different research projects using a variety of epistemological and theoretical positions (Braun & Clarke, 2013). Thus, justifications for its appropriateness are specific to the approach of the researcher and what type of interpretation is suitable for the type of data and research question.

Thematic Analysis is considered to be one of the most theoretically amenable qualitative strategies (Buetow, 2010). Unlike most qualitative analyses, it is identified as being “just a method”, devoid of any pre-established methodological, theoretical, epistemological or ontological concerns (Braun & Clarke, 2013, p. 178). Although Thematic Analysis has no specific theoretical groundings, social constructionism has been used as a theoretical lens within Thematic Analysis. For example, Niland, Lyons, Goodwin and Hutton (2014) conducted a constructionist Thematic Analysis on semi-structured interviews with young people from New Zealand exploring understandings of friendship, and friendship practices. The use of both Thematic Analysis and social constructionism allowed the participants' social world, and the language they used to be the focus of the analysis. In particular, their work highlighted the scope, and usefulness of Thematic Analysis and social constructionism to be used together as an analytic framework. Doing so prioritised the understandings of the participants, whilst remaining sensitive to the constructed, and socially embedded nature of their accounts. As Thematic Analysis, approached from a social constructionist orientation, had been shown to be used as an effective analytic tool, it was considered appropriate to use it as an analytic strategy.

Similarly to Thematic Analysis, Grounded Theory is considered to be a flexible analytic strategy, especially in epistemological variation (e.g. Frost et al., 2010). Grounded Theory arose from the wish to develop a bottom-up approach in understanding social processes, whereby researchers would remain close to the data in their analysis and consistently ground their findings within it (Willig, 2008). Doing so, it was hoped, would create, develop, or advance models of social processes (Smith et al., 2009). For example, Anderson, Standen, and Noohn (2003) used Grounded Theory in their study exploring how nurses and doctors perceived young people who self-harmed. Although this study highlighted some key concerns highlighted by the nurses and doctors, due to the Grounded Theory approach taken there was little opportunity for further interpretation of the participants’ sense-making. Consequently, in using Grounded Theory in-depth consideration of individual experiences and sense-making
are often lost (Willig, 2008). In relation to individual experiences, Grounded Theory seems appropriate to providing a descriptive overview of individual experience, yet inappropriate in examining why this may be the case (Willig, 2008). Further to this, it has also been commented that the aim of grounded theory to generate structured “rational” (Thomas & James, 2006, p. 790) accounts of human experience “relegates” (p.791) the participant’s and researcher’s voice from the written reports. In removing both the voice of the participant and the voice of the researcher, Grounded Theory moves away from my social constructionist stance and my embeddedness within the research process. Due to the focus of this research project being on understanding the sense-making of individuals, and not the generation of a model of human social behaviour, Thematic Analysis was considered to be the most appropriate analytic tool to use.

3.5. Research design: The place of multiple methods in qualitative research

Much attention has been paid to the integration of quantitative and qualitative methods (Lambert & Loiselle, 2008). With a particular focus on how these two seemingly disparate approaches can be consolidated and integrated in an appropriate, meaningful and rigorous way (Morse, 2012). What has been considered to a lesser degree is the combination of within-paradigm methods, in particular the integration of multiple qualitative methods of inquiry.

Qualitative methods are often considered to ‘fit together’ unproblematically (Barbour, 1998; Lambert & Loiselle, 2008). However, rather than being a unified and homogeneous approach, qualitative research encompasses several, sometimes conflicting theoretical, epistemological, ontological and analytical frameworks (Barbour, 1998). Indeed, qualitative research has been conceptualised as being an “umbrella [which] spans a wide spectrum of work” (Barbour, 1998, p. 353).

3.5.1. Mixed or multiple methods?

Firstly, a distinction needs to be established between multiple and mixed methods. Often these terms are discussed as being synonymous with one another (Morse & Niehaus, 2009). Although these two terms are similar in that they promote the integration of differing methods (Morse, 2012), they are not interchangeable. Mixed method designs are characterised by having a “core component” supported by “supplementary component[s]” (Morse, 2012, p. 554). Meaning that for a research project to be a true mixed-methods design, there has to be one main study that other studies are dependent on. These supplementary studies either precede, or develop from, the main study, and are conducted simultaneously or sequentially (Morse, 2012). These studies are considered to be ancillary to the main study and as such cannot withstand
independent critique (Morse & Niehaus, 2009). For a fuller debate on mixed methods see Morse and Niehaus (2009).

Similarly to mixed methods, multiple methods, known also as pluralism of methods (Dow, 1997), method eclecticism (e.g. Frost et al, 2010), or multimethod designs, endorse the combination of different methods within one research project (Morse, 2012). The main distinction between mixed and multiple method designs is that the individual studies in a multimethod project have independent weight (Morse, 2012). Indeed, within mixed methods design there is the inevitable hierarchical weight of one main study (Lambert & Loiselle, 2008, p. 231). Within multiple method design, however, each method is equal in weighting and produces an understanding of knowledge within its own right. This approach thus contends that no one method produces any more ‘accurate’ results than another (Barbour, 1998).

A multiple method design within this project was considered to be appropriate for two reasons. Firstly, the aim of the project was to conduct studies that, although were connected, stood independently of one another and provided different insights into self-harm and friendship. Secondly, in order to do justice to the variety of stories and voices of those who are affected by self-harm a multiple method design was seen as not only appropriate, but necessary.

3.5.2. Multiple methods: Comprehensiveness and appropriateness

According to Lambert and Loiselle (2008), there are three main reasons why researchers choose a multiple method design. Firstly, pragmatism, some participants may only wish to participate in certain forms of data collection, e.g. a preference may be shown for interviews over focus groups. Secondly, to compare perspectives, within this approach researchers wish to understand the differing experiences of different groups about the same phenomenon. Finally, completeness, researchers predominantly conduct multiple method research projects in order to generate a “more comprehensive understanding of the topic” (p. 230).

This exploratory research project was conducted in order to generate a deeper insight into the impact of self-harm on friendship. Through using a multiple method design to develop both in-depth and idiosyncratic insights, as well as consensual understandings I was able to establish a “more comprehensive understanding” (Lambert & Loiselle, 2008, p. 230) of how self-harm within friendship was made sense of.

Further, the decision to use multiple methods has been advocated for reasons of appropriateness to not only the research question, but also the sort of data wishing to be
acquired (Derbyshire, MacDougall & Schiller, 2005). It has been well established that different data collection methods generate different kinds of data and knowledge and are useful for answering different kinds of questions (e.g. Lambert & Loiselle, 2008). For example, the use of focus groups is particularly appropriate for exploring a range of views and generating consensual understandings (Kitzinger & Barbour, 1999). Whereas interviews are more appropriate for research questions focussing on individual experience (Michell, 1999).

Within this project, Study One, a focus group, aimed to ascertain whether, as suggested by the literature review, self-harm was an issue within friendship. Due to the exploratory nature of this study and the focus on generating an initial consensual insight, focus groups were considered to be appropriate. In Study Two, however, I was more interested in the individual sense-making of the friends. As the focus was on individual experiences interviews were considered to be more appropriate. As with Study One, in Study Three I wanted to generate a consensual understanding of the friends of self-harmers. Therefore, focus groups were considered to be most suitable.

It has been argued that although interviews and focus groups generate different kinds of data and knowledge, the understandings generated are compatible. In their study exploring how children understood peers with psychological disorders, Heary and Hennessy (2006) argued that focus group and interview data complimented each other. Rather than the data telling different stories, they concluded that the two data sets covered areas the other had failed to consider. Further, it has been discussed that the most effective way to ensure compatibility across differing data sets is through epistemological consistency (Lambert & Loiselle, 2008).

### 3.5.3. Epistemological and ontological consistency

Although I planned to use multiple methods, the research was approached from an epistemologically and ontologically "monoist" perspective (Caldwell, 1997, p. 102). Throughout the course of this thesis I approached the generation of knowledge and people’s sense of reality from a relativist, socially constructed perspective. In keeping my philosophical approach consistent (Derbyshire et al., 2005) I hoped to generate knowledge and insight that was not only appropriate to the research question, but also similarly grounded (Caldwell, 1997). Through ensuring epistemological and ontological consistency the subsequent integration of the findings from Studies One to Three for use in Study Four meant that issues of philosophical incompatibility were absent (Caldwell, 1997).
3.5.4. **Analytic pluralism**

In this project I used two forms of analysis, Thematic Analysis and Interpretative Phenomenological Analysis (IPA). A full description of how these analyses were conducted is detailed at the beginning of each results chapter. Analysing data in this way has been conceptualised as analytic pluralism, interpretative pluralism, interpretative bricolage, and analytic triangulation. Overarching all of these terms is the focus on using multiple analyses in the hope of generating more rigorous, honest, and trustworthy research. I decided to conduct two forms of analysis, a movement away from "monological forms of empirical research" (Kincheloe, 2001, p. 688), because the analyses were appropriate to the differing data I analysed and the research questions I posed. Further, in using multiple analyses I was able to subject the data to differing levels of analyses, and deepen my understanding whilst remaining sensitive to the participants' stories.

In using different methods of data collection, different types of knowledge are produced (Braun & Clarke, 2013). Thus, not one form of analysis would have been appropriate for all of the data. The interviews produced idiographic data (Smith et al., 2009), whilst the focus groups produced collaboratively constructed data (Kitzinger & Barbour, 1999). Due to IPA's commitment and sensitivity to the idiographic nature of people's stories, it has long been established as an appropriate analysis for interview data but treated with caution for focus group data (e.g. Smith et al., 2009).

Recently, however, there has been a call to reconsider the appropriateness of using IPA on focus group data (Palmer, Larkin, de Visser & Fadden, 2010; Tomkins & Eatough, 2010). In their discussion paper, Tomkins and Eatough (2010) argued that the individual contribution was being "eclipsed" by researchers "privileging the group" as one unitary data unit (p. 245). Similarly, Palmer et al. (2010) discussed the potential to access "rich experiential data" (p. 103) through focus group discussion. In discussing the appropriateness of IPA for focus group data, and for IPA to appropriately answer the research question there has to be a focus from the beginning on trying to make sense of the experiential understanding of participants (Palmer et al., 2010). Further, the researcher has to ensure that the focus group environment is conducive to people discussing their experiences in enough detail for analysis to be feasible (Smith, 2004). As the aim within my focus groups was to develop an insight into the overall understandings of my participants, rather than accessing individual experience, IPA was not an appropriate analysis to use. Further, in using IPA the collective understandings would be bypassed.

Thematic Analysis' epistemological and theoretical amenability has meant that it has been used to analyse a variety of different data, from a variety of topics, in a variety of disciplines (Braun
& Clarke, 2013). However, it is often considered to not be as sensitive to the voices, experiences and individual understandings as other forms of analyses (Braun & Clarke, 2013). For Study Two, interviews were conducted. Thematic analysis, though would highlight trends across the data set, is insensitive to, and obscures, the experiential knowledge I aimed to focus on in the interviews (Braun & Clarke, 2013). Therefore, IPA was considered to be the more appropriate analytic strategy to use with my interview data.

It has also been argued that using multiple analytic strategies is useful in deepening the understanding of a chosen phenomenon (Denzin & Lincoln, 2000). As discussed above, Thematic Analysis is particularly useful for generating insight into people’s understandings and perceptions, and flexible enough to use with focus group data (Braun & Clarke, 2013). However, it is insensitive to formulating an understanding of individual experience, something that IPA is responsive to (Smith et al., 2009). The incorporation of both analyses provided a deeper, layered, and more holistic understanding of how self-harm within friendship is understood whilst conducting rigorous research.

3.5.5. Ensuring integration

Although much has been written about the importance of appropriately using a multiple methods approach, in particular the epistemological and ontological foundations that have to be considered (e.g. Chamberlain, Cain, Sheridan & Dupuis, 2011), little attention has been paid to how the results from multiple methods are integrated (Farmer, Robinson, Elliott & Eyles, 2006). Furthermore, of those who do explore how to integrate findings, most use multiple methods as a means of triangulation to confirm the validity of findings (e.g. Frost et al., 2011), or they use multiple methods of data collection and analysis to form one singular results section (e.g. Clarke, Barnes, Caddick, Cromby, McDermott & Wiltshire, 2015). The focus of this thesis was not to use multiple methods to confirm a primary study, to validate, or to reify one particular analysis. Rather, I was interested in using multiple methods to build up a more comprehensive insight (Frost, 2013) into the impact of self-harm on friendship, and to use multiple methods in order to explore a range of understandings through a series of separate, yet iterative studies.

However, as Sands and Roer-Strier (2006) state, researchers need to demonstrate more clarity in how the findings of multiple methods are integrated. In line with the approach adopted by Lambert and Loiselle (2008), the results from the focus groups and interviews were considered alongside one another, non-hierarchically, in order to develop an overall picture of the impact self-harm has on friendship that embraced the nuances of the participants’ understandings. In practical terms, the results from each of the studies were outlined and then considered in light
of each other in order to build an overall story. Using a similar technique to that of Sands and Roer-Strier (2006), the results were looked at for points of similarity, where the participants across different studies had talked about similar experiences. From here, I looked at how they (differentially) constructed these experiences, where there were absences in knowledge, and where the knowledge from one group “illuminated”, or built on (p. 243), the knowledge generated by another. Through using this technique I was able to remain sensitive to the different types of knowledge created through the different methods, yet acknowledge where the insight generated could be integrated in a meaningful and coherent manner. How these were brought together is explained in more detail in Chapter Seven, section 7.3.1.

In using multiple methods, however, it is also important to fully consider the type of knowledge and insight that each data collection method and analysis creates. The knowledge generated within a focus group is a social creation, and represents a co-constructed insight into the impact of self-harm on friendship. Conversely, the interviews analysed with IPA allowed for the personal experiential sense-making to be the focus of analysis. The studies in this thesis provide different levels of insight for the same story. In using focus groups and Thematic Analysis I was able to gain an insight into the collective understandings of the friends, counsellors, and support providers. Through drawing these findings together with interviews analysed with IPA with the friends, I was also able to build up an understanding of the individual retrospective sense-making of the friends.

Through using a multiple method design I aimed to engage with the multidimensionality of “social interaction and human experience” (Frost, 2013, p.11) of the friends of self-harmers. I further allowed for the iterative nature of the work, and the voices of the participants, those previously unheard, to become the focus of this project. In using what methodological, theoretical, and interpretative tools that I had “to hand” (Kincheloe, 2005, p. 324) I endeavoured to make sense of, and do justice to, the experiences, sense-making, and understandings of the participants and myself as a researcher. As Mason (2008, p. 17) notes, lived experiences and relationships are “lived in different contexts”, using multiple methods embraces the different areas that these relationships are acted in. It engages with the multifaceted experience of being a friend of self-harmer, and addresses how the practice and performance of friendship may vary. Using a variety of accounts from multiple perspectives, alongside the integration of varying methods and analyses, allows for how these practices are similar and dissimilar to emerge (Chamberlain et al., 2011). It was about embracing the diversity, not explaining it away, or ignoring it.
3.6. Ethical issues

This section will detail the general ethical issues across all of the studies. In particular I will discuss how I ensured the participant’s informed consent, right to withdraw, anonymity and confidentiality. Finally, I discuss how I guaranteed participant protection within the sensitive topic of self-harm.

Ethical approval from the Department of Psychology was obtained for all studies, and the development of the support tool. All studies adhered to the British Psychological Society (BPS) code of ethics. All data was stored in line within the University guidelines, all consent forms were held in a locked drawer and all data (audio and textual) were secured in password protected files.

As the studies all used different forms of data collection, more comprehensive accounts of how specific ethical concerns within each study were managed can be found at the beginning of each results chapter.

3.6.1. Informed consent

Upon demonstrating an interest in being involved in the study, potential participants were sent an individual email detailing the specifics of the research, including the information sheet for the study. This ensured that those who agreed to be involved were fully aware of the nature of the study prior to attending (O’Connor, Ashley, Jones & Ferguson, 2014).

In order to ensure that the participants understood the nature of the study and their rights, prior to the interview or focus group they were provided with the information sheet detailing the purpose of the study, what they were expected to do, their right to withdraw from any or all of the study without having to provide a reason. In order to ensure that they fully understood the nature of the study and their rights as participants, I verbally reiterated the content of the information sheet at the start of the data collection process (Goodrum & Keys, 2007).

3.6.2. Right to withdraw

All participants were reminded of their right to withdraw from the study. It was made clear that this was both in terms of the whole study, and any questions they did not wish to answer (BPS, 2009). Participants in Study Two were also told that they could remove their data prior to transcription. I decided against allowing participants to revoke their data at any time as I felt that I would not be able to “unlearn the insight” that these interviews provided (Thorpe, 2014, p. 258). Meaning that in practice, if they had removed their data I do not believe that I
could have conducted the analysis without referring back to their experiences. In terms of the focus groups, the participants were informed that once involved in the focus group they would not be able to retrospectively remove any of their data. I reiterated that they could leave at any time or refuse to answer any questions. This decision was made due to the difficulty of removing a participant from a focus group, and the subsequent impact this can have on the quality of the data (Braun & Clarke, 2013). In the focus groups, after informing them of this, I restated their rights as participants to remove themselves throughout the focus group, or they could refuse to answer any questions (Braun & Clarke, 2013).

3.6.3. Anonymity and confidentiality

Anonymity and confidentiality were ensured, participants were told that any identifiable information, such as names or locations were anonymised (Kaiser, 2009). To further ensure the confidentiality of the participants within the focus group their real names were not revealed, instead participants were invited to choose their own pseudonym (Nabors, Ramos & Weist, 2001).

3.6.4. Participant protection: Self-harm as a sensitive issue

It has been widely demonstrated that self-harm is a sensitive issue, and for some still holds a taboo status (Adams et al., 2005). Consequently, those who have supported a self-harmer may have had the potential to be affected within the research setting.

Although it was not anticipated that any participants would have demonstrated any distress within the interview or focus groups, if they were to have appeared distressed the “research-interview distress protocol” outlined by Druacker, Martsoff & Poole (2009, p.349) would have been followed. In their protocol, Druacker et al. (2009) recommended that when participants demonstrate distress, the researcher should stop the interview, ask if the participant is alright and allow them time to recover composure, if the participant still indicates distress the researcher should ask if they wish to continue, pause or completely discontinue the interview or focus group. When in the focus group if participants were to have demonstrated distress the discussion would be steered in the direction of the other participants whilst the distressed participant recovered and they would have been asked discretely if they wished to continue.

Upon leaving the interviews or focus groups, the participants were encouraged to take the information sheet with them. This detailed the contact details for myself and my supervisors as well as listing formal sources of support if they feel the need to talk to someone.
3.7. Summary

Within this chapter I have provided an overview of the three studies, and the prototype support tool that constitute this research project. I have explained and justified the appropriateness of using a qualitative approach within this project. In particular I have outlined and justified my theoretical orientation and outlined how this has been practically operationalised throughout the project. I have established that, due to the commitment to the multiple voices and kinds of data produced, this was a multimethod project. Focus groups and interviews were used as the main data sources within this project and analysed with Thematic Analysis or Interpretive Phenomenological Analysis. The justifications for my decisions concerning the data collection, and a fuller description of how the collection methods and analyses were carried out can be found at the beginning of each results chapter. Finally, I have also explored some of the general ethical issues across this project, with a specific focus on conducting research on self-harm as a sensitive issue.

In the next three chapters I present the findings from Studies One to Three. The general findings from these three studies will be presented and discussed as part of the Study Four. In the next chapter I will present the results from Study One, an unstructured focus group with those who provide support to University students which aimed to establish whether self-harm is an issue in friendship.
Chapter Four

What are the key issues facing the friends of self-harmers? The counsellors’ perspective (Study One)

4.1. Background

Self-harm has been identified as "one of the most serious health problems" to affect University students in the United Kingdom (Mahadevan, Hawton & Casey, 2010, p. 211). The growing prevalence of self-harm within the student population has primarily been associated with increasing levels of depression and anxiety (Mahadevan et al., 2010). A study conducted at the University of Oxford found that students would present to hospital with self-harm specifically around periods of high stress (Hawton, Bergen, Mahadevan, Casey & Simkin, 2012). Hawton et al. (2012a) found that the number of student visits to accident and emergency would increase between April and June, the key exam time for students. The researchers associated the increase in student self-harm with the increase in academic pressure around examination time. Furthermore, research has also indicated that self-harm usually develops around middle adolescence, thus by the time students come to University, self-harm is a pre-established coping mechanism (Wright, Bewick, Barkham, House & Hill, 2009).

This is in-line with a body of literature that has investigated the more general help-seeking behaviour of young people. When young people seek out formal support they prefer to approach non-related adults who have a pastoral care element attached to their position, such as counsellors or teachers (DeLeo & Heller, 2004; Fortune et al., 2008). It has been established that counsellors primarily provide support for intrapersonal concerns, such as depression (Gilbert, 2000). There is also research, however, to suggest that individuals seek out the support of counsellors for interpersonal relationship problems (Fox & Butler, 2007) such as support whilst being a carer (Hill et al., 1998).

Thus, due to their privileged outsider insight, the counsellors are unique witnesses to the lives of those who self-harm, and would have an understanding of how issues, such as self-harm, can impact upon friendship. Chapter One demonstrated that the friends of self-harmers are an under-researched population, and are a potentially at-risk group. This study, therefore, sought to explore whether counsellors felt that self-harm was an issue within friendship.
4.2. Research aims and question

This study sought to gain insight into the issues raised by the friends of self-harmers within a counselling setting with a view to identifying the support needs of this group in order to answer the research question:

*What are the key issues facing the friends of self-harmers?*

4.3. Method

4.3.1. Participants

Those who provided a counselling role to University students were targeted. Recruitment focussed on: counsellors, mental health workers, and the chaplaincy in a University. In total three females and two males were recruited. For the purposes of this study, all of those involved will be referred to as ‘counsellors’.

All bar one of the counsellors were known to each other. Using pre-existing groups has been identified as a potential issue concerning disclosure. For example, Kitzinger and Barbour (1999) highlighted that participants recruited from within a pre-existing group may already have established norms and ways of understanding their experiences. As a consequence, they suggested that this kind of group setting may inhibit, rather than encourage open discussion. However, the evidence for this is mixed, for example, in her research into people’s understandings of AIDs, Kitzinger (1994) argued that pre-existing groups were advantageous for data collection as “sites of collective remembering” (p. 194). She argued that these types of focus group provided an insight into how people co-constructed their understandings. She further argued that participants who were known to one another, and therefore had insider knowledge could encourage discussion, particularly when the topic of conversation was potentially sensitive. Considering the relatively small number of participants available for recruitment and the opportunity for an insight into the co-constructed understanding of the participants, participants were recruited who were known to each other.

4.3.2. Data collection

One loosely structured focus group was conducted and was co-facilitated with one of my supervisors, Professor Karen Rodham. Rodham’s chartered status allowed the counsellors to use their participation in this focus group to count towards their continuing professional development in terms of facilitated reflective practice.
Although it is commonly accepted that between four and six focus groups would be conducted (Kitzinger & Barbour, 1998), it has been argued that a single focus group can provide enough information to answer the research question (Stewart & Shamdasani, 1990). The participants were drawn from the mental health team, the counselling staff and the chaplaincy from the University, as such there were a limited number of individuals suitable to participate. Thus, due to the practical constraints, such as the small participant pool, it was considered appropriate to use a single focus group (Stewart et al., 2007).

Anonymity and confidentiality were ensured, participants were told that any identifiable information, such as names or locations would be anonymised. The focus group lasted for 100 minutes and was recorded via Dictaphone.

4.3.3. The interview schedule

This study was exploratory in nature and used a loosely structured focus group. The intention was to establish whether self-harm was an issue in friendship, and if so, what issues the friends may face (Frey & Fontana, 1991).

As research has demonstrated that the friends of self-harmers are an at-risk population (e.g. Hawton et al., 2002) the first question aimed to encourage the counsellors to think about some of their views about self-harm more broadly.

This PhD is looking at self-harm and friendship—what do you think of this issue?

Further questions were used as prompts and aimed to explore the counsellors’ experiences in supporting self-harmers and their friends more specifically at the impact upon the friendships:

What experiences have you had of supporting friends of self-harmers?

Is there a pattern in terms of the types of students that come with this problem?

At the end of the focus group the participants were asked whether they felt that everything had been covered that they wished to discuss. Alongside this, participants were invited to talk about any areas they felt, in their professional capacity, were being neglected within this area of research.

4.3.4. Data analysis

The focus group was transcribed and analysed using inductive Thematic Analysis (Braun & Clarke, 2013). Through using an inductive approach themes were data-driven and were
developed outside of a pre-defined coding structure (Feredy & Muir-Cochrane, 2006). In using this approach a participant-led understanding of the key issues was developed.

**The process of Thematic Analysis**

There are five key stages in conducting Thematic Analysis: familiarisation, development of initial codes, theme generation, theme appraisal, and theme categorisation. Due to the iterative nature of the research and reflexive approach taken by myself the stages were not conducted in a linear fashion. Instead, I constantly revisited the data and revised the analysis throughout the analytic process.

1: *Familiarisation*

Familiarisation with the data began at transcription; whilst transcribing the focus group I kept myself aware of the main issues being discussed and these were noted alongside the field notes (Bird, 2005). After transcription, the focus groups were “actively” (critically and analytically) read and re-read (Braun & Clarke, 2013, p.205) in order to get a better sense of the issues. Initial readings were done whilst listening to the focus group to become more immersed within the data and build up a better sense of the pertinent issues raised and discussed (Braun & Clarke, 2006). As the reading went on “initial noticings” (Braun & Clarke, 2013, p. 204) were noted on a separate sheet, these “noticings” were focussed predominantly on key issues that arose throughout the focus groups, or questions that I had about these issues. In accordance with Braun and Clarke’s (2013) recommendation, this was done freely and served the purpose of highlighting areas of interest for later analysis.

2: *Initial codes*

In later stages of re-reading, notations were made highlighting prominent comments, phrases and patterns (Braun & Clarke, 2006). A process of “complete coding”, as opposed to “selective coding” was applied (Braun & Clarke, 2013, p. 206); whereby all data that was considered to be relevant to the question was coded. This ensured that as much of the data as possible was prepared for later analysis. Thus, many sections were coded under multiple codes. The labels assigned to codes were strongly reflected in the data, often using the same words or phrases that the participants themselves had used. Earlier coding was based on “data-driven” (Braun & Clarke, 2013, p. 207) coding whereby codes were very closely linked to the participants talk and little interpretation occurred. As the coding progressed both “data-driven” and “researcher-led” coding (Braun & Clarke, 2013, p. 207) were used; “researcher-led” coding
involved the researcher’s interpretation. On subsequent re-readings these codes developed (Braun & Clarke, 2006).

3: Theme generation

After the repeated reading of the interviews, the initial codes that had been generated alongside the quote were input into an excel file in page number order. These codes were then organised into coherent groups, or thematic clusters that had meaning to the research question. Candidate themes were identified through a “pattern-based analysis” (Braun & Clarke, 2013, p. 223), whereby issues, topics, and ways of talking about them reoccurred across the data set. These themes were identifiable both in terms of their frequency as well as semantic weight, both for the participants, and in terms of answering the research question. All themes, clusters and quotes were then put into a word document and ordered in a way that encapsulated the counsellors’ stories. Using MindGenius, a computer mind mapping tool, the themes identified were laid out and relevant clusters were included (for an example see Appendix A). After this, I explored each of the key themes identified, considering how they related to each other and how they began to answer the research questions.

4: Theme appraisal

Within this phase the themes were refined, including a consideration of whether the candidate themes were substantial enough. Patton (1990) argued for themes to be appraised both internally and externally; meaning that themes were comprised of similar extracts and codes and they were dissimilar to other themes (Braun & Clarke, 2013). Furthermore investigator triangulation was imposed, which included the discussion and validation of arising themes and interpretations in order to develop, validate, and improve the emergent interpretative themes (Thurmond, 2001). A key aspect of this stage was ensuring that the interpretation was faithful to the data and provided an “overall story” (Braun & Clarke, 2013, p. 233) of the participants. Consequently, I re-read the transcript alongside each of the themes to ensure that the theme I had generated was reflective of the counsellors’ experiences.

Within this stage I organised the themes into hierarchical and lateral structures. I developed themes, which detailed the “essence” of a pattern (Braun & Clarke, 2013, p. 206), and subthemes which explained the nuances of each theme. Themes were grouped together because of semantic similarity, and because they explained and reflected a similar aspect of the counsellors’ talk.
5: Theme categorisation

The final stage of this analysis focussed on defining and redefining each of the themes and subthemes in relation to the research questions. Theme names were developed based on either a poignant comment made by the participants that neatly summed up that theme, or they were defined by their thematic “essence” (Braun & Clarke, 2006, p. 92). Within this stage, extracts were also used to elucidate and substantiate the themes. The themes, subthemes and extracts were compiled in a word document and extracts then sorted, cut-down, deleted and organised to provide a coherent and representative account of the focus group. Data was used both “illustratively”, whereby quotes were used to demonstrate a theme, and “analytically”, where the quotes would then be subject to further analysis to develop the theme and the nuances within it (Braun & Clarke, 2013, p. 252).

4.4. Results

Results are presented from the Thematic Analysis (Braun & Clarke, 2013) of the counsellors focus group. Three main themes were identified: Time of Transition, Role Shift, and The Challenges for the Counsellors, an outline of these themes is shown in Figure 1. The first two themes encapsulate the reported trends of the self-harmers and their friends. The final theme, Challenges for the Counsellors, explores the impact on the counsellors of working with this issue.

![Figure 1: Master themes in Study One](image)

The first master theme, Time of Transition, provides a context for the data set. University was characterised by a series of transitions, such as the initial move into University and forging new friendships, or moving out of University halls of residence and into privately rented accommodation. The counsellors talked about how those who self-harm tended to seek help after the initial move to University, whereas the friends of the self-harmers were more likely to seek help in their second year. The housemates of the self-harmers sought help across all years.
The second master theme, *Role Shift*, encapsulates this observed change in friendship. The change in the friendship role was identified by counsellors as normally occurring in the second year of university when students would move into privately rented accommodation. The transition away from University halls of residence and the result that the University was no longer responsible for the living arrangements of the students meant that students were forced to accept responsibility for themselves. Within this theme, secrecy was explored as playing a contributory role in making the friends feel more responsible, or burdened with the knowledge. The help-seeking preferences of the friends and housemates are discussed alongside the patterns in role adoption and rejection. The counsellors highlighted two ‘breaking points’ at which friends and housemates would seek support. For some of the housemates this point came very quickly after an initial self-harm episode. For others, there had been a period of time before seeking help when the housemates had taken responsibility for the self-harmer. The implications of these two ‘breaking points’ are discussed.

The final master theme, *Challenges for the Counsellors*, focusses upon the challenges or conflicts that the counsellors themselves were faced with as they supported the self-harmers and their friends through this transitional time. The conflicts experienced by the counsellors were focussed chiefly around their professional obligations. Primarily, the counsellors talked about the difficulties they faced in managing the expectations of those who cared about the self-harmer; they discussed how on occasion they had to prioritise the confidentiality of their client over the well-being and reassurance of others.

### 4.5. Theme: Time of transition

The first master theme, focussed on University as a constant period of transition, from the initial move to University, to moving into privately rented accommodation and finally, the transition out of student status. Students who live in University halls of residence are normally expected to share a kitchen and potentially a bathroom with groups of other students. It is within this environment that many students will begin to create the first bonds within University (Chow & Healey, 2008), often fostering a sense of, sometimes intense, social identity and belonging (Wilcox, Winn & Fyvie-Gauld, 2005). Ultimately, it is within the first year, and specifically in halls of residence, that many students experience support, friendship and new social experiences, experiences that later influence their socialisation and safeguard them in the years to come (Wilcox et al., 2005).

The second period of transition was marked by the movement out of University accommodation and into privately rented accommodation. This is the first opportunity that many of the students have to choose whom they live with. This process begins between the
middle and the end of the first year, when students work out who they want to live with for the next academic year. This change in living arrangements is accompanied by changes in their social and personal circumstances. Moving into privately rented housing provides less of an opportunity to establish the sense of belonging to a bigger social group (such as halls of residence). There are usually less people to share amenities with, and an increase in responsibilities. For the first time, these young adults are now responsible for their own bills, as well as living environment. In University accommodation, when there is a personal issue with one or more of the students, the University is responsible for the well-being of the students and is obliged to support them when they are in crisis. The movement into private housing removes some of the responsibility of care from the University.

The counsellors talked about the two key transitions, the first move to University, and the subsequent move into privately rented accommodation as being significant times at which they were counselling those who self-harmed, as well as their friends or housemates. The typical pattern described by the counsellors was that those who self-harmed and first-year housemates tended to seek the counsellor’s support within the first year; whereas the friends tended to seek support in the second year.

Within the Time of Transition master theme there are three subthemes: The micro-community, Retriggering Transition and Second Year Woes, as demonstrated below in Figure 2. Each of these themes is associated with the University experience as being a time of change and uncertainty. The first subtheme, The micro-community explores how the counsellors constructed the University itself and its distinctive academic and social environment that new students are brought into. The Retriggering Transition subtheme considers the initial move to University, with specific focus on how this change is thought to affect self-harmers. The final subtheme, Second Year Woes focusses on the experiences specific to the second year, in particular this theme accounts for the counsellors observations that friends, some of whom were also housemates sought out support in their second year.

![Figure 2: Subthemes in the Time of Transition master theme.](image-url)
4.5.1. Subtheme: The micro-community

The Micro-Community sub-theme begins to explore how the counsellors constructed the University as being a distinctive academic and social environment. Specifically it was characterised by the pressure to succeed and to fit in.

It seems to be a lot of pressure here about how you fit in and um (.) you know (.) it’s got this sort of micro-thing. (Kimmie)²

In conversation about the move to university, Kimmie highlighted that for all students, not just those who self-harm, the move to university can be a “traumatic” experience. This is in part due to the new environment that first years are faced with. Although this experience is relatively common to all first year students, the counsellors felt that this University in particular had its own micro-community with a real “pressure” to succeed academically.

The status of the University as one of the top institutions in the country appeared to have filtered down to the students own internalised “pressure” to succeed.

Jake: I wonder if it is the fees then (.) but it’s not the first-I’m sure you’ve experienced this (.) students who don’t want to get a first-they want to get over 85 per cent

Baxter: Yeah (.) I had a couple of them

Victoria: I’ve had someone who came back who had just practically mit circs (.) they had a first said they weren’t happy with the mark that they’d gotten

Lucricia: I had a student (.) my very first student when I was a bit naïve about these things and I wouldn’t say she was quite suicidal but she was in a desperate state coz shed done so badly in this exam and it turned out that I think she’d got 85 for it but she got 90 in everything else

All: Mmm

² Transcription conventions can be found in Appendix B.
This extract details a discussion about the increasing use of mitigating circumstances ("mit circs") within the student population. Jake referred to the students increasingly using mitigating circumstances as an "insurance policy". He talked about how previously mitigating circumstances were used to prevent failure, however, they were now being used to safe-guard the students’ first class grades. This pressure or drive to succeed, fostered by the University appears to have permeated into the students attitudes towards their own achievements. It is this sense of pressure and expectation that the counsellors attributed to the student's "vulnerability". The pressure to fit in, make new friends and be successful was highlighted as being key to (re)triggering self-harm in the first year.

4.5.2. Subtheme: Retriggering transition

The second subtheme, Retriggering Transition considers the initial move to University, with particular focus on how this change affects self-harmers. The counsellors reported higher numbers of first year undergraduates who self-harm seeking support for themselves, in comparison to the friends or housemates. As outlined earlier, the move to University is a specific time of transition for the students, away from familial support to more social and independent forms of support. Friendship formation often occurs within halls of residence, something that Kimmie referred to as "very much a pot luck of who you’re put in with". This “pot luck” combined with the move to University as being potentially “traumatic” can make it a potentially "(re)triggering" time for students.

I think people are quite vulnerable at this stage in their first year (.) about fitting
in (.) you know (.) linking, linking to that yeah maybe maybe vulnerability to
retrigger something. (Kimmie)

The group agreed that almost exclusively within the first year it was the self-harmers who sought the counsellor’s help, rather than their friends or housemates. As noted in the quote above, Kimmie talked about the first year acting as a “retrigger” to self-harm. For example, she refers to failing to form friendships or social connections in the first year. The importance of Kimmie referring to difficulties in making friends as being a “retrigger” suggests that many of those who are seeking help from the counsellors were self-harmers prior to the move to University. Thus, rather than University acting as a catalyst for a new behaviour, it reactivated the previous coping mechanisms of the students.

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3 The University defines mitigating circumstances as “conditions which temporarily prevent you from undertaking assessment or significantly impair your performance in assessment”. This includes both long-term and short-term physical, mental and situational conditions.
4.5.3. Subtheme: Second year woes

The final subtheme, Second Year Woes encapsulates the counsellors’ talk about when the friends and housemates would seek help because of a self-harmer. There was a trend within the accounts of the counsellors that suggested that the second year and the changes that occurred at this stage prompted the friends and housemates to seek out support. Specifically, the counsellors identified the transition into privately rented accommodation as a catalyst for the friends, and especially the housemates to seek out support. Victoria stated:

_I don’t think it hits until they’re moving into their own (.) houses and getting to know each other (Victoria)_

Victoria’s comment implies that the friends failed to grasp the reality of the situation when a friend self-harms until they moved in with them, and then it “hits” them. Suggesting that either the friends, that are now housemates, were unaware of the self-harm before agreeing to live with the self-harmer, or that the friend did not understand seriousness of the self-harm.

It is when students become aware of how living with a self-harmer impacts on them that the counsellors reported seeing an increase in help-seeking of the friends and housemates. Jake commented that in some situations, the housemates asked for the immediate removal of the self-harmer from their accommodation.

The counsellors discussed why the housemates were more willing to focus their help-seeking on the removal of the self-harmer. They explored the notion of responsibility, specifically an increase in their feeling of responsibility, as being key to their motivations for the housemates seeking support from the counsellors.

_We’d kind of have to go back to them [the housemates of a self-harmer] and say that it’s nothing to do with the university; you’re in private housing contract (.) And there’s something really interesting there about the transition and students realising for the first time in their life that there’s nobody above you who’s going to sort this out (.) you’re just there and you’re living with this person (Jake)_

As previously discussed the move into privately rented accommodation was seen by the counsellors as being a further transitional stage for the students. At this stage the students take on more responsibility, not only for themselves, but also the people that they live with. There was a dispersion of responsibility in halls of residence, ultimately the students know that if there is a problem the University would have an obligation to resolve that issue. When they are in privately rented accommodation the University’s duty of care concerning the students' living
situation ceases and students have to resolve issues themselves. The counsellors suggested that it was this realisation of their own responsibilities and that there was “nobody above” them, that came as a surprise to the students.

4.6. Theme: Role shift

The counsellors discussed a change in friendship, wherein the friends took on roles and responsibilities that lay outside of a ‘normal’ friendship. The counsellors interpreted the change in friendship as the friend adopting something similar to a parental role.

Upon finding out about the self-harm, the counsellors reported that the friends would either reject the opportunity to support the self-harmer and ask for the self-harmer to be removed from their accommodation, or the friends would attempt to provide support.

There are two subthemes within this master theme; Responsibilities: Parental Role & Secrets, and Boundaries, these can be seen in Figure 3. The first subtheme, Responsibilities: Parental Role & Secrets, outlines the counsellors’ talk about how the students’ relationship with their self-harming friends changed. The counsellors remarked that the friends who did support the self-harmer adopted a parental role, one that was, in part, maintained through the self-harmers’ requests for secrecy. In so doing, the counsellors noted that the normal boundaries of friendship had deteriorated. Alongside this new role, the friends also adopted the accompanying responsibilities.

The second subtheme, Burdening addresses the impact of that this new role and set of responsibilities had on the friends. Specifically this focuses upon the counsellors’ belief that many of the friends sought out support because they felt burdened and could not ‘share’ their experiences of supporting a self-harming friend. As a result of this burden friends would support the self-harmer until they themselves reached a breaking point, usually triggered by external pressures such as exams. The counsellors also discussed how the friends of the self-harmers would avoid seeking support for fear of losing the friendship with the self-harmer.
4.6.1. Subtheme: Responsibilities: Parental role & secrets

This sub-theme focuses principally upon the counsellors’ accounts of friends who had attempted to support the self-harmer. Before exploring the counsellors’ reports of those who did take on a supporting role, it is also important to note that they also experienced a few housemates who had refused to support the self-harmer.

The only other thing that I go back to because is (.) wanting people removed we talk a lot about friend wanting support but that is another thing that happened this year there was private housing and erm essentially (.) you know the housemates came and were saying you know (.) what’s accommodation going to do? We’re living with this person and we don’t want to (Jake).

In most cases where the housemates were seeking support from the counsellors, the primary aim of the housemates was to get the self-harming student removed from their accommodation. Unlike the friends of the self-harmer, the housemates were not seeking support to help the self-harmer or to flag them up as being potentially unwell to the institution. The motivating factor was the self-harmers removal. It could be said that this is an ultimate act of rejecting the role of carer.

For those who did attempt to support the self-harmer, the counsellors talked about the friends and housemates taking on a new role within the relationship. The counsellors talked about a movement away from a typical friendship. Specifically, the counsellors said that friends took on a “parental” role as they tried to work out how best to support the self-harmer.

Victoria: They [the friends] almost take on (.) almost a parental role
Kimmie: Yeah
Jake: It is parental (.) I think yeah that’s the word that comes to my mind
The counsellors constructed the friendship as being altered by the self-harm. The behaviours and actions of the friend are more akin to that of a carer, specifically a parent. What this demonstrates is the awareness of the counsellors that the friends of self-harmers often take on roles that over-step their boundaries as friends. The counsellors specifically talked about the friends adopting roles that are usually associated with a greater level of care and involvement than friends; that of being a parent.

To add another layer of complexity to the adoption of a parental role, the counsellors felt that students lacked the skills to support their self-harming friend.

_The lack of sort of appropriateness as well (.) what is ok, what should be (.) be dealing with-what's normal? What isn't ok? Where do we start and stop and for example (.) Jake having people completely going too far and clearing up blood._ (Baxter)

For some students this may be the first time that they have ever been around those who self-harm, and the sense of not knowing what is appropriate may have meant that the friends took on more responsibility than was appropriate. There was also a sense of the friends not being quite sure of what was and was not normal behaviour and how they should or should not react to it. Leading the counsellors to observe that the friends often felt like “they should be doing something” (Baxter).

Indeed, the notion of appropriate behaviour or knowing how to deal with a self-harmer may also be indicative of why some friends do not seek support from the counsellors. In discussion about the help-seeking of friends, Jake commented that:

_The other thing that's just occurred to me is actually the number of friends we see coming forward is probably masked massively because (.) a lot of people probably tell a friend that they they harm themselves and the friend has experience of it already from their school (.) or other areas of their life (.) so you know they don't get really frightened and come and tell us (Jake)_

Here Jake highlights that the true number of friends who are supporting self-harmers could be far higher than the counsellors were aware of. He attributed the lack of friends seeking help on their previous experience or knowledge of self-harm. This prior experience, he argued, provided the friends with an insight into how to appropriately take care of a self-harmer. It is possibly an awareness of appropriateness that means the friends to feel like they can cope, or at least do not feel the need to seek out support from the counsellors.
As a consequence of this new role, the counsellors commented upon the adoption of a new set of responsibilities. These responsibilities usually stood outside of the remits of ‘normal’ friendship. When discussing one group of housemates in particular, Jake outlined the practical responsibilities that the friends adopted:

They [the friends] would just get up in the morning when this person had gone out in the middle of the night to an ambulance to go to hospital and they just cleared up all the blood around the house (Jake)

In the friends figuring out how to appropriately support the self-harmers, the counsellors talked about the friends as taking on inappropriate responsibilities, such as clearing up the blood after a self-harm episode. This sense of responsibility also filtered into other aspects of the self-harmers’ well-being. For example, Baxter animatedly talked about a student who had sought help because she feared her friend would fail her degree. When he questioned her; “whose responsibility is that?” the student identified that it was her friend’s responsibility, yet the student still believed that she could not just let her friend fail. This sense of overriding responsibility also impinged upon other areas of the friend’s lives. For example, Victoria commented that even on nights out the friends “might feel so responsible that they might need to be looking after that person”, to the extent that they would cut a night short so that they could check up on the safety of the self-harmer. From the experiences of the counsellors, many of them found the involvement of the friends in the care of the self-harmers to be excessive, as such their focus was to encourage the friends to relinquish these unnecessary responsibilities.

When talking about this overriding sense of responsibility, and how friends seemingly take on more responsibility than they should. Baxter argued that the extra responsibilities taken on by the friends were not specific to the friends who support self-harmers.

Baxter: I don’t think this is, I don’t think this is just common to self-harm

INT-A: No?

Baxter: What I think people talk about here is

INT-A: It’s general?

Baxter: Emotional distress (...) general behaviour and how young kids sort this out (...) and nights out they’ll be looking after each other for all sorts of reasons

All: Mmm

Baxter: They might bump into the ex-boyfriend there’s all sorts of things going on

All: Yeah
Baxter: And I don’t think self-harm is any different in that sense

In contrast to the other counsellors, Baxter argued that friends routinely took on responsibilities or acted in seemingly excessive ways, such as looking after each other, as a course of normal friendship. Rather than self-harm causing the friends to take on more responsibilities, self-harm just created the environment to allow those behaviours to exist. He contended that 'self-harm' could be replaced with “emotional distress” or “bump[ing] into the ex-boyfriend” in terms of friend support.

The counsellors also discussed the impact that secrets had over the supportive roles that friends adopted. They highlighted that those who seemed less able to cope, were the ones who were asked to keep the self-harming a secret from others.

Victoria: I think that brings up for me the responsibility that people feel and it is different I guess in different cultures as well (.) because self-harm is so secretive (.) if they share that with a friend and they ask that friend to keep it secret then they start to hold a huge amount of responsibility for that person

Kimmie: Yeah (.) yeah

Victoria: And that’s where the problem starts to arise

Jake: Well that’s something I was going to tell earlier which links to your point that a lot of what we see is people coming very frightened and very worried

The notion of secrecy and sharing information was a very salient issue for Victoria in particular, who, on multiple occasions made reference to secret-sharing as reinforcing the friends’ sense of responsibility over the self-harmer. By the friends being asked to keep the self-harm a secret the new role and responsibilities adopted by the friends continued to be reinforced. By being told that they were the only ones who knew about the self-harm, the friends believed that they were taking on the sole responsibility for that person. They believed that there was nobody else to rely on in-case they failed to help the self-harmer. Furthermore, by being asked to keep the self-harm a secret the friends were not able to talk through their experiences with anyone else, meaning that their new behaviours and sense of responsibility continued to go on unchallenged.
As the focus group progressed it became apparent that the counsellors sometimes doubted the ‘secrecy’ of the self-harmers’ stories. They speculated about a series of calls that had come in about “a somebody”:

We’re hearing about a somebody we think over the last few weeks we’ve had calls about a somebody out there (.) and (.) and calls from different people, and we’ve no idea if this somebody is the same person and they’re already being well looked after or whether this somebody is a somebody else (.) but then I guess it becomes second and third hand and it might be that they’ve all been told that they’re the only person I’m telling this to. (Victoria)

Victoria was suspicious about this series of calls which highlighted issues around the authenticity of the ‘secrets’ told by the self-harmer, as well as providing examples of how the self-harmers might manipulate or co-ordinate the support from their network.

However, Baxter argued that this pattern was not a trait distinctive to self-harm friendships.

Well I think the more we talk about this the more I’m thinking about group dynamics with the students because we get (.) I see a lot of situations like this that aren’t necessarily about self-harm (2) But there might be a relational dynamic where there’s one particular person, seems everything seems to be the conduit for everything (2) And occasionally that could be self-harm but a lot of other times it can be a personality thing (.) another behavioural thing (.) erm so that’s not an uncommon presentation from young people. (Baxter)

Expanding on what Victoria talked about in reference to one self-harmer impacting upon a group of other students; Baxter suggests that this is not something that is exclusively a result of self-harm. He argued rather, that one person acts as a “conduit”, or channel for issues within the group. Instead of seeing self-harm as the chief reason for distress within a group, he suggests that sometimes one person, or their personality, is the main cause, or at least the main vehicle for much of the issues within the group. He further removes himself from the position that self-harm has inherent qualities that affect the dynamics of a group by attributing group conflict to being a common trait amongst “young people”. Here, Baxter is arguing that distress caused within a group is not always attributable to self-harm, rather the person causes the distress and self-harm is a manifestation of this distress.
4.6.2. Subtheme: Burdening

This final subtheme, *Burdening*, begins to address the impact of the parental role and associated set of responsibilities adopted by the friends. The counsellors talked about the help-seeking of friends who felt burdened due to being unable to share their experiences with others as a consequence of being asked to keep the self-harm a secret. The counsellors argued that the secrets kept by the friends for the self-harmers eventually turned into a burden. It is when the secrets turned into a burden that the friends sought help.

As previously mentioned, the counsellors talked about the friends’ sense of responsibility becoming compounded when asked to keep the self-harm a secret.

*I think it does because (...) yeah because they then will they can’t share that responsibility with anyone until it gets too much for them and they feel they have to say something* (Victoria)

The counsellors identified that the friends of self-harmers could only provide a limited amount of support. When supporting the self-harmer and keeping secrets became too much for the friend, they reached a breaking point which led them to seek help. It is keeping secrets about the self-harm that counsellors, and in this extract, Victoria, attributed to the friends’ difficulties in coping. Through being unable to “share” their experiences and responsibilities the friends felt burdened by their knowledge. The counsellors agreed that this was a key determining factor in many of the friends seeking out support.

For those who attempted to support the self-harmer the counsellors talked about them seeking out informal support. As Victoria stated, the friends “*would have already done a bit of sharing quietly*”. Although this allowed the friends to share their experiences and in so doing gain some social support of their own, it was suggested that sharing within a group of friends was not always beneficial. Victoria stated that through talking about the self-harm within a pre-established group the secret “*becomes a secret that’s held by a bigger group and it, it just feeds that secret really*”. In seeking out friends within the same group as the self-harmer, the secret is maintained, rather than it being between two people, was being maintained within a group of individuals.

In some instances talking about their experiences was unavoidable, in the quote below Jake talks about a group of housemates who had sought help because of a self-harmer they were living with. The counsellors noted that the friends' behaviour and responsibilities over the self-harmer slowly began to increase over time.
And for some of them then it was reminding them you know (.) this isn’t something you should be expecting to (.) be you know, a part of (.) this is something out of the ordinary (.) But they were kind of they were very they were all very very nice you know (.) and they slowly but surely kind of gradually over kind of a long time without support initially things had happened and they’d done their best to try and make it all better the next day and it got worse and worse and they’d just done a bit more and a bit more (.) and because all three of them were doing it they were all kind of normalising to each other (Jake)

In this example Jake talks about the process of how the friends of a self-harmer slowly adopted more and more responsibility for the self-harmer’s care. He constructed it as being a gradual development, over time the friends had taken on more responsibilities. Although he identified that they had been taking on a caring role in order to help the self-harmer, they had accidentally begun to normalise the behaviour. The normalisation of behaviour was not limited to the self-harmer, whose behaviour went unchallenged; the friends also normalised their own behaviour through gradually intensifying the care they provided.

This kind of support was only sustained for so long and eventually there came a point at which the friends began to seek out other forms of support. This was usually motivated by an external factor, such as exams. In the extract below Jake is talking about his experiences with the same group of housemates from the previous extract.

Jake: At first I think they probably had taken a huge chunk of responsibility and you know on some level there was a bit of rescuing (.) well a lot of rescuing going on and they thought that maybe they were going to make this person okay, you know (.) erm and then (2) erm, yeah over time it became it changed to point of just being like (.) we’ve got exams.

Victoria: Yeah (.) I think that’s it really (.) not realising the impact

Jake: We can’t go on

Baxter: There so many got to work hard (.) we’ve come first (.) our studies-what’s the phrase I’ve heard of? I’m not going to let this student ruin my degree

Jake: Mmm
The key motivational factor to seeking help reported by friends was their degree; specifically that in continuing to support the self-harmer, their degree would be jeopardised. In this case Jake talks about friends’ fears over their exams; elsewhere Baxter also talked about students seeking help saying “I’m not going to let this (.) student ruin my degree”. Formal help-seeking was commonly done when supporting the self-harmer became a tangible risk to their own futures. What is also interesting in this extract is that Jake refers to the friends “rescuing” the self-harmer, and attempting to “make this person [the self-harmer] okay”. He constructed them as attempted rescuers, those who neglected themselves and their priorities in order to support or help the self-harmer. Although the help-seeking of the friends could potentially challenge this construction, through shifting the blame onto external factors, such as exams or their degree, the friends were able to maintain the construction of the rescuer.

The tendency for the friends to place themselves in a sacrificial position was also highlighted when the counsellors discussed barriers to help-seeking. Through being unable to tell people about the self-harm, when provided with the opportunity to get help for the self-harmer, many of the friends were reticent to tell the self-harmer to seek help, for fear of losing a friendship.

_They were worried about that she would reject them (.) you know they were (.) they'd been friends for quite a while erm and they were worried that if they told her she would take it the wrong way and she (.) they were interfering and they would lose their friendship, so that was quite a big ask. So we spent quite a lot of time exploring (.) that versus them worrying about (2) her health, because she obviously was at quite high risk then, so, it was looked at the balance of it and in the end they decided they would take that risk. (Kimmie)_

This quote from Kimmie highlights the perceived “risk” for friends in telling the self-harmer that they were worried about them and had sought help on her behalf. The “risk” to the friends in this instance was the potential loss of friendship. The friends believed that the only way to keep their friendship with the self-harmer was to avoid getting her help, or “interfering”. After discussion with Kimmie, the friends decided to take that “risk”, ultimately the friends were willing to relinquish their friendship for the sake of the self-harmers wellbeing. Similarly to the rescuing that Jake talked about, that the friends had been putting the needs, or wishes of the self-harmer above their own.

Although there was talk about the more usual motivators for self-harmers seeking help, such as personal distress, counsellors also raised the role of friendship for the self-harmer. For some self-harmers, the potential loss of friendship motivated them to seek help.
The feedback from the relationships was actually informing her that the behaviour was frightening them and therefore she really needed to do something about it. And I just found that really interesting, the way that came to the surface as far as she was concerned she drank like everybody else she got a bit out of order she forgot things she got herself into some very potentially dangerous situations but she seemed to be able to wear that on her own but being part of the social group where other people became aware of it that became harder and harder for her to accept that. So it was through the influence and the mirroring of the normality that came back that informed her that things weren’t right (Jake)

Unlike the expected reasons for self-harmers’ help-seeking, such as personal distress, the counsellors also talked about the self-harmers who were motivated to seek help because of their relationships with others. In Jake’s account, a client identified she had a problem through comparing her behaviour to that of her friends. Initially the client seemed not be concerned about her behaviour, it was only through comparison and feedback from her social group that she began to question her actions. Jake talks about the friends “mirroring normality”; the friends acted as a comparison to her behaviour, a comparison that highlighted her abnormal behaviour. It was through this mirroring and feedback about her behaviour via her friends that encouraged the client to seek support. This indicates that not only do friends play a vital role in being supportive; they also help establish what is, and is not appropriate behaviour.

Similarly, Baxter also talks about how a client was motivated by their social group to seek help.

I think of this particular student and even though her behaviour was enough to be very concerned about and very worried about she wasn’t particularly worried about that. What she was more worried about was her social standing. And the impact the behaviour had on whether or not she could remain part of this social group (Baxter)

In Baxter’s account, a client had sought support because of her fear of isolation from her social group. Although Baxter believed the self-harm to be serious enough to seek support for, the client did not; her motivation for seeking support was purely based on her threatened social standing. What this suggests is that the fear of losing friendships acts, in this case, as a higher motivating factor to help-seeking than her behaviour. Whether or not the loss of friendship was intentionally used as tool to encourage help-seeking, the potential threat of losing friends does suggest that the friends of self-harmers, and the social support they provide, play a vital role to the self-harmer in more ways than one.
Although many of the self-harmers had asked their friends to keep their self-harm a secret, many appeared to unaware of the burden this then placed on their friends. When asked whether the counsellors thought the self-harmers were aware of the responsibilities that their friends had taken on, such as cleaning up their blood, the counsellors reported that in most cases the self-harmers were surprised about the burden they had placed onto their friends. For example, Jake was talking through his experience with a client whose housemates (who were also friends) had sought help on their behalf.

Jake: I saw the person myself and I did have this direct conversation and they were seemingly absolutely shocked and blown away but their housemates were burdening (.) sort of bearing this burden

Victoria & Kimmie: Mmm

The counsellors felt that self-harmers were often surprised at the level of responsibility and subsequent burden that their behaviour had placed on others around them. This naivety was also explored by Kimmie who discussed a self-harmer who had asked her friend to “keep her tablets to stop [her from] overdosing”, yet failed to be “aware of the impact of that at all”. The counsellors attributed the self-harmers surprise at the burden they placed on others on their perception that they were being secretive, and trying to avoid burdening others. This suggests that the self-harmers in these situations were not aware of the impact their behaviour was, having on their friends. The self-harmers lack of awareness about their impact on others, however, could be a result of friends not telling the self-harmers when they feel overwhelmed.

Although the counsellors had worked with self-harmers who expressed surprise at the burden they were for others, the counsellors also questioned the genuineness of this naivety. Leading on from Jakes previous quote, he adds:

Jake: I don’t know (.) I mean this is quite a unique case for me (.) the degree to which the person sort of profess to be oblivious I found quite unusual, whether or not that tells us whether they really were or not (.) I’m not sure

Victoria: Yeah

Kimmie: Mmm

Through discussing this particular case it became apparent that Jake mistrusted the naivety reported by the self-harmer. He suggested that it was difficult to be sure whether or not the
self-harmer knew the impact it was having. As discussed elsewhere Lucricia highlighted that sometimes the behaviour of those who self-harm can be quite “*manipulative*”. It could be argued that a faux naivety could be an act of manipulation; through saying they were unaware of their impact on others, they may be able to escape judgement or questioning about this impact.

On the other hand, the counsellors also discussed how for some self-harmers the self-harm was kept as much a secret as possible in order to *avoid* burdening those around them. Following on from Jake’s discussion of his client, Victoria states:

*I think there’s something about the (*) that is part of why its secret because people don’t want to be a burden (*) but it also might be what got them to that place in the first place, they couldn’t share a worry because they felt it would be a burden so they started to find ways of coping with it themselves, then it became even more secretive to avoid being a burden.* (Victoria)

Here, Victoria challenged the view that the self-harmers were often disingenuous about their knowledge of their impact on others. In fact, Victoria argues that often self-harmers try to keep their feelings and their self-harm a secret in order to not burden others. Victoria argued that for some keeping their self-harm a secret would ultimately perpetuate the self-harm. Essentially Victoria challenges the self-focussed perception of the self-harmer, and they actually become an inadvertent burden through trying not to be.

**4.7. Theme: Challenges for the counsellors**

The previous two master themes have focussed on what the counsellors can tell us about the impact of self-harm upon a friendship. However, throughout the focus group it became clear that in supporting the self-harmers and the friends of self-harmers there was a very real impact upon the counsellors, this is explored in the final master theme, *Challenges for the Counsellors*.

Through providing support to self-harmers and their friends, the counsellors were faced with a series of challenges, or conflicts. This first subtheme sets out the counsellors understanding of their therapeutic role for the self-harmers and their friends. The second subtheme encapsulates the challenges that the counsellors faced when working with multiple interested parties.

Figure 4 outlines the two subthemes within this master theme: *The Counsellor’s Obligations*, and *Managing Expectations*. The first subtheme, *The Counsellor’s Obligations* sets out what the counsellors’ role was when providing support for the self-harmer and the friend(s) of the self-
The requirements for each of the groups varied greatly. For the self-harmers, the focus was predominantly placed upon addressing and challenging the thoughts and experiences that lead to a self-injurious act. For the friends, the counsellors talked about ways to relinquish the friends’ mis-acquired parental role and establish self-care.

In the second subtheme, *Managing Expectations*, the counsellors talked about how parents, University staff and friends, in particular, had specific expectations of the care that should be provided to students. This subtheme explores the conflict between managing the expectations of those who are concerned about a student and the counsellor’s professional obligation to the confidentiality of their client. Additionally this theme also explores how the counsellors often found there to be an over-reaction to self-harm by both self-harmers and also those around them. As a result of this (mis)use of the counselling facilities the counsellors talked about the need for awareness training with the staff and students.

![Figure 4: Subthemes in the Challenges for the Counsellors master theme.](chart)

### 4.7.1. Subtheme: The counsellor’s obligations

This first subtheme, *The Counsellor’s Obligations* outlines the role of the counsellor when providing support to students who self-harm, their friend(s) and housemates. The requirements for each of these groups differed. For the self-harmers attention was paid to challenging the thoughts and experiences that lead to a self-injurious act. For the friends who supported the self-harmer, the counsellors aimed to get the friends to relinquish their mis-acquired parental role and establish self-care. For those who did not support the self-harmer, usually first year housemates, the counsellors would explore, when feasible, routes of looking at alternative accommodation.

The counsellors did not talk much about their role with the self-harmers, and what they felt they needed to do in terms of their support. As Jake pointed out, they predominantly tried to explore reasons behind the self-harm episodes:
I would just explore a lot about where they're cutting (.) when they're cutting how deeply (.) what's going on for them when they cut (.) how they deal with the cut afterwards (.) is it an escalating pattern (.) or is it a stable pattern (.) All that kind of stuff (Jake)

Very little reference was made to how the counsellors supported the self-harmers. This may have been because there might have been an assumed knowledge about how to support someone who self-harms, one that therefore might not have needed explaining. Alternatively this may not have been discussed as the counsellors knew the focus of the focus group was to look at the impact on friends and friendships, rather than the self-harmers themselves.

On the other hand, the counsellors talked more about their professional role when their client was a friend of the self-hamer. Some counsellors talked about providing the friends with a space where they could “vent” their frustrations. However, the majority of the counsellors talked about the friends redirecting their attention away from the self-harmers. For example, Jake talked about making the friends put themselves first.

Jake: Yeah, and the other thing is about really encouraging them to put their own needs above the needs of the other person(.) because they get themselves into dreadful states some of them (.) trying to manage it and, you have to make them realise (.) it’s ok to put yourself first

All: Mmm

Jake: Which it seems to be something which a lot of them struggle with

All: Mmm

Kimmie: And I was just trying to think about generally when we're working (.) when I'm working with people I've always looked at what other resources are available (.) it's just trying to think actually (.) in terms of support (.) sometimes it's useful its sometimes helpful to go off and see what other things might consolidate that

As previously outlined, the tendency for friends to put their needs as secondary to the needs of the self-harmer was a key therapeutic concern for the counsellors. As the focussing on distancing the friend from supporting the self-harmer was a key concern for the counsellors,
the adoption of responsibilities beyond friendship may be something common to those who support a self-harmer over a prolonged period of time. Thus, the focus of the counsellors was in reducing the responsibilities that the friends had taken on.

**Baxter:** Really acknowledge the limitations of the role of being a friend; I think that's the first step

**Victoria:** Yeah, so relieving them of that responsibility (.) letting them know they've shared it then very much looking after themselves and the impact it's having on them (.) so that they can get their lives back on track

In order to help the friends and refocus the attention on themselves, the counsellors talked about their therapeutic role as taking away the extra responsibilities that the friends had adopted, and to recognise the limits of being a friend. The counsellors focussed on this being achieved through sharing their experiences, further highlighting the negative role that the counsellors believed secrecy played in maintaining the unequal friendship roles. Essentially, the main focus of the counsellors was to re-establish the boundaries of a normal friendship.

**Baxter:** I think the first thing when you're dealing with friends of someone with self-harm is (2) not encouraging them to go on and be the therapist and

**Kimmie:** Yeah

**Baxter:** Really acknowledge the limitations of the role of being a friend (.) I think that's the first step

The ultimate aim of the counsellors was to encourage the friends to restore the boundaries and responsibilities of the friendships that they had previously had with the self-harmer. Alongside this was the teaching of the friends of what was, and was not, appropriate within a friendship. It is interesting that Baxter states that the friends need to “acknowledge the limitations of the role of being a friend”. What Baxter indicates is that friendship should be, in terms of support, a limited resource. Through the counsellor’s focus on diminishing the support the friends provide, it suggests that the friends often misinterpreted how much support they were expected to provide and often went beyond what was realistically expected of them as a friend.
4.7.2. Subtheme: Managing expectations

This second subtheme considers the counsellors’ experiences of managing the expectations of those who were concerned about a student versus their professional obligations concerning the confidentiality of their client. For instance, the counsellors talked about the increase in fees meaning that the expectations of those who cared about the self-harmers altered.

Baxter: I think that's changed with fees and parents paying fees and expectations and entitled to know which counsellor my child's speaking to because I'm paying nine grand for them to be there.

Jake: So I can tell them what to say to them

Baxter: Yeah (.) exactly (.) there is that element (.) yeah

With this fee increase, the counsellors also talked about the expectations of their services as coming under more scrutiny from the parents of the students. In the extract above Baxter recalled being asked to provide the name of the counsellor supporting the student, other counsellors talked about being asked by parents as to why they had not got involved in a student's care. What this suggests is a general shift towards a more consumer based model to care, support and education. Those who were in some way financially supporting the student, such as parents had “expectations” concerning their right to confidential information about their children and the support that their child received.

Expectations such as these were not solely confined to the parents, the counsellors also talked about friends wanting the counsellors to actively seek out students in crisis, such as in this extract from Kimmie:

I had an interesting one where it was a friend who came to me first (.) before the student did where the student was, amongst many things was erm (.) self-harming by eating lots erm in a very short space of time and shutting herself away (.) so there were elements of depression as well (.) and it was her friend who came (2) to me to ask me to see her (.) and that was quite tricky from a confidentially point of view. (Kimmie)

As had been discussed by others, Kimmie was recalling her experience with a friend who had asked for the counsellors to intervene with her self-harming friend. Something that Kimmie.

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4Over recent years University fees have continued to increase, with homes students now paying in the region of £9,000 per year and non-EU students paying nearly double this.
was not opposed to; instead the only barrier she talked about was issues around confidentiality.

Issues surrounding confidentiality was a salient concern for the counsellors. The counsellors talked about the role of confidentiality as being more restrictive to the well-being of the students, rather than safeguarding them.

Kimmie: I've just thought of an interesting issue in a sense relating to this erm if you have a situation where you had friends saying they were concerned about somebody from the confidentiality point of view we can't necessarily tell them that we're seeing them

Victoria: No () that's right

INT-A: So you can't actually reassure those friends

Kimmie: Yes () so I just suddenly thought about that that's I mean it's happened to several () it's happened to academics or anything in the sense erm that's sometimes it's just interesting that confidentiality that it can erm () you know, not always be in everyone's best interests

Many counsellors reported that when the friends and family would contact them about a student, they were unable to inform them as to whether or not that student had sought help. The counsellors raised this as a challenge when they felt unable to reassure the friends, rather than the parents of a student; indicating that their primary concern was the well-being of students. Kimmie talked about confidentiality as not acting in "everyone's best interests"; that maintaining the confidentiality of one student may clash with the well-being of other students. Prioritising the anonymity of one student over the reassurance of another was a key point of professional conflict for the counsellors. The counsellors managed this challenge by urging the student to tell their friends that they had sought help, by doing this the counsellors could begin to contact with the student.

The counsellors also talked about how students were often being sent to them unnecessarily, due to being upset over situations or events that they felt would make anybody upset. This was done particularly by uneasy staff members.

Jake: You do get students who do () like you were saying get sent to us because they've cried

INT-A: Yeah
(giggles)

Jake: We must never see you cry

Baxter: Grandmas just died

Jake: Yeah

Baxter: It's perfectly normal

INT-A: Yes

Baxter: It'd be strange if they weren't crying

As evidenced here, the counsellors discussed that often students were being sent to them due to staff members feeling uneasy with crying students. Earlier in the focus group Jake commented that those “outside of these services can get very (.) very anxious”; he was making particular reference to staff members. The somewhat jovial inference throughout the focus group was that often students were sent to them because of normal reactions to situations, highlighting the counsellors’ stance that the academic staff had a general unease with distressed students. The counsellors inferred that often those who were sent to the counselling team were sent, not because they needed support, but rather because the academic staff felt unable to support them.

A similar trend was also found within the student population, the counsellors discussed how often the peers or friends of self-harmers would be hyper-aware of self-harming behaviours.

Jake: Well it's [self-harm] on a continuum thing isn't it? Varies so it's life threatening at one end and then stuff which is you know (.) extremely benign at the other (.) so I think you're right there (.) people hear the phrase and then they assume naturally that it’s something very very concerning (.) you know.

Baxter: And first years can be just on the lookout for that

Jake: Yeah, exactly

Baxter: Antenna out! They’re reporting all sorts of things that would be very benign

Similarly to how the counsellors talked about the responses of the academic staff, the counsellors also talked about friends and peers over-reporting the self-harm of others. The
counsellors attributed this over reporting to the increased awareness of worrying behaviour. Instead of making those in danger and those around them more aware of the warning signs, the counsellors talked about the first years, in particular, being hyper-vigilant of suspect behaviour, they had their “antenna out”. Meaning that the counsellors often spent time talking to those who may not necessarily require therapeutic intervention.

As well as those around the self-harmer becoming fearful of the self-harm, the counsellors also reported self-harmers themselves being concerned about their own behaviour.

_You don’t want to play it down, but you do hear people who say to you I harm myself and erm (...) and you’ve got to explore it with them and you find out it’s sort of gently scratch their knuckle with a blunt nail a finger nail (...) you know and for them that’s obviously an expression of how bad they’re feeling (...) but in the context of some of the other stuff you do sort of think ok we won’t spend much time dwelling on this. (Jake)_

It was clear throughout the focus group that there was a perceived lack of awareness amongst both academic staff, but also students. Throughout the focus group there seemed to be a real sense of students not knowing what constituted and what did not constitute normal behaviour. Baxter also referred to this when talking about questioning clients about their suicidal thoughts. He argued that often people have “fleeting thoughts when something goes wrong (...) now that is so normal that’s beyond the pale (...) we shouldn’t be talking about it”, yet for the clients this was a key concern for them.

A consequence of parents, friends and University staff lacking adequate knowledge about self-harm was that the counsellors themselves were put under more pressure.

_If someone is managing (2) self-harm which is a sustained coping strategy (...) I think I agree that, that actually at the moment (...) it’s ok (...) but if, you know (...) if friends or their tutor finds out about it and they massively over-react they’ll come back to me and they’ll be a real kind of sense of ‘this person cuts themselves, what the bloody hell you going to do about it? Kind of thing, and that’s a really difficult place to be because you know (...) whilst you’re still trying to make good clinical decisions about this person (...) you’re also aware, potentially there’s a person in the academic department who has a very different (...) and potentially ill-informed view of it (...) and if something you know if things don’t work out that’s going to put you in a very difficult position (...) adds another tension to the role. (Jake)
This highlights that often, although the self-harmer had a good understanding of their own behaviour, those around them did not. This lack of understanding, especially of the academic staff, brought further conflict to the counsellor’s role. Specifically, the academic staff expected the counsellors to intervene with the self-harmer and stop the self-harm; the counsellors felt that they were seen as the problem solvers. Thus, not only were the counsellors supporting the self-harming student, they also had to manage the expectations of the staff members. The student in distress was no longer their sole concern.

As the knowledge surrounding self-harm was lacking, or in some cases inaccurate, the counsellors suggested improving the awareness of staff and students through educational workshops about self-harm.

**Victoria:** I think you’re right and I think that something that we used to do in the FE colleges was run self-harm awareness erm training (.). more for staff than students-I think in this age group we could aim it at students more (.). erm but there people found it really useful because it did help people see what was a crisis and what needed support and what was somebody’s way of coping and that they were managing very well.

**Kimmie:** I think you’re right that would be really useful

**Jake:** Well it’s on a continuum thing isn’t it? Varies so it’s life threatening at one end and then stuff which is (.). you know (.). extremely benign at the other (.). so I think you’re right there (.). people hear the phrase and then they assume naturally that it’ something very (.). very concerning

A clear issue for the counsellors was the lack of accurate understanding that others had about self-harm, this issue was predominantly demonstrated through people being hyper-sensitive to self-harm like behaviours. Whereas those who self-harmed usually had a relatively good grasp of their self-harm and would seek help when necessary. The counsellors felt that friends, and staff would benefit the most from self-harm awareness and educational training. The emphasis of this training was not to identify worrying behaviour, rather it was to help staff in particular, differentiate between managed coping strategies and potentially serious behaviour.
4.8. Conclusion

The aim of this study was to establish whether self-harm was an issue for the friends of self-harmers through considering the problems raised by the friends in a counselling setting. This was done in order to answer the research question:

What are the key issues facing the friends of self-harmers?

By conducting a loosely structured focus group with the counsellors an insight into some of the issues raised by friends has been established. Further, there has also been a consideration of the impact caring for these students had on the counsellors. Within the focus group three main themes were identified and are presented within this chapter. Firstly, the counsellors identified that University was a constant time of transition and how at each stage the students displayed different trends in their help-seeking preferences; this was outlined in the first master theme, Time of Transition. In the second master theme, Role Shift, the counsellors talked about the changes that occurred in friendship once self-harm had been identified as a problem. They discussed that friends often took on the role of parent and adopted the associated responsibilities, responsibilities that fell outside of the remits of normal friendship. This new parental role, the counsellors argued, continued until the students would reach a breaking point, normally an external stressor, such as exams which meant that they would seek out the support of the counsellors. The final master theme, Challenges for the Counsellors explored the impact of caring for these students. In particular the focus was chiefly upon how supporting these students often caused professional conflicts that that had to negotiate.

This study has also begun to explore the impact that secrecy can have within a friendship, specifically the counsellors reported the friends feeling burdened with their unshared knowledge. Additionally this chapter has provided new insights into the experiences of those who support self-harmers, their friends and housemates. The findings indicate that they often have to manage the expectations of their clients’ friends, tutors and parents.

Although a key consideration in focus groups is the reaching of a consensus, this focus group also allowed for differences to be explored. In particular one counsellor, Baxter, stood apart from the others involved. The views and opinions that he shared often challenged the consensus that the other counsellors had arrived at. When these challenges occurred they were outlined and discussed. For example, in the subtheme Responsibilities: Parental Role & Secrets when the other counsellors discussed how friends would take on responsibilities, Baxter argued that the taking on of extra responsibilities was just a common trait to friends in general. He argued that self-harm could be replaced with “emotional distress” or “bump[ing] into the ex-
“boyfriend” in terms of the support friends provide. Thus meaning that this study embraced the consensual understandings, and also allowed for challenging understandings to be raised and discussed.

A key limitation of this study is that the stories are all based upon the professional experiences of counsellors. Thus, the stories included are based upon the counsellor recollections of self-harmers, their friends and their housemates that have sought help, rather than those who dealt with it privately. The stories therefore, could be based on more extreme or upsetting events. This is addressed in the next study which will focus on the experiences of self-harmers outside of a therapeutic setting.

Furthermore, it should also be noted that the focus of this study was to look at how the counsellors made sense of their client’s sense making. Specifically the counsellors are making sense of the sense making of self-harmers and their friends. Often considered within the realms of meta-analysis or the re-reading of academic work is the “triple hermeneutic” (Holt, 1991, p. 60). The triple hermeneutic begins with the initial construction of the phenomena by the participants, followed by the interpretation by the researcher and finally the interpretation of the reader (Shaw, 2011; Watson, 2001). Essentially, the triple hermeneutic is “a construction of a construction of a construction” (Holt, 1991, p. 60). The triple hermeneutic of this study, however, is focussed upon the participants and the researcher. The first is the construction of the experience by the self-harmer or the friend, with the second being the sense making by the counsellors of the self-harmer/friend’s account; finally, the third is the interpretation of the counsellors accounts by myself.

This study was conducted to explore whether self-harm within a friendship was an issue. The results from this study have demonstrated that the friends of self-harmers are an at-risk population. Indeed, the counsellors highlighted that the friendships became strained and altered by the impact of supporting a self-harmer, and that often the friends fail to know how to support the self-harmer. This study highlights the need to further consider the impact of supporting a self-harmer on their friends. In the next chapter I will present the findings from an interview study conducted with friends of self-harmers.
Chapter Five

Self-harm & friendship: A retrospective consideration (Study Two)

Study One demonstrated that self-harm was an issue within friendship, and showed that young people struggled to cope with a self-harming friend. In this chapter I present the findings of in-depth interviews with friends who were retrospectively looking back on their experiences of supporting a self-harming friend. The results provide an insight into how friends make sense of providing support.

5.1. Research aims and questions

This aim of this study was to explore how friends talked about their experiences of supporting a self-harming friend over the life-course of the friendship in order to answer the research question:

How do the friends make sense of the experience of being a friend of a self-harmer?

5.2. Method

5.2.1. Participants

Study one, a focus group with the counsellors provided the bigger picture about the impact of self-harm on friendship, and established that the self-harm of a friend was an issue for University students. In order to get an overall understanding of the impact of having a self-harming friend, recruitment was focused on students and staff members of a South-West University who had supported a self-harmer in the past.

Poster (Appendix C) and online (Appendix D) adverts were used to recruit participants. They were placed around the University grounds, and on the University online noticeboard.

In total sixteen individuals responded to recruitment, seven were excluded prior to interview as they either: attended a different university (1)\(^5\), were based abroad (1), they had professionally supported the self-harmer (2), the self-harmer was a colleague (1) or the self-harmer was a sibling (1). A further three individuals did not respond when invited to arrange

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\(^5\) Throughout this thesis students who were attending other institutions were excluded. As I could not be sure of the support systems available to those individuals should they have become distressed due to their participation in my research, I was unwilling to interview them.
an interview date. In total six individuals participated in the interviews, two men and four women (aged from 21 to 30).

5.2.2. Data collection

Semi-structured interviews were conducted. All participants were fully informed as to the nature of the study (Participant Information Sheet can be found in Appendix E). Participants were also assured that all data would be kept in accordance with University guidelines and all information would remain confidential and anonymised. Participants were provided with the opportunity to discuss any issues they had prior to the interview commencing.

Although there are no set guidelines concerning how many interviews to conduct, Morse (2000) argues that sample size is dependent on the complexity and extensiveness of the research question and practical constraints. Previous qualitative research concerning self-harm has typically conducted between three and ten interviews (Harris, 2000; Wilstrand et al., 2007). Further, Smith and Eatough (2007) argue that in order to “do justice” (p. 39) to the participants’ stories in an IPA-analysed project, researchers should conduct research with “relatively small sample sizes” (p. 39). Due to the exploratory nature of the study, the practical constraint of participant attrition, the precedent set within the small body of existing self-harm research, and the focus on doing justice to the participants’ stories, six interviews were deemed to be an appropriate number for this investigation.

Ethical Issues: Interviews and power

The role of the researcher within interviews has been discussed, specifically in relation to power relations between interviewer and interviewee (e.g. Karnieli-Miller, Strier & Pessach, 2009). Traditionally the researcher is the powerful one within the interview as they direct the flow of conversation and topic (Braun & Clarke, 2013). Research that has considered the role of power within interviews has focussed on two broad areas; populations that are disempowered due to their position within society, and populations that are disempowered within the interview setting due to the status of researcher and participant (Braun & Clarke, 2013).

Rapport building has been identified as the main route through which issues of power can be mediated (Braun & Clarke, 2013). Efforts were made to ensure the participants felt comfortable and the interview was a friendly environment. This was achieved through being sensitive to the participants, by understanding the sensitive and difficult experiences that they may have faced (Mason, 2002), and having respect for their stories (DiCicco-Bloom & Crabtree, 2006). It was also made clear to the participants at the beginning of the interview that the focus
of the research was on their experiences and it was emphasized that they were the experts. Through explicitly stating to the participants that they were experts, it was hoped that the participants would feel “empowered...as authentic speakers” (Russell, 2000, p. 407), and encourage them to feel more at ease with discussing their experiences.

5.2.3. The interview schedule

The interview schedule had four key areas: introductory questions, relationships, help-seeking, and closing questions. How these questions were developed is outlined below.

*Introductory Questions:* The interviews began broadly in order to encourage an open narrative and to ensure the participants to discuss their experiences using their own terms (Smith et al., 2009).

*You’ve agreed to take part in this study because you know someone who has self-harmed – Can you talk me through this?*

The next two questions were aimed at engaging the participants in talking about their experiences to a greater extent, and discussing the key issues that they felt were important.

*How did you feel when you found out about the self-harm?*

*Can you talk me through how you reacted?*

*Relationships:* It has been well established through the research conducted with parents and health professions, that relationships *are* affected by self-harm (Byrne et al., 2008). Indeed, this was supported in Study One, with the counsellors reporting that the friends took on responsibilities that lay outside of their friendships. The following two questions were developed in order to understand how the participants talked about their friendships post-disclosure.

*Did finding out about self-harm influence your friendship?*

*Did the time you spent together change after you found out about the self-harm?*

Research conducted with the carers of self-harmers demonstrated that the caring role could have a detrimental impact on other areas of life, such as: mental and physical well-being (Sawatzky & Fowler-Kerry, 2003) and relationship quality (McDonald et al., 2007). The only information known about the impact of self-harm on friends, however, is that they themselves may go on to engage in self-harm (e.g. Hawton et al., 2002). Therefore, the following question
was developed in order to get a better understanding of how the friends felt self-harm affected themselves outside of the friendships.

Did knowing about the self-harm affect other aspects of your life?

Research has demonstrated that, for some, when issues are introduced into friendships there are repercussions for that relationship. As demonstrated by Bor et al. (2004)’s research with the friends and family of recently diagnosed HIV positive patients found that some friendships grew stronger over time whilst others completely deteriorated. As the focus of this investigation was on the life-course of the friendship, this question was asked in order to ascertain how the participants felt about the progression of their friendships.

How do you feel about this person now?

Help-seeking: This series of questions focussed on the help-seeking experiences of the participants. As has been established in previous chapters, the friends of self-harmers are regularly used by both self-harmers as a support system (e.g. Evans et al., 2005), and identified by health professionals as gatekeepers to self-harmers (e.g. Klingman & Hochdorf, 1993). However, little is known about the friends’ own help-seeking preferences. These questions were developed in order to gain insight into how they used support systems, if they used them at all, and what their experiences were.

Have you had the opportunity to discuss self-harm with anyone?

Did you explore any outlets for help?

If so, where was it sought? Was it useful?

If not, why did you not seek out help?

If you were faced with a similar situation now, would you seek help?

In order to ensure that all topics were covered that the participants wanted to cover, the final question aimed to address any areas or issues that the participants wished to expand upon or that they felt were important.

Is there anything that you wish to talk about that you don’t feel we have covered?

5.2.4. Data analysis

Interpretive Phenomenological Analysis (IPA) as outlined by Smith et al. (2009) was used as the analytic framework for this study.
The process of Interpretive Phenomenological Analysis

There are six key stages to conducting IPA: initial reading, noting, developing themes, linking themes, the next case, and finally, patterns across cases. IPA is traditionally conducted idiographically, meaning that data is analysed on a case-by-case, or interview-by-interview basis with integration of findings done at the end (Willig, 2008). Conducting the analysis idiographically ensures that the participants’ individual experiences are getting full focus (Willig, 2008).

1: Initial reading

Analysis began with the reading and re-reading of the first interview conducted (Smith et al., 2009). Doing so provided an insight into the “overall feel” of the interview (Storey, 2007, p. 53) and a sense of what the participant was trying to get across within this setting. Following Rodham, Fox, and Doran’s (2015) recommendation, whilst reading the transcript, the audio recordings were also listened to, thus providing me with more of a sense of the participant’s voice within the analysis. Doing so helped me to explore the story that they wanted to tell, focus on, or avoid (Smith et al., 2009). Whilst re-reading the transcripts I also became aware of how I was initially reacting to the interview and as such noted down my feelings, alongside the field notes, about my position as a researcher. This included; whether I had sympathy for the participant, whether I could relate to them, as well as the instances that I found it difficult to understand their point of view.

2: Noting

Whilst re-reading the transcripts initial notes were made in the right hand margin (Storey, 2007) and relevant sections were highlighted or underlined (Smith et al., 2009). Initial notes were made in similar language to that of the participant, ensuring that the analysis reflected the participants’ talk (Quinn & Clare, 2008). In line with Smith et al.’s (2009) recommendation, noting was done in three ways: descriptively; describing the content of the talk; linguistically, consideration of the specific language used; and conceptually, often done through questions, this is the focus of the beginning of deeper analysis. Notes were made in the form of comments on areas that were considered to be important either by the participant, or myself (Storey, 2007). Further, notes were also presented as questions to myself as the researcher, this was used particularly when sections required further interpretation later (Quinn & Clare, 2008; Smith et al., 2009; Storey, 2007). Attention was also paid to how the participants’ story progressed, where there was saliency and where the participants had begun to modify their sense-making.
3: Developing themes

In the left hand margin of the transcripts the initial notations were developed into themes. This part of analysis is seen as an “analytic shift” (Smith et al., 2009, p. 91) requiring the start of deeper interpretation. In the previous section the main focus had been on grounding the notations in the participants talk, this stage placed the researcher more centrally within the interpretation of the data (Smith et al., 2009; Storey, 2007). Themes were labelled in such a way that aimed to “capture” an aspect of the participants’ understanding (Smith et al., 2009, p. 92); whether this was done using the participants’ own words (Quinn & Clare, 2008), or in line with the “essence” of that particular theme (Willig, 2008, p. 58). This stage of analysis provided the beginnings of deeper interpretation and outlined what the participants said in thematic clusters. Later stages work up these thematic clusters and began to explain how or why the participant’s talked about their experiences in a particular way.

4: Linking themes

This stage of analysis involved linking the emergent themes together and mapping out how they worked with, or against each other (Smith et al., 2009). This section begins to develop the level of interpretation and think more about how or why the participants made sense of their experiences as they did. The list of initial themes was organised into a word document with example extracts and printed out. These were then cut out and organised into more accurate themes, and master themes. This part of the analysis encouraged me to think about which themes were of particular importance in answering the overall research question and which themes were either irrelevant, or could be merged into other themes (Storey, 2007). Themes were grouped both in “abstraction” (Smith et al., 2009, p. 96), whereby similar emergent themes were clustered together and master themes were developed out of a shared element; as well as in “subsumption” (Smith et al., 2009, p. 97) whereby an emergent theme requires the master theme status and other emergent themes came underneath it. For each transcript a mind-map was created which organised each of the master and sub-themes (an example of which can be seen in Appendix F).

5: Moving onto the next case

As previously outlined, IPA is done idiographically and as such each transcript is considered on a case-by-case basis (Smith et al., 2009). Once each of the previous stages had been conducted on each transcript, the process began with the next transcript. Focussing exclusively on one participants’ account at one time meant that the story the participant was trying to tell was of primary importance and in-keeping with the “idiographic commitment” (Smith et al.,
2009, p. 100) of IPA. Doing so, however, was at times difficult; themes or ideas that had been generated from previous transcripts unavoidably influenced the reading of subsequent interview transcripts. Consequently, efforts were made to note when this occurred, and when similarities arose they were noted within the notation and themes. Efforts were also made to allow new themes to be generated from the transcripts through following the guidelines outlined previously.

6: Patterns across cases

The final stage of analysis draws together the themes across all of the cases and looking for comparisons, points of similarity and difference (Smith et al., 2009). The mind maps created for each of the interviews were laid out and compared and themes were moved around and expanded in the form of written notes. Some themes were relabelled and amalgamated. What resulted was a larger mind map of the relevant themes (some were renamed) and examples from all of the cases.

The integration of positioning theory

As a result of the inductive approach adopted it became clear that participants actively positioned themselves and others. This included assigning specific roles and behavioural expectations to themselves, the self-harmers, other friends and family. For example, being a friend to a self-harmer meant that the participants were responsible for the self-harmers emotional well-being. As a consequence, I further reconsidered and interpreted the data using a positioning theory orientation.

Universally, Positioning Theorists argue that within social interactions individuals will cooperatively and, in some cases complimentarily, construct positions which both ascribe and inhibit specific behaviours for one another (Harré & van Langenhove, 2008). Termed ‘subject positions’ (Davies & Harré, 1990, p. 4) these positions manifest both within relationships (e.g. self-harmer and carer), and as a self-construction (Hermans, 2001; Sampson, 1993). Early theorists argued that individuals could choose to adopt or reject these subject positions (e.g. Davies and Harré, 1990). Later theorists found ‘subject positions’ to be too prescriptive and argued that the individuals acted with more agency and instead responded to ‘subject calls’, or opportunities, to take up positions (Drewery & Winslade, 1997, as cited in Burr, 2003). For instance, Sampson (1993) argued that individuals can exercise innovation as to how they answer the ‘subject call’. He argued that individuals were agentic and can interact with the position that has been offered to them; not only can they accept or resist it, they can also change it.
What is universally agreed upon is that the positions are a product of both the interpersonal and the intrapersonal (Davies & Harré, 1990; Drewery, 2005; Harré, 2004). They are negotiated and demonstrated through social interactions, yet are informed by, and subsequently affect how the individual understands themselves and frames their experiences.

The use of positioning theory is well documented within health research, ranging from the masculine identity and the utilisation of health provisions (Noone & Stephens, 2008), to the positioning of HIV positive women (Lawless, Kippax & Crawford, 1996). It has also been used by researchers to consider the dynamics of relationships; such as research conducted by Ritchie (2002). He considered the interpersonal relationships between school aged children, finding that many would provide, accept and reject subject positions for both themselves and others. Furthermore, research carried out by Ussher, Kirsten, Butow & Sandoval (2006) found that the way in which one entity was positioned (in this case a cancer support group) would interact with how they positioned others around them (such as family or friends). They found that the cancer support group, which they positioned as critically engaging, altered the positioning of family and friends, whereby the position of carer would be replaced with their pre-existing role, that of spouse for example.

With the overall aim of the research being to explore the impact of self-harm upon friendship, positioning theory offered an appropriate framework within which to consider the data. Using positioning theory as an analytic framework helped to orientate me and guide my analysis in understanding how the friends came to navigate their changing friendships. Positioning theory was helpful in coming to understand how the participants negotiated becoming a carer to their friend. For this, attention was paid to how the participants talked about becoming, or indeed, rejecting the role of carer, and how much control they felt over this caring opportunity. Furthermore, once in the role of carer positioning theory was used to highlight how the participants discussed their role in relation to others around them, how their position to the self-harmer compared to others around them.

5.3. Results

It became clear that the participant’s accounts contained similar experiences. Three stages of change were identified (see Figure 5).

Once self-harm was recognised as being an issue within the friendship, the participants began to reconsider their friendship. As a consequence of taking on responsibilities that lay outside of a ‘normal’ friendship, the participants began to renegotiate their role from friend to carer. How they made sense of this process is discussed in the first master theme, Shifting Roles.
After renegotiating their role within the friendship the participants began to attempt to make sense of their new role. The participant’s sense-making involved comparing themselves to others who were close to the self-harmer. How participants discussed the role of others, and how this was used to cement their position within their friendship is discussed in the second master theme, *Relationship to Others*.

Finally, it was clear that the participants’ friendships deteriorated over time. Some participants reported friendships that completely dissolved, whilst others reported a decline in the intensity of their friendship. How they understood and constructed their part in this deterioration is explored in the final master theme, *Deterioration of the Friendship*.

![Figure 5: Process and master themes in Study Two](image)

**5.4. Master Theme: Shifting roles**

The first master theme, *Shifting Roles*, is aligned with the first stage of the process. Within this stage self-harm was identified as an issue within the friendship. The participants then began to renegotiate their role within the friendship in light of the extra responsibilities they had adopted. The extent to which participants became involved in the care of their friends varied in intensity and included both practical and emotional support. For example, some participants played an active role in their friends’ wound management:

*She’d gone and bought scissors () and she came back from the park () with daffodils with her arms just dripping () I helped her clean herself up (2) and made sure she was alright (Laura)*

Whereas others’ focussed on providing face to face and online emotional support:

*She kind of wrote it as a blog and I think I was one of the first people to () read it so she’s on Facebook chat all the time so I’m just like are you alright () Kind of have you done anything drastic? (Jim)*

There are three subthemes under the *Shifting Roles* master theme: *Pushed, Jumped* and *Fell*, as outlined below in Figure 6. Each subtheme is aligned with how the participants differentially constructed their role acquisition. The participant whose account constitutes the *Pushed*
The subtheme constructed her transition to carer as something that she was pushed into by others. The Jumped subtheme discusses how participants either discussed their transition as something they actively embraced, jumped into, or actively rejected, jumped out of. The Fell subtheme represents the participants who discussed their role acquisition as being passive, something that they fell into doing.

The three subthemes are linked by an overarching theme of control, and the struggle to attain it within the friendship. Across the three subthemes the participants used the concept of control as a key tool when discussing their role acquisition. For instance, the participant within the Pushed subtheme presented herself as having no control over her new role. Conversely, the participants within the Jumped subtheme present themselves as having control over their role, they either actively chose to be involved, or to remove themselves.

![Figure 6: Subthemes in the Shifting Roles master theme.](image)

How participants reported their role shift was friendship-specific; if they had more than one friend who self-harmed they did not necessarily adopt the same role for each friend. For example, Tom reported having three friends who had self-harmed. He was particularly involved in supporting his friend Sarah, often presenting himself as being emotionally available whenever she needed him. This included going for a drive, listening to music, and talking in-depth about her self-harm and her feelings associated with it. In comparison he presented himself as taking on a more passive role with the second girl, Ruth, offering the opportunity, should she need it, to talk to him about how she was feeling. In contrast, Tom talked about actively resisting being involved in Mike’s self-harm and his attempts to remove himself completely. This friend-specific behaviour was also seen in other participants’ accounts and suggests that how individuals negotiated the roles of carer and friend and provided support was not a result of an individual’s propensity to support; rather it was a result of the subtleties of the friendship.
5.4.2. Subtheme: Jumped

Within this subtheme, the accounts of the participants who presented themselves as either jumping into, or out of their caring roles are discussed.

Jumping in

This theme encapsulates the experiences of one participant in particular, Tom. Within this subtheme Tom presented himself as actively embracing his new caring role and willingly providing support to one of his friends, Sarah.

I find emotions quite easy to deal with and you know (.) I enjoy it in a way it’s (.) I mean, I’m not being morbid (.) I’m not saying that, you know (.) I found it sort of kinky of anything like that I do I do quite enjoy sharing emotions with people I think it’s an interesting experience (2) again not to (.) make it out to be like huge fun and stuff (.) but you know it’s interesting, to share an experience with somebody and have somebody share that with you (.) it’s something that you can take an active role in (.) it didn’t feel like I was being dumped on (Tom)

Tom presented his involvement in the care of his friend as being something he was not only interested in, but also enjoyed. He constructed his new role as something that he embraced and was actively involved in. Tom presented his involvement as being one of mutual gain, he was able to feel like he could support, and his friend could be supported. Through constructing his active involvement in his role acquisition he presents himself as having some control within the friendship, he was not “being dumped on”, rather he was allowing the self-harmer to discuss her feelings with him.

Tom made sense of the role change as being a consequence of having natural caring abilities which made him well placed to support his friend.

I suppose the best way to explain it (.) this is something that I probably wasn’t aware of at the time but its, it’s clear to me now (.) I have four younger sisters [interviewer: mmm] and and I’m the big brother to all of them (.) and my whole life I’ve been the big brother (.) and I think, and I’ve been told by girlfriends as well err (.) that I sort of behave to everybody like a kind of big brother I’m quite fraternal. (Tom)
Through reflecting on his experiences Tom presents himself as having natural caring qualities that made him suitable to support his friend, namely that he considered himself to be "fraternal". Through presenting himself as "fraternal" Tom constructed his experiences through gendered understandings of care. In doing so, he provides himself with a safe identity within which he can justify his involvement in the care of his female friends without threatening his masculinity.

Jumping out

There were also participants who jumped out of supporting their friends, and who successfully resisted becoming their friends' full carer.

Although Tom had presented himself as naturally caring when discussing the support he provided his female friends, he also jumped out of supporting his male friend.

*I mean it it's not a very PC thing to say the () the thing is supposed to say is oh he self-harmed and we should be () sensitive to him but no there's a big attention gatherer and and the best thing to do was to say 'oh right, well done Mike’ and move on. (Tom)*

Although Tom presented himself as enthusiastically supporting his female friends, he was resistant to supporting his male friend, Mike. In justifying his lack of involvement with his male friend, Tom denigrated Mike’s self-harm. Throughout the interview Tom referred to Mike as self-harming for the wrong reasons, e.g. he was an "attention gatherer", and was open about it without seeking support. In contrast he talked about the women's self-harm as something they “were very private about” and did for ‘real’ reasons, e.g. “having a bad body image”. Through questioning the validity of Mike's actions Tom undermined Mike's self-harm and subsequently constructed a justification for not supporting his male friend, whilst still supporting his female friends.

Laura also distanced herself from the emotional care of her friend, but provided necessary practical support when needed, such as cleaning wounds. She jumped out of the position of responsibility and in so doing pushed her friend’s boyfriend into adopting the role of carer.

*I think if he [the self-harmer’s boyfriend] hadn’t have been there I really don’t know what I would have done () I think it would have affected me a lot more profoundly because when you know that somebody else’s sort of caring for that person more than you’re able to () because of the relationship they had () then that () yeah I was very reassured and
he was very sensible er person and erm () yeah I think that again helped me to try and put it to the back of my mind (Laura)

Laura suggests that there was an expectation of support surrounding her friend which she fulfilled practically; she provided accounts of how in many instances she cleaned and dressed her friend's self-inflicted wounds. However, she rejected the opportunity to provide full emotional care and identified her friend’s boyfriend as the more appropriate individual to fulfil this need. In having another person present who she considered to be closer to the self-harmer, Laura presented her avoidance of support as a result of having someone more appropriate taking on the responsibility. Further, Laura considered her lack of involvement as being a consequence of her inability to support her friend to the same extent as the boyfriend; simply put, she constructed herself as not being the best available carer.

Earlier on in the interview it became clear that Laura felt ashamed about her lack of involvement in the self-harmer's care.

But knowing that he was you know () or had already tried the only things that we could think of but yeah () I () because it was probably coming up to final exams () Which sounds awful because obviously her well-being () I think we we both knew that it was a cry for help more than a suicide attempt () erm but yeah I did feel a little bit ashamed at that (Laura)

Laura presented herself as feeling uneasy about her lack of involvement with the self-harmer's care. She explained her role-avoidance as being due to three issues: her final exams, the futility of her previous support, and belief that the self-harm would not escalate. These issues were outside of Laura's perceived control, she presented herself as exhausting all routes to help the self-harmer, she believed that the self-harm was low-level and she was facing her own pressure. In explaining her role-avoidance as one of fatigue and the rest of external pressures she presents herself as the exhausted friend who was unable, not unwilling to provide support.

5.4.1. Subtheme: Pushed

Amy’s experiences encapsulate the subtheme ‘Pushed’. She presented her role acquisition as something she fought against and was forced into by others, specifically her pastoral care teacher.

She [the pastoral care teacher] sort of said that it was my responsibility to look after her and watch her and that I should let her know if () you know how things were going () and I should be the sort of intermediary because Tara
didn’t want the school to be involved and ( ) I just felt ( ) it was too much responsibility (Amy)

Amy discussed her role as carer as being a product of the school intentionally placing her in the position of responsibility, a position that she deemed to be beyond her ability. In discussing how the school pushed her into her new role she presented herself as having no control over her role acquisition, and she portrayed herself an unwilling carer. It was clear that she resented the position that she had been put in;

I felt quite angry at the school because I felt ( ) erm ( ) even then I felt i-it wasn’t right that I’d been put in that position and it wasn’t my job to be doing this ( ) and I’d gone to my guidance teacher and then head of pastoral care and erm ( ) I sorta lost respect with the school in a way for them doing that ( ) coz I just thought ( ) that’s your responsibility ( ) that’s not my job to be doing this (Amy)

In her account, Amy focuses heavily upon responsibility, making it clear that, to her, these were activities that fell outside of the remit of friendship. She considered the self-harmer’s welfare to be the responsibility of the school, yet felt obliged to take on the role herself. Through constructing the school as being unwilling to take responsibility for the self-harmer, and her subsequent adoption of the responsibility, she places herself as the unwilling yet selfless friend. She further justifies her derision for the school, and their perceived inability to provide support, through discussing how she felt that other ‘at risk’ students were also inadequately supported.

Later, in the interview the resentment that Amy originally directed towards the school was redirected towards her friendship group, and one friend in particular, Ruby.

She [Ruby] didn’t seem to accept responsibility that I’d felt about it so she never did anything she just ( ) said that’s really bad I’m really worried (flat tone) ( ) but kind of ( ) didn’t seem to me to be worried enough to do anything with that worry [interviewer: yeah] ( ) just left it ( ) just okay it’s not my problem sort of thing. (Amy)

Responsibility, and who had responsibility for the self-harmer’s welfare played a key role in how Amy constructed herself as being pushed into her caring role. However, in discussing the role of other friends in the support of the self-harmer Amy believed that the responsibility she had unwillingly adopted should have been willingly adopted by other friends. She bemoaned having responsibility placed upon her, yet condemned those who did not do the same. In
criticising others for not supporting the self-harmer to the same extent as she was, Amy was able to present herself as the helpful, selfless, and better friend.

Although Amy presented herself as resisting her new role and resenting her new responsibilities, once in the caring role she became unwilling to relinquish it. This was demonstrated in her discussions of alternative support systems.

*I knew I couldn’t tell my parents because (.) I think teenagers know that they can’t tell their parents things (.) because their parents will do the right thing and will tell another adult and if (.) you know I didn’t want that to happen (.) so erm (.) and I didn’t tell my parents. (Amy)*

Throughout the interview Amy constructed herself as the unwilling carer and was only in that position because the appropriate caregiver refused to support the self-harmer. However, when alternative and more appropriate helps sources were identified that could have reduced some of the responsibility she had for the self-harmer, she rejected them. She reported rejecting the additional help not because she did not want it, but rather that the self-harmer would not appreciate outside interference. Through simultaneously complaining about, yet protecting her role as carer she was able to construct herself as a victim and martyr. In so doing she was able to present herself in such a way which invited sympathy for her situation.

5.4.3. Subtheme: Fell

This theme highlights the experience of passively assuming the new role of carer, which was demonstrated by four participants. All noted their own pre-existing assumption that someone had to adopt the role of carer when a friend was self-harming. This is exemplified in Tom’s account; he stated that there was an intrinsic need for his friend to have support.

*She did need somebody to hang around with and I-I-I (.) you know (.) I don’t (.) I’m not like a saviour or anything (.) but it was cool to hang around with her and I was aware that that (.) that was like, useful for her (.) to have someone around (Tom)*

This perceived need opens up the opportunity for people to support the self-harmer. Participants within this subtheme spoke about their progression from friend to carer as neither something they felt forced to do, nor something that they jumped at the opportunity to be involved in.

There were two main routes that led people to ‘fall’ into this new role. Jim exemplifies the first route by presenting himself as temporarily supporting the self-harming friend, or ‘filling a
void” until a more appropriate person was identified. Once in the role his talk about little active involvement with the friend and interaction was superficial. He adopted a pseudo role, only providing care for his friend in minimal ways. He discussed avoiding any support which was too involved; for example, he demonstrated his care for his friend through minimal emotional (such as private messaging “are you okay?”) and practical (seeking advice from others) involvement.

I’m not (.) I don’t know (.) I do know her but I’m not overly friendly with her so I’m kind of having to fill a void that perhaps I wouldn’t automatically with my other friends I’d immediately try and do something (.) it’s kind of filling a void where she hasn’t got anyone else to do it so I’m kind of standing in for it. (Jim)

Taking this stance allowed him to distance himself from any form of permanent responsibility for the welfare of his friend. Not only did this status allow for him to negate himself from being any form of permanent support, it also allowed him to justify his low involvement in her care. Through presenting himself as being a temporary or marginal support system for his friend he was able to justify his level of support.

The second route concerns the progression to supporter as being something that just happened within the friendship. Neither of the participants, Katy or Rosie, whose accounts exemplify this subtheme had any recollection of being told explicitly about self-harm; it was something they reported slowly picking up on over time. Once these participants adopted the supportive role they talked about being actively committed to the care of their friends. Their experiences were presented as being something that did not jeopardise their position as friend; rather the role of carer complimented the relationship they already held. This is all the more surprising when both participants outlined being very involved in the support of their friend, for example Katy recounted a story where she’d followed her friend across a city after she had taken an overdose:

But she rang me up about 3 in the morning (.) and I’d missed the first call and I’d just seen it then coz my light on my phone was flashing and I didn’t have a clue and it sort of already had a bit of a bad gut feeling and I rung her up and she was crying and saying oh I’ve done something really stupid (.) I don’t know what to do (.) I and all of this so I rang the ambulance for her erm got the ambulance to go to her place and then (.) managed to somehow (.) you know call a cab and eventually got one and got to her place and by the time I’d got there the ambulance had already left and gone to this hospital which was completely on the other side of town (.) so I had to get another cab round
across there and eventually found the place and erm (.) I mean she was fine.

(Katy)

Although she played an active role in her friend’s support, she presented her support as naturally occurring within the friendship. Furthermore, experiences such as this did not pose a challenge to her, or act as a point of tension within their relationship. She presented the experiences as being almost mundane and herself as being a measured and appropriate friend. This is evidenced in how she talked about finding out about the self-harm:

I think it [self-harm] just sort of came up or something I mean we were really open with talking about stuff like that anyway so (.) so that (.) that just came up because we both had very (.) I mean more or less serious sort of depression phases and sort of being down and hating life and all that rubbish (.) but she was (.) like a lot worse (giggles). (Katy)

Although both participants initially described a relatively smooth role shift, as the interview progressed it became clear that the transition was not without complication.

I’m sure we did have conversations (.) I just don’t remember them (giggles) (.)
Erm (.) I’m sure I would have asked whether (.) just making sure that if she is (.) that she’s not infecting herself and that she’s being safe and (.) that (.) I’m sure there was some concern at some point of loss of blood (giggles) because there were (.) there were times where she (.) it was really bad and (.) erm (.) yeah, I don’t know whether my subconscious brain has just eradicated a lot of memories as but I-it’s probably a protective thing (Rosie)

Rosie discussed difficulties along the way, even going so far as to say that her subconscious removed memories in order to protect her, suggesting that the transition from friend to carer was not always so straightforward. In constructing her caregiving as being straightforward, even when she suggests that she struggled and that her “subconscious brain has just eradicated a lot of memories”, Rosie is able to protect her role as carer as being positive. Further, Rosie was very focussed upon the notion of protection, even seen above in reference to herself. This rhetoric was also used in reference to her friend, and how she was the protector of her friend.

And kind of (.) what do I (.) there’s kind of this sense of wanting to protect your friend [interviewer: yeah] from professionals as well [as other peers] because actually if she doesn’t want to say anything she doesn’t have to say anything.

(Rosie)
Neither Rosie nor Katy resented their position or rationalised their involvement, instead both of them were resistant to others such as friends, peers, and health care professionals interacting with their friend. Rosie was incredibly protective of her friend both in reference to other peers and health care professionals asking her friend questions. Through protecting her friend, Rosie was able to reassert a sense of control over her situation. Through being able to protect her friend she positioned herself as caring, and prioritising the welfare of her friend.

5.5. Master Theme: Relationship to others

The second master theme, Relationship to Others is associated with the second stage of the process. Once the participants had acquired their new role they then made sense of their new position within their friendships. The participants did this through comparing their friendships to relationships held between the self-harmer and their family and other friends. The participants presented the other relationships as negative and unsupportive. They went on to discuss their own friendship with the self-harmer as supportive, and hence constructed their relationship as superior to others. Through portraying the self-harmers’ other relationships as inferior, and in some cases detrimental, the participants were able to establish a sense of purpose within their new caring role.

Figure 7 shows the three sub themes within the Relationship to Others master theme: Friendship, Rivals, and Family. Each subtheme focusses on how the participants made sense of their modified roles and friendships. The first subtheme, Friendship outlines how initially the participants positioned themselves as the one closest to the self-harmer; predominately they talked about themselves as being the “best friend”. Once the participants had established themselves as being the closest person to the self-harmers, they began to compare themselves to others. The Rivals subtheme discusses how the participants began to negatively construct other friendships held by the self-harmer. The other friendships selected tended to be the friendships that posed a threat to the participants’ new role. Similarly, within the final subtheme, Family, the participants present the self-harmers’ family as having a negative impact on the self-harmer. In so doing, the participants constructed their own friendships as equating to, or exceeding, the self-harmers’ family bonds.
How the participants began to understand their position within the self-harmers’ relationships with others was contingent upon secrecy and disclosure. For the participants, secrecy and disclosure were used to not only maintain the role that they occupied within the friendships, but also to signify that their friendships were superior. Secrecy acted as a marker to the participants of the closeness of their friendship.

*I felt like with friends erm (.) that I think that’s quite a safe environment where you can be (.) the special one or the singled out one but you’re all kind of the same level anyway (.) Whereas with the school I didn’t want to be the one that everyone spoke to erm (.) but I think although I think (. ) I’m sure I relished it in some ways being the chosen one (giggles) that she would talk to. (Amy)*

After being told about her friend’s self-harm, Amy’s friendship was dictated by secrecy. On revealing the self-harm, Amy reported being told that she was the only one who knew about the self-harm, making her feel like she was the closest one to her friend. Indeed, she talked about herself as being “the chosen one”. Talking about herself as such, Amy constructed herself as someone special, someone that the self-harmer had deliberately chosen to tell above all others. Through constructing herself as such, she placed herself in a superior position to others.

Even when others in the friendship group knew about the self-harm and Amy's position was challenged, she still attempted to preserve her superior friendship with the self-harmer. She discussed having “clandestine conversations” with the self-harmer that were to be kept secret from other friends.

Although the secrecy was constructed as being beneficial for the self-harmer, in keeping secrets the participants were able to protect their own role within the friendships. This ultimate demonstration of privacy acted to further affirm their friendship bonds and segregate their friendships from all others, it’s what defined their friendship and the roles that they had within it.
5.5.1. Subtheme: Friendship

This subtheme provides a context for the subsequent two subthemes. Within this subtheme, how the participants began to reconstruct their friendships is discussed. The participants all constructed their friendships in terms of closeness, and this was done to differing degrees (e.g. from best friend to friend). For those who were more involved in the care of the self-harmers, they considered their friendships to be closer than others who knew the self-harmer. In so doing the participants were able to justify their involvement in, as well withdrawal from, the care provision the care of the self-harmer.

Amy and Rosie were the only participants to specify that it was their best friend who had self-harmed.

*I was at school (.) probably between the year of (.) kind of year nine (.) year nine ten all the way to all of year eleven probably (.) So it was erm, my best friend who was going through erm a difficult time and erm (.) it was also had to take some time off school coz she was suffering with depression. (Rosie)*

*Yeah, erm, it was when I was in, high school (.) Erm and erm (.) In fact there were a couple of people but the one (.) the one person in particular was erm (.) er (.) one of my best friends. (Amy)*

The act of categorisation of their friendships served a dual purpose for the participants. Both Amy and Rosie were highly involved in their friend’s care, and both referred to the self-harmer’s as being their best friends at the time. Through establishing themselves as having a close friendship they were able to justify their involvement with the self-harmer. In so doing, their position as carer and their care provision was necessary, normal, and appropriate.

For Rosie the position of best friend also afforded her the opportunity to present herself as having a unique and unrivalled insight into the self-harmer’s life;

*I’ve seen parts of her life that other people may not necessarily have ever seen [interviewer: yeah] (.) Erm and I guess that (.) we both have that (.) understanding (.) we’ve all both grown and we’ve changed but we’re still (.) I don’t know (.) still really good friends. (Rosie)*

In stating that she has seen aspects of the self-harmer’s life that was otherwise hidden from others, Rosie presented herself as being an insider, the only insider. Through placing herself as the best friend, and the only one to witness an otherwise secret life, her friendship is portrayed
as being superior and herself as special. Rosie was also incredibly focussed on maintaining the privacy of the self-harmer;

*I mean if somebody was to ask me about it then yeah (.) but equally so I wouldn’t go into nitty gritty details either because I still feel that that’s her life and erm (.) those things are still partly confidential between me and her* (Rosie)

In maintaining the privacy of the self-harmer, Rosie also protected her own position within the friendship. If the self-harm were to be disclosed to others, the newly restructured friendship and her superior role within it could be challenged.

Participants also talked about the friendships being unequal. The participants talked about their friendships with the self-harmers, as well as the self-harmers’ friendships with them as having different levels of closeness. As demonstrated by Laura;

*This was somebody who I went to university with and I lived with for erm (.) second and third year (2) And she was in my halls of residence as well and she was really good friend of mine (.) Yeah I didn’t really realise initially that she self-harmed (.) it took quite a long a long time because you don’t necessarily look (.) for things like that. (Laura)*

*I was her best friend at university and my memory of it (.) I think that is the first time that I (.) remember realising (.) I might have noticed that she had marks on her arms before that but I never sort of (.) or that she would always cover up (.) she’d always cover up her arms* (Laura)

In the first extract Laura discussed the friendship from her perspective stating the self-harmer was her friend, her “really good friend”. However, when she discussed the friendship from the self-harmer’s position, in the second extract, she constructs herself as being the self-harmer’s “best friend”. Although subtle, she constructed her friendship as being imbalanced and presenting her friend as being closer to her than she is to her friend. In so doing Laura distanced herself from the friendship. Like all of the participants, Laura talked about how she would provide care without the prospect of reciprocation. Through distancing herself whilst maintaining the closeness of the friendship, she was able to justify her friend’s reliance upon her, and her provision of support.

Like Laura, Jim also distanced himself from his friend. Initially he talked about his “friend” who self-harms, yet as the interview progressed he further detached himself from the self-harmer.
I’m not too close to her (.) I’m kind of still keeping that detachment a bit so (.) Trying to put it to the people who help more rather than borging in going this is the right thing to do without actually knowing what I’m talking about too much (Jim)

Jim was the only participant to mention being questioned by other non-mutual friends about his involvement with the self-harmer. In response he stated that he would feel guilty if he did not help, a wholly self-orientated explanation. Throughout the interview Jim presented his friendship as being tenuous, himself as “filling a void”, and his involvement as being fuelled by obligation rather than through genuine care. He made it clear that his role within the friendship was to outsource care for his friend (via tutors etc.), and provide nothing more than superficial support. In discussing his detached demeanour, and superficial friendship Jim was able to construct his limited support as being appropriate to the friendship he held with the self-harmer.

5.5.2. Subtheme: Rivals

In establishing their position within their friendships, the participants began to make sense of their new status through comparison to other friends; this is discussed in this subtheme, Rivals. Those that the participants compared themselves to were presented as posing potential risks to the participants’ friendships with the self-harmer’s. The participants negatively constructed these individuals through portraying them as being bad friends, or bad influences. The participants constructed a friendship hierarchy within which they positioned the self-harmer, themselves and other friends. Below is an extract from Amy that exemplifies how she negatively constructed Tara's (the self-harmer) friend, Ruby as being a bad friend.

Her first reaction was (.) to Tara [the friend who self-harmed] (.) she just said I can’t believe that you didn’t tell me that (.) I can’t believe how could you tell her and not me?’ and erm (.) and then (.) so and that that became the sort of focus of everyone’s attention was that (.) Ruby had been usurped in the group and what were we going to do? Because you know (.) she was really upset about that and it sort of shifted the attention right the way from (.) from the actual problem (.) And then erm and then I remember thinking it was really odd that that was Ruby’s main concern (giggles) (.) not that her best friend had been self-harming (.) that she hadn’t been told (Amy)

Amy described a fraught relationship between herself and Ruby, only sustained through having mutual friendships with Tara. Prior to the school being informed of the self-harm, and the
forced adoption of the caring role, Amy stated that she was the only one to have known about the self-harm and felt that she was the “chosen one”. However, this all changed after the self-harm was revealed. Amy presented Ruby’s reaction to finding out about the self-harm as being selfish as her distress was about being excluded from the secret, rather than being focussed on Tara’s wellbeing. Throughout the interview Amy reinforced her position as the selfless friend, the one who prioritised her friend’s care above all else, this stood in stark contrast to how Amy talked about Ruby. Through discrediting Ruby, Amy was able to reinforce and authenticate her position as being the best and most supportive friend. Amy’s feelings of being threatened by Ruby were clear throughout the interview; at one stage Amy described her friendship with Tara as usurping Ruby’s position. Thus, Amy presents herself and Ruby as rivals for Tara’s friendship and the position as best friend. Without this Amy would have not only lost her standing within the friendship group as a whole, but also with Tara, she will no longer be the “chosen one”.

Katy also felt threatened by other friendships held by the self-harmer. She positioned herself as superior through constructing the other friends as being a bad influence.

_I think all they did together was get drunk (.) Sooo at the end of the day I’m not sure how many of those were actual friend friends and how many were just kind of drinking buddies like (.) yeah we go out we get drunk together (.) at the end of the day you go out you get drunk but you go home on your own and you’re still drunk (.) just drunk and that’s it (.) so it’s not people you’d have a conversation with when you’re sober._ (Katy)

Katy talked about the decline in her friendship with the self-harmer as happening when they started at their respective Universities. It was at this point that she began to question the genuineness of the self-harmer’s other friendships and the impact that they could have. She presented the other friends as being hedonistic, unsupportive, and nothing more than “drinking buddies”. Katy presented these friendships as superficial and only appropriate for fun and drinking; when the self-harmer was sober those friendships were no longer appropriate, supportive, or positive. Although Katy had got drunk with the self-harmer she never presented herself as having a negative influence on her friend. She also never talked about her role within their friendship as being anything less than fully supportive. Through questioning the influence of the self-harmer’s other friends Katy established herself as the most appropriate person to support her friend. Thus she reinforced her position as the better friend, the most supportive friend, and the close confidante to the self-harmer.
However, not all participants were as suspicious about the role that other people played in the care of their friends. Laura was very positive in her talk of how others, particularly her friend’s boyfriend, took on the role of carer. This is never more apparent than when she talks about their tumultuous relationship.

*I really don’t know what I would have done if he hadn’t have been there (.) but (. ) now thinking about it ( .) whether he (.) that that was actually the right thing to do because they were having this (.) sort of on off relationship when it was (.) yeah it probably (.) It might have been better if he if he hadn’t have had to take that role but (.) Yeah (.) Yeah (.) he’s still a very sensible person (.) so I’m sure he could deal with it (giggles). (Laura)*

Many of the other participants denigrated others who were potential threats to their role by presenting them as being bad friends or bad influences. In doing so, the participants portrayed them as being unsuitable for supporting the self-harmer. However, when Laura mentioned a reason why the boyfriend may not have been appropriate, that he and the self-harmer had a tumultuous relationship, she dismissed it. As discussed earlier, Laura had successfully jumped out of the role of carer, and pushed the boyfriend into it. Thus, she had no superior position to protect and may explain why she did not critique the boyfriend or his involvement.

Similarly, Tom talked about other friends in the friendship group as not wanting to be involved in his friends care.

*I think everybody treated that sort of thing [self-harm] in the same way that they would do if they found out somebody in the group was gay (.) they wouldn’t be (.) totally sure about whether to speak about it or not but they would probably err on the side of not speaking about it (.) just in case they offended anybody (.) or more accurately just in case the person who was gay was having difficulty with it (.) they didn’t want to step on their toes. (Tom)*

The other friends’ compliance meant that Tom’s position remained unchallenged and there was no need to try and further establish his position within the group through judging others. This stance allows Tom to construct himself as superior to other people. Although his group of friends may have been resistant to providing support or actively offering it, he was not, he actively sought the position of confidante and as such he distinguishes himself from the rest of his friendship group.
5.5.3. Subtheme: Family

Within this final subtheme, how the participants made sense of their experiences through comparing themselves to the self-harmers’ family members is discussed. The participants constructed the family members of the self-harmers as the ones who were closest to them, and consequently the ones who should have been responsible for their care. The participants positioned the parents as being at the top of the hierarchy of people surrounding the self-harmer. Through placing them as such, the participants were able to critique their involvement in terms of how involved they were, the efficacy of their involvement, and the subsequent impact it has on the self-harmer.

In positively comparing themselves to the self-harmers’ family members, the participants were able to present the self-harmer as vulnerable and further establish themselves as the best person to support the self-harmer. The participants generally constructed the family as not caring enough for the self-harmer:

*Her mum commented on it [her blog about self-harm] and just went erm love you phone me! And just like with the best will in the world would you not just phone your daughter like? So erm (.) I suppose that’s always been seen as a bit strange that erm(.) kind of (.) even if her mum can just react like oh well just phone me (giggles) (.) She’s just written a blog about how she’s going to self-harm and make (.) my mum would be on the train (.) on her way here (giggles). (Jim)*

For example, Jim critiqued the self-harmer’s family through comparisons with his own parents. Through questioning the parenting style of the self-harmer’s parents he was able to present them as not fulfilling parental responsibilities and consequently constructs the self-harmer as being unsupported, alone, and weak.

For some participants, the family and parents were not just unhelpful; they also talked about them as triggering episodes of self-harm. The participants presented them as antagonistic and detrimental to the welfare of the self-harmer.

*And then her parents, but her parents were, don’t think her relationship with her parents wasn’t (.) great (.) Erm, so that was quite errr (.) difficult I think (.) then forced her down certain routes (.) sort of education and her brother (.) and her brother had big issues as well (.) and I think that used to (.) sometimes trigger instances. (Laura)*

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Through negatively constructing the self-harmers’ family, such as referring to them as “triggers”, the participants were able to question the parents assumed status as the closest person to the self-harmer. By suggesting that the family members should have done more to support the self-harmer, or that they had caused the self-harm itself, the participants presented them as failing to fulfil their responsibilities. In turn, the self-harmers were depicted as being let down, alone and vulnerable. Therefore, the support that the participant’s provided, however minimal, was not only necessary, but also still more helpful than the help provided by the families.

The participants’ scepticism about the self-harmers’ family was further demonstrated when the participants discussed how the self-harmers did not want their families to be involved in their care.

Tara, she was really adamant that she didn’t want her parents to know (.) erm (.) And I think I didn’t know of anywhere else to go for help other than the school (.) and other than my parents and I knew my parents (.) wouldn’t know what to do (.) other than speak to her parents. (Amy)

Throughout the interview Amy had made it clear that she had enjoyed the secrecy surrounding the self-harm, at one point stating that she “revelled” in being the “chosen one”. Above is an excerpt from Amy which outlined how Tara was resistant to letting her family know. Through maintaining the secrecy between them, and excluding the self-harmer’s family members, Amy was able to safeguard her role as being the closest one to the self-harmer. Through the self-harmers’ requests that the secret was not to be told to their family, the participant’s understandings of themselves as being the person best placed to support the self-harmer was reinforced. Having their position validated by the self-harmers meant that the participants further solidified their role.

Some participants went further than just questioning the family relationships; they implied that they had knowledge and insight about the self-harmer that would normally be associated with being family members. In other words, participants would equate themselves with the self-harmers family members, as exemplified by Amy:

When she came into the room and I could see from the look on her face that she was angry at me (.) You know that like (.) sort of best friends or sisters thing where you can give each other a look that you know you’re not talking when nobody else can see it. (Amy)
Amy initially constructed the relationship as “best friends” yet immediately increased this to “sisters”. As previously established all participants presented the family as being the ones who should be closest to the self-harmer. When Amy talked about her friend she likened their relationship to that of sisters, not friend, or best friends, she superseded her actual friendship status with that of family member. Through intensifying the relationship they held she presents their bond as stronger, and placed herself as being the closest one to the self-harmer. She further demonstrated their close relationship by stating that they could communicate via just a “look”, a look that “nobody else can see”. Their bond transcends verbal communication; she is so close to her friend she no longer needs words.

Rosie also positioned herself as the closest person possible to her friend.

Rosie: I think her cousin knew about it, I knew about it (.) erm, her mum became aware of it because her mum found kni-I mean those razor

INT: Oh, the razor blades?

Rosie: The razor blades like under her carpet (giggles) and obviously the time she had overdosed or self-harmed to the degree that she had to be taken to A and E erm (.) so her parents were obviously (.) aware of it. Erm (.) other than that I think those were the only few people that actually knew (.) Erm and the people who would ask about it in school (.) if they saw her scars

Rosie utilised a two-fold approach in securing her position in relation to the self-harmer’s family. Firstly she implied that her friend’s self-harm was secretive and only an elite group of people, including herself and her friend’s parents and cousin, were aware of it. Initially she established herself alongside the family members through knowing about the self-harm and had previously in the interview talked about attending counselling sessions with the self-harmer and her family. However, she swiftly distinguished herself apart from them. This was done subtly through the level of disclosure she presented herself as having in comparison to others, this is the second step. Although the family are part of the elite group who know about the self-harm, it was also suggested that they were not as involved as she is, they were only “aware of it”. Through using this phrase she constructed the self-harmer’s family as having a superficial understanding of the self-harm, not the motivations or the associated feelings. Whereas throughout the interview Rosie had made it clear that she was her friend’s confidante, her understanding and insight into her friend was privileged and unrivalled. This insight
surpassed that of her friend’s family. Through positioning herself above the friend's family, she established herself as the pivotal person to her friend. She was the one who has not only the deepest insight into her friend’s life, but was also the person her friend turns to for support.

5.6. Master Theme: Deterioration of the friendship

The final master theme, Deterioration of the Friendship is associated with the last stage in the process, how the participants made sense of their fading friendships. The friendships became strained and began to deteriorate when the participants became geographically distanced from the self-harmers, for example, the transition into, and out of, University. Although some of the participants initially tried to maintain their friendship via the internet or mobile phones, the majority of the participant’s experiences suggest that caring for a self-harmer was contingent upon geographical closeness.

The decline in friendships ranged from a complete discontinuation of the friendship, to a dwindling friendship, to only one almost intact friendship. Importantly, all participants talked about deterioration in their closeness. At the time of the self-harm they all talked about their friendship as being far more intense, and their bond stronger. However, when the participant’s discussed current relationships with the self-harmers, it became clear that none remained best friends, at most they were “really good friends” (Rosie). The change in their roles, and subsequently their friendships, meant that they were unable to re-establish their previous friendships, or establish new roles in order to maintain the friendships post disclosure.

There are three subthemes within this master theme: Growing Apart, Surplus to Requirement and Not Me! Within the first subtheme, Growing Apart, the participants’ sense-making of friendship deterioration as a consequence of the friendship growing apart and themselves is discussed. Within their accounts much of the support provided by the participants was contingent on them being in close physical proximity to the self-harmer. Participants also constructed their deteriorating friendships as being a consequence of the self-harmer no longer needing them for support. This is discussed in the second subtheme, Surplus to Requirement. Participants either considered this to be a result of the cessation of self-harm which meant their friend no longer required support, alternatively the self-harmer identified others from whom to gain support. The final subtheme, Not Me! draws together the participants’ accounts of how they constructed their agentic role within the friendship deterioration. Participants considered the loss of the friendship as being a consequence of uncontrollable external factors, and not a product of their own behaviour. This was either an outcome of a situation (e.g. going away to university) or a result of the self-harmers actions (e.g. they stopped all contact). Through constructing the deterioration within the friendship as
a consequence of external factors the participants were able to maintain the positive presentation of themselves as supportive friends, only stopped through the actions of others or external events outside of their control. An outline of these can be seen in Figure 8.

![Deterioration of Friendship diagram]

**Figure 8: Subthemes in the Deterioration of Friendship master theme**

**5.6.1. Subtheme: Growing apart**

This first sub-theme encompasses the participants who talked about their friendship as deteriorating gradually, something that happened naturally and as a consequence of change in situation. For these participants, going to University played an influential role in their deterioration; this is exemplified in Amy's account:

*It [self-harm] went on until () I'd say at least we were 17 (2) I’m not sure if it went on after that coz I you (.) you leave school in Scotland at 17 to go to uni so I stopped having that intimate knowledge of what she was doing () so erm () but I know it was still going on when she was 17 () at school. (Amy)*

As outlined earlier, Amy was focussed and active in maintaining her role within the friendship, even equating herself to that of being a sister to the self-harmer. However, as she talked about the deterioration within the friendship she constructed herself as taking on a more passive role, she talks about her “intimate knowledge” just stopping, and the friendship fading away. The decline in closeness was solely attributed to changes in their circumstances. Amy constructed the deterioration not as a result of her actions, the self-harmers actions or even the self-harm; the friendship deteriorated due to geographical distance. Through constructing it as a product of an uncontrollable external factor Amy preserved her selfless construction; if the friendship had deteriorated as a result of the self-harm she would not have been able to present herself as being the non-judgemental confidante. Throughout the acquisition and discontinuation of her role, Amy understood her involvement as a consequence of external influence; she adopted the role because she was forced to and she was removed from the role because of geographical changes. Thus she successfully positioned herself in a role which
meant that she could accept praise for supporting the self-harmer, whilst avoiding critique for when she fails to.

However, not all participants provided accounts which suggested that the friendship had deteriorated. Rosie was the only participant whose account suggested that she had maintained a close friendship with the self-harmer:

*I think that the most difficult part of our relationship was when I went off to university and she was still at college and that was a tricky one year where (.) because up till then we were pretty much been joined at the hip and this was the first time we were separating (.) and I was moving on with my life whilst she was still (.) at college and I think that was a difficult time for her (.) erm (.) But then she went (.) off to university and she’s (.) finally got her (.) degree and even though I’ve been working for four years I went to her graduation and for me that was a really proud moment (.) to see her graduate (.) Erm so no my feelings towards her haven’t changed at all (.) we’ve you know, had ups and downs. (Rosie)*

Rosie’s account differed from the other participants’ stories; she maintained that her friendship was nearly as strong as it was whilst she was supporting the self-harmer. As explored in the previous master theme, Rosie’s transition to being a carer and confidante was presented as being a relatively natural progression within the friendship itself. The roles were not incongruous with their friendship and as such the change did not pose any particular alteration. Although the transition to University was a difficult time within the friendship they were able to maintain closeness in a state of geographical distance.

5.6.2. Subtheme: Surplus to requirement

This sub-theme explores the experiences of the participants who talked about the decline in their friendships, and their role, as being either a result of the self-harmer stopping the self-harm or other people taking over their role. As the friendship and roles within it had been altered in order to accommodate the self-harm it became difficult to re-establish the friendship and their role as it had been pre-disclosure, or to cultivate a new role and friendship type. The participant’s accounts suggested that their new caring role within the friendship only worked within a supportive friendship. Thus, when support was no longer required the friendships either deteriorated or ceased completely. Tom outlined how he encouraged his friend to desist self-harming:
I actually cut my arm (.) with her, to see what it was like and er (.) I think that was a major turn off for her (.) not to put too fine a point on it and I (.) and I like to think that was when she stopped cutting her own arms actually, because I think as I remember although she didn't say it to me she really sort of (.) she behaved differently afterwards and I think (.) seeing that sort of thing happen in the real world to somebody else actually (.) she's quite a soft person deep down (.) That she didn't really like it (.) I think that she saw that it was a bit silly (.) coz I was being silly about it I didn't really chop myself up in a serious way (.) but I think she realised that (.) that my acting towards it in a quite playful and silly way was erm (.) was actually quite a er, a good way to deal with it and after that I think she took it a bit less seriously and I don't think she she did it again (.) I don't remember seeing (.) her do it again. (Tom)

Tom positioned himself as being the pivotal person in his friend's decision to stop self-harming; he does this through the extreme action of cutting himself in front of her. Through presenting himself as causing the desistance in self-harm he enacted the ultimate demonstration of support. Consequently he constructed himself as almost a hero, or a saviour figure, he was the only person who was able to stop her from injuring herself. This could represent a final shift of his role within the friendship, from friend to carer, and from carer to saviour.

I think eventually she got, she got a bit erm (.) bored of just having a guy hanging around (.) her and er she wasn't very happy with her boyfriend so I think she sort of got rid of all of all of her (.) connections at the same time (.) And er I didn't really have much else to do with her after that (.) we were probably good friends for about (.) as I remember 6 to 8 months (.) something like that (.) Er (.) so a good portion of sixth form (.) but after that I didn't really talk to her. (Tom)

This suggests that the friendship, minus the self-harm was no longer compatible with the role of carer that he had adopted. His role as carer and his subsequent presence within the friendship was no longer necessary, he was surplus to requirement. Although the friendship did decline, presenting himself as being so influential meant that he was able to preserve a benevolent self-construction; he was the indisputable helpful friend. Even when the friendship and his position had deteriorated he was able to maintain the selfless positive self-image that had accompanied the role. Although the friendship had declined, his positive presentation of self did not. It is also pertinent to note that the full onus for the deterioration is placed with the self-harmer, “she got rid of all or, all of her (.) connections at the same time”. This completely
removed Tom from any associated blame for the deterioration of the friendship as it was a result of the self-harmer's actions, not his. This is emphasised as he talked about there being multiple friendships, he was not singled out. Thus, he presented himself as being devoid of any responsibility for the friendship deterioration.

However, not all of the participants attributed the deterioration of the friendship to the friend stopping the self-harm, other participants, such as Katy suggest that the role of supporter was transferred over to others.

*I think she had other friends actually (.) she talked to about that as well (.)I think a lot of her friends were into in that direction as well (.) but I don’t know how much (.) sort of (.) I wouldn’t say negative influence I think a (.) a sort of emo’ey environment they sort of fuelled each other in a way (.) so it was a bit of a co-dependence (.) “oh I will get better but we don’t really need to” (whispered) (.) it’s normal (Katy)*

Unlike Tom, Katy's friend continued to self-harm, yet found those who would support the behaviour, rather than be positively supportive, as Katy positioned herself. Through positioning the other friends as “fuelling” the behaviour and constructing their friendships as being a consequence of “co-dependence”, she inferred that their friendships were built on the normalisation and subsequent continuation of self-harm. This lay in stark contrast to how she constructed her own role within the friendship, which was to support her friend without perpetuating the self-harm. Thus she implied that the reason for the deterioration in her friendship was a result of others being present who would not actively challenge, or deter her friend's self-harm. Thus, Katy was able to preserve her self-construction as that of being a helpful, supportive, healthy influence, as well as someone who provided on-going support.

*We do still talk and if there’s anything serious then we’d still talk to each other (.) Erm (.) and when she went off to uni it was (.) kind of like she’d be okay and then we’d always end up talking online when she wasn’t okay (.) erm or she’d ring me and she’d be crying and it would be like coz she’d feel so out of place or (.) this was going on (.) or that was going on and I think it was just her way of dealing with it really. (Katy)*

Although Katy outlined a decline in the closeness of the friendship, she still highlighted the continuation of emotional support. This support was constructed as unidirectional; support was only provided, rather than received. Similarly to Rosie, this could be a result of how she came to acquire her role. She too had become a carer as a result of a natural progression within
the friendship. Thus, the behaviours that were associated with her as carer were not incongruous with the established friendship; this may mean that in ceasing to be the main carer she was still able to maintain the friendship that she held previously. Through maintaining her role she was able to preserve her self-construction, that of being a helpful, supportive and a healthy influence.

5.6.3. Subtheme: Not me!

How participants transferred the blame of their friendship deterioration away from themselves is discussed within this final subtheme. This was demonstrated in two ways. Either, participants inferred that the friend’s personality was responsible for the decline of the friendship, not them or the self-harm. Alternatively, one of the participant’s friendships was relatively new and as such the self-harm acted as a barrier to its development.

Tom implied that the deterioration in the friendship was due, not to himself, but the personality of his friend.

_I don’t think it [self-harm] affected my relationship with her directly (.) I think her personality certainly did (.) And I think that from her point of view self-harming was part of her personality (.) so I would tell you looking at it from outside (.) it probably did erm have an effect on our relationship (.) but it would have all been from from her side (Tom)_

When asked about whether he believed self-harm had a damaging role in his friendship, he completely dismissed the possibility that it had. Instead he suggested that it was the “personality” of his friend that had caused trouble within the friendship, and that self-harm only acted as an aspect of the self-harmer’s personality. He further stated that the potentially negative influence within the friendship had come “from her side”, as far as he was concerned the self-harmer was the only one responsible for the demise of their friendship. In so doing, Tom completely disassociated himself from any responsibility for causing the deterioration of the friendship. He does this in two ways; firstly he suggests that the self-harmer has a negative personality, and secondly that he would not have jeopardised his friendship because of the self-harm, to him self-harm was a non-issue. This allowed Tom to maintain his understanding of himself as being caring; if he were to have caused the decline of the friendship as a result of having negative views about self-harm he would no longer be able to present himself as being the “fraternal” friend.

However, there was one participant in particular, Jim, whose friendship developed at the same time as he discovered his friend had self-harmed. Unlike the other participants who had all had
an established friendship prior to the disclosure, Jim’s friendship was formulated when he adopted the role of carer.

*I haven’t really spoken to her () it’s kind of a hard thing to bring up in conversation () you’re like how’s it going? So erm I haven’t mentioned it I () none of her latest kind of blogs has been kind of about it () presumably she knows I’m there if she wants to () Again there isn’t she’s because of the whole year and a half of kind of being really down in the dumps she’s alienated almost all of the friends she did have () so she hasn’t really got anyone to talk to at the moment () so I don’t think I’d be her first choice anyway () but it’s just kind of () I’ve kind of taken again that void that () her she’s kind of alienated people (Jim)

Jim constructed the relationship he had with the self-harmer as distant and distinct from his other friendships. In particular, he constructed the friendship as being functional as he was filling a “void”. When he talked about how the self-harmer had “alienated almost all of her friends” he did not align himself within this category, if he had said that she had alienated almost all of her other friends then he would have equated himself as a friend. This is further emphasised when he says that he would not have been “her first choice”, implying that there were others that he considered to be far closer to her than he was. Thus Jim firmly established his role as only a temporary low-level support system within the relationship, and had no intention of attempting to develop it further. He was unable to fully establish the friendship prior to the disclosure about self-harm and presented himself as unwilling to attempt to develop it in the future. He talked about his involvement with his friend as being mediated exclusively through the internet, predominantly monitoring her online presence via personal blogs and Facebook. He also only communicated with her via Facebook if his monitoring highlighted concerns about her self-harm. Alongside this Jim was constantly looking for alternative sources of support and presenting himself as a stop-gap. The only thing that the relationship seemed to be built on is the support that he felt obliged to provide. Like other participants, the self-harm and the caring role took precedence over established friendships, causing many to deteriorate. However, in Jim’s case there was not an established friendship prior to the disclosure of the self-harm, therefore with the necessity for his position being slowly decreased his friendship did the same.
5.7. Summary

This second study was conducted in order to look at the experiences of the friends of self-harmers, and how they made sense of their experiences over the life-course of the friendship. The research question for this study was:

How do the friends make sense of the experience of being a friend of a self-harmer?

Within this chapter I have begun to explore the experiences of the friends of self-harmers. When self-harm was identified, participants began to reconsider their friendship, and their role within it. This first stage was outlined in the first master theme, Shifting Roles. Participants renegotiated their role from friend to carer; they managed this transition with varying degrees of willingness. Secondly, participants began to make sense of the role change, alongside their ability to support. They did this through comparisons made between themselves and the significant others of the self-harmer. This stage was outlined in the second master theme, Relationship to Others. Finally, over time the friendships deteriorated; this occurred either when the self-harming discontinued or when more suitable others for the role were identified. How participants understood their role within this deterioration was outlined in the third master theme, Deterioration of Friendship.

This study confirms that the friends of self-harmers are affected by their experiences of supporting a self-harmer. This study allowed the exploration of the lifecycle of a friendship, from the introduction of self-harm to the deterioration. A limitation of this study, however, is that participants were looking back retrospectively, in some cases over a number of years. Subsequently, Study Three focussed on the experiences of friends who were currently, or had more recently supported a self-harmer.
Chapter Six

Focus groups with the friends (Study Three)

The previous study highlighted the impact that self-harm has on the life course of a friendship. Friends were pushed, jumped, or fell into the role of carer with varying degrees of willingness. Over time the participants reported deteriorations in their friendship with the self-harmer. As Study Two had been focussed on the retrospective accounts of friends a considerable amount of time had elapsed since they had been in a supportive role. As a consequence, it is possible that participants may have positively reframed their experiences (Smith, 1994). Therefore, Study Three aimed to gain an insight into the experiences of friends who had recently supported, or who were currently supporting a self-harming friend.

6.2. Research aims and questions

In this study I sought to gain a deeper understanding of the experiences of friends who were currently, or who had more recently supported a self-harmer. The research question for this study was:

How do friends make sense of the impact of self-harm on their friendship?

6.3. Method

6.3.1. Participants

Participants were University students. Recruitment was conducted through posters, University hosted participation websites, and the University online noticeboard. In addition, participants were also recruited via the Psychology department’s research participation scheme (RPS) (SONA Experiment Management System). As part of their course requirements first year psychology students were required to participate in research studies. Study Three was advertised as offering an hour and a half's worth of course credits. The use of these schemes as a means to recruit participants has been well documented within social research, and has been used in research on sensitive and controversial topics (e.g. Walsh & Malson, 2010)

In total, 22 students participated, nineteen females and three males with a mean age of 20 years old with a standard deviation of 2.8 years participated. The average time between interview and supporting a self-harmer was 3 years.
6.3.2. *Data collection*

In total, five focus groups were conducted, four focus groups had four participants and one had six participants. One focus group was solely comprised of participants recruited from the RPS, and two focus groups had a mix of RPS recruited participants and traditionally recruited participants. The focus groups lasted between 60 to 90 minutes. All participants were informed of the nature of the study prior to attending. Emails were sent which included the information sheet. Immediately prior to commencing the focus group the participants were all provided with information sheets. I explained how the focus group would be run and highlighted that if they did not want to continue with the focus group they could leave at any point, or withdraw from any or all of the questions. Due to difficulties in removing individual data from focus groups it was also made clear that they would be unable to withdraw their data from the study. Participants were assured that all data would be kept in accordance with the University guidelines and any identifiable information, such as locations and names would be anonymised.

In conducting focus groups, ethical requirements, such as confidentiality and anonymity may be more difficult to ensure due to the presence of others (Gibbs, 1997). To further ensure the confidentiality of the participants within the focus group their real names were never revealed, instead participants were invited to choose their own pseudonym (Nabors, Ramos & Weist, 2001). In so doing, participants were able to maintain a sense of anonymity within an inherently non-anonymous setting.

Further, ground rules were co-created between myself and the participants (Farquar & Das, 1999). These ground rules clarified the expectations of the participants and myself, and provided the opportunity to ensure that other participants respected the confidentiality of the other participants (Farquar & Das, 1999; Wilkinson, 1998a).

The number of focus groups conducted has largely been left to researcher discretion; as Kitzinger and Barbour (1999) state, researchers can conduct anywhere from one focus group to over fifty. Both Kitzinger and Barbour (1999) and Asbury (1995) suggest that the number of focus groups to conduct is dependent upon three key areas: saturation of data, the complexity of the question and practical limitations. Asbury (1995) in particular suggests that most focus group-based research requires between three to four focus groups of between six and twelve participants, with more conducted if new issues are still being raised or if the topic itself is complex. Recruitment for this study was halted at five focus groups. Five was considered to be appropriate due to the exploratory nature of the study, and the focus on looking in-depth at the collective sense-making of the friends. On completion of the fourth
focus group, similar issues and themes were being discussed by participants. The fifth focus group was conducted to ensure that there were no new themes. As previous research exploring other sensitive issues has used around five to six focus groups (Cossrow, Jeffrey & McGuire, 2001; Grogan & Richards, 2002), it was deemed that five focus groups were appropriate for the purposes of this study.

In the same way that there is ambiguity about how many focus groups to conduct, there are differences in guidelines about the number of participants to have within a focus group. Some researchers suggest that focus groups should have between six to twelve participants (Asbury, 1995). Others suggest anywhere between three to six participants is appropriate (Kitzinger & Barbour, 1999). Willig (2008) suggested that more than six participants may discourage disclosure, and others state that they may be inappropriate for more sensitive research (Braun & Clarke, 2013). In order to generate maximal discussion without alienating participants each focus group consisted of between four to six participants. The focus groups were held at mutually convenient times and were conducted in quiet seminar rooms on the University campus.

**Focus Groups for sensitive topics**

Focus groups have been considered an efficacious form of data collection when exploring collective understandings (Braun & Clarke, 2013; Wilkinson, 1998b) and to provide an insight into how collective sense-making is constructed “in action” (Wilkinson, 1998a, p. 181). Researchers have argued that as “people do not operate in a social vacuum” (Kitzinger, 1994, p. 112) focus groups, unlike one-to-one interviews, allow for an insight into co-constructed meanings and social understandings. In other words, this form of data collection encourages further discussion that would not be feasible within an interview as it allows for participants to explore, challenge and critically think about their own experiences, and finally attempt to co-construct a collective understanding (Kitzinger, 1994, 1995).

Focus groups might appear to be a counterintuitive method for encouraging discussion about sensitive topics due to the presence of others. However, it has been well established that, if conducted thoughtfully and with reverence for the participants, focus groups can be a lucrative form of data collection (Braun & Clarke, 2013; Farquar & Das, 1999; Kitzinger, 1994, 1995; Wellings, Branigan, & Mitchell, 2000). Researchers have suggested that focus groups can increase self-disclosure, rather than inhibit it (Farquar & Das, 1999), and may even encourage participants to disclosure potentially “discrediting experience(s)” (Wilkinson, 1998a, p. 192).
Increased self-disclosure is attributed to the increased power that the participants have within a focus group compared to the researcher, put simply research participants outnumber the researcher and as such would feel more at ease discussing potentially taboo topics (Farquar & Das, 1999; Kitzinger, 1994, 1995; Wilkinson, 1998b). Furthermore, the presence of others may encourage quieter participants to come forward, especially if their experiences resonate with the other participants (Kitzinger, 1995); indeed the more forthcoming participants may “break the ice” for quieter participants (Wilkinson, 1998c).

**Prompt Methods**

As an introduction to the focus group participants watched a short clip taken from the television documentary: ‘A World of Pain – Meera Syal on Self Harm’. In this clip adolescents were involved in a group discussion about their experiences with self-harm and self-harmers. The intention behind using this clip was to encourage participants to explore their own experiences in a less direct manner. The use of prompts within research is well documented as being an efficacious way in which to encourage discussion and debate within focus groups (Braun & Clarke, 2013; Kitzinger & Barbour, 1999), particularly within sensitive topic research (Wellings et al., 2000). Speer (2008) argued that through using a prompt, such as a video, the discussion becomes participant-led; whereby the emphasis falls upon what they interpret the stimulus to mean and they discuss their opinions on it and issues around it. It has also been suggested that the use of video, compared to a text stimulus, generates more discussion, and provides more opportunities for participants to discuss their views (Gavin, 2005). Thus, the video was intended to create a focus around which the participants were able to discuss self-harm more generally drawing on their own experiences, understandings and sense-making (Punch, 2002). The video acted as a comparison through which the participants compared their own experiences and understandings against those talked about within the video.

**Inclusion and Exclusion criteria**

Before deciding on the video used within the focus group, I considered a range of potential stimuli. These included: extracts from the previous study, posters, leaflets, online stories, radio shows, and online videos either of personal accounts, television documentaries or promotional material used to highlight self-harm as a health issue.

Researchers who use prompt methods as a focus of discussion commonly use vignettes or group tasks (Kitzinger & Barbour, 1999). Video clips are less commonly used, but have been shown to be useful in exploring social understandings (Gavin, 2001). For instance, Gavin
(2005) used television programmes (‘Beverly Hills 90210’ and ‘Sex, Girls and Kiss Curls’) in focus groups to explore how the media influenced understandings of AIDs. The clips were used to encourage group discussion and engagement. Unlike vignettes, which overtly encourage participants to put themselves in the situation presented, the use of videos encourages participants to discuss their experiences and understandings in relation to those presented within the video clips (Punch, 2002). Furthermore, the use of television as a facilitator for discussion has been established within more ‘naturalistic’ studies (Press, 1991). For example, Wilkinson (1999) argued that families sat watching the television provided a naturally occurring opportunity to explore understandings as the family members would watch and discuss the television programme. It was anticipated that the use of video clips would bear more similarity to everyday discussions, ones that arise from the stimulus of a television show and the participants would feel more willing to engage in discussion (Braun & Clarke, 2013; Wilkinson, 1999).

With the rise of the internet, many videos relating to people’s experiences with self-harm have been released online, particularly through the video sharing site YouTube (Lewis, Heath, St Dennis & Noble, 2011). Consequently, YouTube was identified as being the most appropriate search engine through which to identify potential videos. In order to identify potential videos the three main terms used to define self-harm were used as search terms: self-harm, self-injury and non-suicidal self-injury (NSSI).

Videos had to be “character videos” or those that included people, as opposed to “non-character videos” (Lewis et al., p. 553). Non-character videos do not include a person within them, they are normally characterised by emotive audio, dark visuals and the uploader’s written stories, accompanied by pictures of: themselves, art and images of self-harm or self-harm paraphernalia (Lewis et al., 2011). Character videos are typified by the uploader talking about their experiences with self-harm, although still melancholic these videos tend to be less artistic (Lewis et al., 2011). As character videos are more engaging and do not distract the participants by having to read (Punch, 2002), only character videos were included within the search criteria.

Due to YouTube being a global website, videos are also uploaded by those outside of the UK. Since the focus of the study was on students attending a UK university only videos uploaded within the UK, or by someone living in Britain would be included.

It was important for the video to also be as visually and audibly clear as possible. Videos that were visually unclear were excluded because of poor camera quality and poor lighting. Videos also had to have clear audio, as such videos which were difficult to follow due to audio
disruption were excluded (e.g. videos that had been filmed outside). Research that has used videos has predominantly used ‘short video clips’ in order to maintain attention and create a clear and coherent narrative. In their study of farmer’s attitudes towards the control of bovine tuberculosis, Naylor, Maye, Ilbery, Enticott and Kirwan (2014) used short video clips of between two the three minutes in length to generate discussion in focus groups. Thus, videos, or relevant sections of videos which were longer than five minutes were excluded.

Researchers have used videos from popular television series (e.g. Gavin, 2005). In using extracts from television series there was more chance that the participants may have been distracted from the task of the focus groups because of their prior knowledge about the character’s storyline (Punch, 2002). Therefore, it was decided to use isolated videos that were not part of a television series.

The final three minute video clip used was taken from an hour long documentary aired by the BBC in 2009 and made publically accessible on YouTube in 2012. The video clip was of a focus group of young people, estimated to be between the ages of 16 and 18 within a school setting. In the clip, the young people discussed their general beliefs about self-harm, personal experiences with self-harm, and the self-harm of others. This video was selected as it met the inclusion criteria of being a character, or person-based video, originating from the UK, being visually and audibly clear, being under five minutes in length, and by being a free-standing video.

6.3.3. The interview schedule

The focus groups followed a loosely structured interview guide. Due to focus groups being an interview space that encourages participants to interact with one another it was more suitable to use a loosely structured interview schedule as opposed to a semi-structured interview schedule (Braun & Clarke, 2013). A key difference between a loosely structured and a semi-structured interview schedule is the directed focus of the interview schedule. A loosely-structured interview, which has fewer questions, is more helpful in exploring the breadth of understanding of the participants. Semi-structured interviews are often more focussed on key issues and have a higher number of questions aimed at exploring the specifics of experience (Taylor, 2005). Using a loosely structured interview schedule allowed for prompts to be used to open up, specify and generally guide the discussion whilst maintaining the participant-led ethos of the focus group.
In order to encourage the participants to collectively begin to explore their understandings, and discuss their experiences in their own terms, participants were initially asked about what they thought the clip was about (Gavin, 2005).

*What do you think this clip was about?*

As the previous two studies had highlighted that self-harm did have an impact on friendship, the second question aimed to encourage the participants to engage more in some of their experiences:

*The people in this video have talked about their self-harming friends—but didn’t mention the impact it had upon them—what do you think the impact may have been?*

In the first two focus groups, it became clear that the participants were talking about what advice they would give to others in the same situation. Consequently, later focus groups were specifically asked:

*What advice would you give to other friends?*

Similarly to the previous studies the focus groups ended on a question which aimed to address any areas that have not been covered.

*Is there anything that you wish to talk about that you don’t feel we have covered?*

### 6.3.4. Data analysis

The focus groups were transcribed verbatim and analysed using thematic analysis (Braun & Clarke, 2013). This was the most appropriate analytic technique to use as it allowed a consideration of the participants' collective understandings of the impact of self-harm within a friendship. The analytic procedure as set out by Braun and Clarke (2013) was followed, for an in-depth outline of this see Chapter Four.

As I wanted to further understand how the participants navigated their new role and how they made sense of their experiences in relation to others, the data was considered within a positioning theory framework

### 6.4. Results

Three participants in separate focus groups disclosed that they had self-harmed, in each case information about their own self-harm was only discussed in the group when it provided a context to their stories of supporting their self-harming friend (a fuller discussion about the implications of this issue can be found in Chapter Eight).
Flo talked about her own personal self-harm as being triggered by feeling unable to cope with her friend’s self-harm. Flo initially disclosed her self-harm to her self-harming friend due to believing in the reciprocity of disclosure in the friendship; “I confided in her because she confided in me”. Although Flo anticipated support, the self-harming friend, used Flo’s disclosure as an opportunity to try a different form of self-harm.

The overarching theme was Secrets and Power. Under this theme were the two main themes: Sharing: Trust and Betrayal and One-way Friendship. The Chosen Ones theme bridges the overarching theme and the two main themes. From this, a series of recommendations for friends of self-harmers was also discussed. An outline of the matrix of themes can be seen in Figure 9.

Figure 9: Matrix of themes in Study Three

The overarching theme, Secrets and Power, provides the context for the rest of the themes. The participants’ stories were heavily influenced by the impact of secrets, particularly in terms of how they felt secret-keeping inhibited their ability to share their feelings. They tended to understand self-harm to be a private and therefore secret act, and they had either been told by
the self-harmer that they were not to talk to anyone else about it, or they had assumed that it was a secret and took it upon themselves not to share the information. The self-harmer's decision to share their secret meant participants felt that they were afforded a level of trust by the self-harmer. Therefore, to talk about the self-harm, the self-harmer, or even their own personal experiences and feelings felt like an act of betrayal. This meant that the participants only felt comfortable talking to others if either the self-harmer had already talked to the other person about the self-harm, or if the participants had gained permission to do so beforehand. The friendships between participants, the self-harmers, and others were negotiated through secret keeping and secret sharing.

All of the participants talked about being afforded a significant amount of trust by the self-harmer when the self-harm was disclosed to them. Their sense-making about their position as friend and confidante is explored in the theme, The Chosen Ones. This theme explores the participants' understandings about why they were chosen above others, especially friends whom the participants believed to be closer to the self-harmer.

In becoming a part of the self-harmer's secret and understanding their position within the friendship to be one of a trusted confidante, the participants constructed their experiences of sharing, and therefore support, as being mediated by both the actual and the perceived preferences of the self-harmer. How participants constructed their sharing is considered in the first theme, Sharing: Trust and Betrayal. There was a contradiction in how participants spoke about sharing and how they reported their own experiences. They spoke about the benefits of sharing whilst providing support. Indeed, when asked what piece of advice they would give to a friend currently supporting a self-harmer the overwhelming majority suggested talking to someone. In practice, however, they only shared information when they felt the self-harm had become more serious, or when the self-harmer became too much of a burden to support. The value that participants placed in maintaining the confidentiality of the self-harmer continued despite some of the self-harmers being open about their self-harm, in some cases, to the extent of “attention seeking” (Focus Group 3; Sasha). It became clear that some participants were more dedicated to maintaining the confidentiality of the self-harmer than the self-harmers themselves.

The final theme, One-way Friendship, is a further exploration of how participants talked about the change of their role in their friendship with the self-harmer. Most of the participants who had become involved in the support of their self-harming friend talked about their friendship becoming unequal, and them becoming, as one participant called it, a “semi-counsellor” (Focus Group 1; Connor). For some, this completely altered their friendship, they made sense of this
change as being similar to bereavement; they had lost the friend that they knew. Others talked about this change in friendship as being something that superseded their role as friend, but did not irreversibly change it. In other words, some of the participants talked about the two roles as competing, and that in supporting their friend they spent time in the semi-counselling role rather than the friendship role. Associated with this new way of “doing” their friendship, participants also talked about their feelings of responsibility over the welfare of the self-harmer. Often the participants talked about taking on too much responsibility, this sense of responsibility was further compounded by their focus on ensuring the privacy and confidentiality of the self-harmer. The implications of this are discussed.

6.5. Overarching Theme: Secrets and power

Across all of the focus groups, the participants talked about secrets as being significant to their experiences. In particular, participants talked about how keeping the self-harm a secret impacted in other key areas of their lives and relationships with others. One participant talked about her life “unravelling” (Focus Group 1; Flo) through feeling unable to talk to anyone about her concerns.

When questioned about whether they had been asked to keep the self-harm a secret, only a minority said they had been told not to tell anyone. Instead the majority of participants talked about them keeping the self-harm a secret because they had “the sense that it's not something they [self-harmer] want shared around, it's not something you’re going to run and tell other people (...) it's not gossip” (Focus Group 5; Harriet). In this sense self-harm was considered by the participants as being a very private issue only to be told to a select number of people. Irrespective of whether or not the participants were told to keep the self-harm secret, all of the participants talked about the importance they placed in maintaining the confidentiality of their self-harming friend.

Despite the participants’ commitment to maintaining the secret, it was apparent that the self-harmer did not do the same. The friends talked about the self-harm as starting off as a secret shared with only a select number of people, usually close friends and family. Over time, it became clear that, for some the ‘secret self-harm’ soon became widely known.

At the start like I think it was just me she told (...) then her boyfriend found out (...) but then like as it progressed it got worse and worse so she’d be just like crying and walking round college so everyone found out by the end so yeah (...) it's like different at the start (Focus Group 3; Lola)
Across the focus groups it became clear that many of the self-harmers told others about their self-harm. Some participants talked about small acts of sharing with other friends. Other self-harmers, illustrated by Lola’s quote above, told other peers about their self-harm, or at least demonstrated that they were distressed. As Lola states, the self-harmer’s behaviour changed over time, in selectively sharing the self-harm and maintaining the secret-status, the self-harmer fulfilled the expectations of the friends. Indiscriminately disclosing the self-harm, however, transgressed the expectations of the friends. Thus the secret, and potentially the friendship was changed, as Lola stated; “it’s like different at the start”.

Other participants, however, discussed self-harmers who would disclose their self-harm as if it were a secret to different groups of friends who were known to each other.

*I think my friend was bit of an attention seeker, like not in a horrible way but she was a bit of an attention seeker like, she’d kind of () quite weird () she’d get close to people like really really quickly and then tell them everything but then obviously these people aren’t real friends if that makes sense and then so then gossip was spread around. (Focus Group 3; Sasha)*

Sasha’s experiences were not uncommon; the self-harmer’s disclosure threatened her position as sole, or at least key, confidante. To deal with the threat to their position, the participants negatively constructed the self-harmers as being “attention seeker[s]”, and those they told as not “real friends”. In presenting the other friends as not “real friends”, Sasha intimated that she was a real friend, the one who properly supported the self-harmer and fulfilled her expectations of what a friend is.

This highlights a potential mismatch in the understanding of friendship between the participants and the self-harmers. The self-harmers’ approach to friendship challenged the participants’ own understandings and expectations of friendship. The participants constructed friendship in terms of loyalty and commitment, and themselves as being the better friend for not being judgmental. The secret-sharing of the self-harmer transgressed the participants’ own understandings of what friendship was. In keeping the secret between themselves and the self-harmer the participants’ friendship was special and they held a privileged position. By the self-harmers sharing widely the exclusivity of the friendship and the participants’ privileged position within the friendship was challenged; instead of being the only confidante, they were one of many.

Once it became clear that the self-harm was no longer a secret many of the participants maintained their commitment to keeping the self-harmer’s secret. Melody talked about a friend
of hers who was outwardly distressed and the self-harmer’s behaviour “aggravated the rumours” (Focus Group 5). Although Melody talked about the self-harmer potentially promoting the rumours about the self-harm, it became apparent that Melody still prioritised the self-harmer’s confidentiality, even when the self-harmer was obviously socially showing distress;

_I know I never lied to protect her (.) I never went oh I know she’s not self-harming coz I knew and it didn’t occur to me to lie but (.) yeah I used to tell a lot of people they shouldn’t be talking about that if they didn’t know what was going on._ (Focus Group 5; Melody)

Secret-sharing and secret-keeping were used as tools for participants to negotiate their position within the friendship, particularly in comparison to those outside of their friendships. Put simply, the disclosure by the self-harmer to others threatened the participants’ special friendship. Through the participants’ commitment to the privacy of the self-harmer, something that other friends used for “gossip” (Focus Group 3; Sasha), the participants constructed themselves and their friendships as being superior to the other friendships.

### 6.6. Theme: The chosen ones

Within this theme an exploration of how participants constructed themselves as being selected by the self-harmer above potentially more suitable others is discussed. This theme bridges the gap between the overarching theme and the two other themes. In being involved in the self-harmer’s secret the participants understood themselves as being the _chosen ones_. Thus, the secrecy they held and the commitment they had to maintaining the self-harmer’s confidentiality impacted on who they felt comfortable sharing with. This theme not only provides a contextual story for why secrets were so important to the participants, it also provides an insight into how the participants began to construct their role as friend and confidante. Through considering themselves as the _chosen ones_ the participants understood their position as being the only ones suitable to provide support to the self-harmers.

Many of the friends explored why they thought they were chosen by the self-harmer to be the confidante:

_Flo:_ _I think that’s kind of one of the fundamental things in friendship (.) not that you’d necessarily turn to the person who’s closest to you but the person you (.) you feel most comfortable about how they’d react (.) Like you can have someone you’re really close to but you know you can’t deal with the way they’d react (.) like if you had someone you felt you could confide in everything with_
when they’re the sort of person who’s going to get really upset and hysterical and try and fix things but you don’t want that (.) you won’t turn to that person (.) you’ll turn to someone you’re not as close to but who’s just going to sit and listen and nod like (.) is there anything-do you wanna say anything else? Or is that it or something?

Maddie: Yeah (.) I think that’s it (.) I think it’s the reaction that (.) I think that that was when I say how to distinguish between the people that (.) they can tell and they can’t (.) I think it’s the reaction that they’ll give (Focus Group 1)

Rather than constructing themselves as the closest person to the self-harmer, the participants described themselves as the most understanding, non-judgmental friend of the self-harmer. The participants therefore considered themselves to be the chosen ones, not due to having an especially close friendship, but because they felt they were perceived as being able to remain calm, supportive, and open-minded in how they reacted to the disclosure.

Participants also felt that closeness within a friendship may act to prevent, rather than encourage, disclosure.

Maddie: There are friends who she was equally close to, but for some reason she just absolutely dreaded them knowing (2) because she knew that it would completely change (.) maybe it was the fact that they were even closer friends (.) so she knew that if she told them and it would change something it (.) it would be bad. Because she knew that it would completely change (.) And I (.) because she was equally close to all of them (.) but there was just something about the like (.) I don’t know what it (.) maybe it was (.) the fact that they were even closer friends (.) so she knew that if she told them and it would change something (.) it (.) it would be bad

Connor: It would really matter

Maddie: Yeah (.) So although I was close to her

Flo: Maybe it mentally change the friendship (.) and as scary as that was for you guys (.) maybe she didn’t (.) she just couldn’t bear
the thought of changing the friendships she had with them as well

Maddie: Yeah (.) Yeah (.) Whereas with me she knew (.) she knew (.) I don’t know what it was with our friendship

Flo: Yeah

Maddie: But she knew it (.) nothing (.) it wouldn’t change anything

Flo: Yeah (Focus Group 1)

This suggests an almost strategic element to the self-harmer's decisions; by confiding in the participants the self-harmer could ensure the maintenance of all of their friendships, ones where self-harm was discussed and ones where it was not. As Antonia in focus group four put it; “they were afraid that if those friends found out they would be treated differently (.) and they didn’t want that to happen” (Focus Group 4; Antonia). The participants constructed their friendship with the self-harmer as being stronger, and more able to withstand the disclosure of self-harm. Thus, the participants presented themselves as being less judgmental and more supportive. In so doing, they were the better friends because they were more able to support the self-harmer.

The participants’ accounts suggested an almost functional approach to friendship where some friendships are appropriate for some activities, but inappropriate for others. The participants’ accounts suggested that how they ‘did’ the friendship impacted upon what was shared with the friend. For example, a drinking friend may not be an appropriate friend to share concerns with as the focus of activity is mostly on drinking and socialising rather than the supportive aspects of friendship.

Since the participants understood themselves to be the chosen ones, they became protective over the self-harmer and the secrecy that they felt differentiated their friendship as superior to the self-harmer’s other friendships.

6.7. **Theme: Sharing: Trust and betrayal**

Through secret-sharing and secret-keeping the participants constructed their role within their friendship as that of close confidante. The participants routinely constructed self-harm as a private and thus secretive act. Whether the participants shared their experiences with others was dependent upon the actual and perceived preferences of the self-harmer.
Across all focus groups there was talk of how the disclosure of the self-harm by the self-harmers required a great deal of trust and bravery, as Holly from focus group two put it; “I think it took quite a lot of guts for her to tell me because she’s scared herself” (Focus Group 2; Holly).

In order to warrant the trust they believed had been placed in them, participants began to prioritise the secret-keeping because they believed it was not their secret to tell:

>You’re holding onto this secret that’s theirs but like you say (.) you get asked questions about it and you can’t say anything and you end up (.) sort of not lying but (.) omitting the information and kind of just scooting over things when actually all you wanna do is tell someone coz it’s you as well (.) like you’re kind of having to go through each day. (Focus Group 2; Nancy)

The disclosure of the self-harm was generally viewed by the participants as an indication that the self-harmers wanted to stop self-harming. Thus any breach of this trust by the participants was interpreted as a threat to the positive steps already made. In the quote above, Flo, like many of the other participants, talked about how she was negatively affected by the self-harm of her friend. However, she was reluctant to talk to others about her friend’s self-harm; the secret-keeping within the friendship meant that she felt unable to seek support for herself. She constructed her friend’s need for secrecy as taking precedence over her own wellbeing.

In prioritising the self-harmers’ secrets, the participants described disclosing any information concerning the self-harmer as a breach in trust. Some members of focus group five talked about how even coming to a confidential focus group aimed specifically at their experiences caused them concern:

>**Melody:** It almost feels like I’m betraying their trust coming and saying (.) yes I knew five people who self-harmed regularly (2) it feels a bit guilty to me

>**All:** Yeah

>**Harriet:** They are really personal issues and erm a lot of people (.) well people that I know who self-harm, it’s not it’s not obvious scars that they’ve got that people can see (.) it’s so it’s something that they’ve tried to cover up themselves (.) so when they’ve come to me not to tell them (.) to tell me then it’s really been a matter of
The importance participants placed in their secret-keeping was attributed to the perception that they were chosen because they were non-judgmental and could ensure the confidentiality of the self-harmer. The sharing of information even in the form of their personal experiences, worries and feelings was considered to be a “breach of trust”, a betrayal. It was this fear of betraying the confidence of the self-harmer that the participants felt obstructed them from seeking help.

Flo: You can’t tell anyone because if you like if you do that you risk losing their (.) confidence (.) and in that case it could be even worse because they won’t talk to anyone (.) so you’re scared because you don’t want to leave them all alone in-case they reject you for telling someone

Evvie: Mmm

Flo: And in that case (.) it could be even worse because they won’t talk to anyone

Maddie: Yeah

Flo: So you’re scared because you don’t want to leave them all alone in case they reject you for telling someone (.) but you don’t wanna be the only one who knows

Maddie: Yeah (Focus Group 1)

Many of the participants referred to the potential loss of friendship as key in their motivation to maintain the confidentiality of the self-harmer. In particular they framed the friendship loss in terms of the perceived detrimental impact it would have on the self-harmer’s well-being. In placing themselves in such a pivotal role the participants presented the self-harmers as being incapable of ensuring their own wellbeing.

There are two subthemes within this theme; Politics of Sharing and Sharing is Caring; both of which highlight how the participants talked about their sharing with those outside of the friendship dyad. The first subtheme, Politics of Sharing, considers how the participants talked about who they felt they were allowed to talk to about their experiences. This was dictated predominantly by the self-harmer’s either stated or assumed preferences. The second
subtheme, *Sharing is Caring*, focusses on how the participants talked about their own sharing, or support-seeking outside of their friendship with the self-harmer. Specifically, the participants only sought help when either they feared for the wellbeing of the self-harmer, or when the participants felt unable to continue supporting the self-harmer without having support for themselves. In both cases their support-seeking was understood as being for the wellbeing of the self-harmer.

### 6.7.1. Subtheme: Politics of sharing

The participants discussed their experiences of sharing with others. They either chose to talk to someone within the same friendship group as the self-harmer, or they sought support from friends that the self-harmer did not know. They framed their decision to share their experiences as being dictated by the actual or perceived preferences of the self-harmers; i.e. the participants who had been told not to tell anyone favoured seeking support from those that the self-harmer did not know.

In discovering that other friends of the self-harmer knew about the self-harm, the responsibility that participants felt for the wellbeing of the self-harmer was reduced. As Flo stated in the first focus group;

> If there’s a big group you know that even if for whatever reason you can’t answer the phone or you’re not there for them they got loads of other people they can turn to and you know they will turn to them (.) if you’re the only person they can talk to (.) that’s a lot of responsibility (.) you shouldn’t have the full responsibility for that person. (*Focus Group 1; Flo*)

The dispersion of responsibility within friendship groups meant that the self-harmer had more people to seek support from. Participants referred to having others who the self-harmer could turn to within the friendship group as acting as a “safety net” (*Focus Group 1; Connor*). Thus allowing the participants, should they wish, to withdraw or decrease support. However, the others in the group were recognised as being a back-up, not a surrogate carer to the self-harmer. In constructing other friends as being a “safety net”, the participants maintained their position as the primary, preferred supporter of the self-harmer whilst decreasing their feelings of responsibility.

Some participants talked about their friendship groups as providing good collaborative support whilst not challenging their position as the main confidante to the self-harmer;
Mel: I think it’s definitely easier having other people there like I you know (.) I’ve had the experience of being the only person who knows and that is a very different experience to being like, more recently (.) in a group of people and my friend has sort of decided to (.) fill in some people in the group with sort of vague you know something’s going on (.) I don’t want to give you the details (.) just don’t press me right now and then there being a few more of us who know and it’s completely different because it takes that pressure off you (.) because you know you still look out for them and you’re still worried about them (.) but it’s different not being the only person that knows (.) it’s a very different situation (.) I do think those two things if there’s more than one of you it’s a lot lot easier

Edward: Also the other people have also ways of knowing how to make the person tick as well (.) like there different ways (2) And that usually helps (.) because it means can they not only (.) they not only get a potentially different perspective on the matter (.) but they can also (.) like have their own (2) make their own judgement of what (2) what’s going on (.) and of course in that respect they can offer their own advice (.) I think basically it’s a matter of two heads are better than one (Focus Group 4)

Participants framed seeking help within a friendship group in terms of a “two heads are better than one” approach (Focus Group 4; Edward); whereby the care for the self-harmer was a group enterprise. Even through the use of a group support setting, the participants’ position as key supporter was maintained. For instance, Mel talked about the self-harmer only telling others “vague” details about the self-harm, thus she constructed herself as having more knowledge and providing the majority of support. Through acknowledging the presence and usefulness of others, whilst maintaining the most intimate knowledge, her position as confidante was maintained whilst still reducing her sense of responsibility or isolation.

For some, sharing the responsibility with others was disappointing. The participants constructed other people’s ability to support the self-harmer as being below their expectations of support within a friendship:
Claudia: One thing that was kind of frustrating was that a certain point where you’re not the only one who knows that (.) like the other friends they kind of feel I don’t know (.) scared about that or just (.) I don’t know if they see the thing as to like have different and so you’re maybe the only one who’s taking care of this person (.) because I’m speaking of several persons (.) and so this was I think the most (2) heavy thing (.) because you were almost alone and sometimes you were seeing things that were...really hard for you and you didn’t have anyone to speak about it (.) because you were like taking care of someone and you didn’t have any other person (.) like safe persons to speak about that

Sasha: It kind of brings you down as well (.) it kind of you’re feeling how they’re feeling (.) like you sort of become (.) not like one person (.) but it’s like when they’re feeling and you get pulled down as well

Naomi: Yeah (.) and I felt like I had to be available like all the time in case she rang (.) so yeah (.) it was hard (Focus Group 3)

When other friends knew about the self-harm, the participants had expectations of the friends’ involvement in the support of the self-harmer, namely that other friends should be willing to embrace the same responsibilities that they had adopted. Claudia, above, constructed her experiences in supporting the self-harmer as being isolated and lonely. The unfulfilled, potentially unrealistic, expectations she had of her friends’ willingness to be involved meant that her own negative experiences became more exaggerated. Through the discussion between the participants it became more evident that other friends’ lack of willingness to become involved in the care of the self-harmer meant that the participants felt more responsible, and had to be constantly available to the self-harmer. Other participants highlighted similar experiences whereby mutual friends failed to take responsibility for the wellbeing of the self-harmer. For example, Nancy in the second focus group stated that in her friendship group her mutual friends were “judgemental and not particularly understanding” (Focus Group 2; Nancy).

In constructing the perceived lack of understanding and subsequent involvement by the other friends the participants framed themselves as the superior friend, the one who was not judgemental. Especially within the third focus group it became apparent that in the perceived rejection of the self-harmers by other friends, the participants felt that they took on the majority of the responsibility for the self-harmer;
Sasha: *In our group of people a lot distanced themselves so it ended up at one point just being me and her (.) like I (.) even though I had my other friends I couldn’t really like leave her because if I left her she would have no-one else so it’s kind of (.) I lost a lot of my friends in the process as well (.) and then you sort of just become joined at the hip.*

Naomi: *Yeah that happened to me (.) like our friend group sort of split (.) like quite significantly during it (Focus Group 3)*

Many of the participants talked about how they felt other friends began to distance themselves from the self-harmer. The participants believed this was because the other friends could not cope with the self-harm. As demonstrated by Sasha, and Naomi above, by supporting the self-harmer’s when others failed to, the friendships with other friends dwindled whilst the friendship with the self-harmers often became far closer than the participants expected.

Other participants talked about preferring to seek support outside of the friendship group as a means of maintaining the confidentiality of the self-harmer.

*I told my housemates at uni because they didn't know her and like there was no need for me not to talk about it with other friends so I've (.) like yeah I've had support (.) erm (.) but none of them know the person. (Focus Group 2; Holly)*

Holly spoke about her experiences with a friend from home who had repeatedly self-harmed and was eventually sectioned. When asked about her support seeking Holly talked about the self-harmer requesting that mutual friends were not to know. This left Holly in a difficult situation when she wanted to seek out support for herself. This was a commonly reported experience and in other focus groups, participants talked about the difficulty in seeking support when in high school or college due to “interconnected circles” (Focus Group 4; John). These interconnected circles acted as a barrier to the participants’ support seeking, they were fearful that the self-harmer would find out about it and interpret it as an act of “betrayal” (Focus Group 4; John). In comparison, the participants talked about University as being a better environment to garner support from others;

*When I’ve been at university it’s different because I have very separate social circles (.) so you know (.) I have other friends I know I can discuss stuff and it’ll never get back to that same person (.) so I think it’s easier dealing with it in this sort of setting. (Focus Group 4; Mel)*
Thus for the majority of the participants, University provided an environment that made support easier to access whilst maintaining the confidentiality of the self-harmer. Through having separate social circles the participants talked about feeling more comfortable in using their friends for support. This highlights that much of the support at University provided to those who self-harm and their friends predominantly came from other University students; a network of friendship-based support was created around the self-harmer.

6.7.2. Subtheme: Sharing is caring

When the participants did seek out support, they consistently constructed their help and support seeking in prioritising the welfare of the self-harmer. How they understood their help-seeking is explored in this subtheme, Sharing is Caring. The help-seeking of the participants was done both directly (i.e. telling the self-harmers parents), and indirectly (i.e. through getting support for themselves in order to be able to support the self-harmer). In framing the help-seeking as being done in the best interests of the self-harmer, the participants were able to reduce some of the guilt associated with this act of “betrayal” (Focus Group 4; John).

When the participants sought help on behalf of the self-harmer, they predominantly focussed on the family members or partners of the self-harmer.

*Victoria:* Erm I told her mum, because erm I’m at uni and she called that and I was really worried about what she was going to do that night (.) normally I would then get her to come to my house but obviously I’m at uni so I actually had to call her house and tell her mum (.) just to make sure she wasn’t on her own (.) but I felt really guilty about doing that but erm (.) yeah it’s difficult.

*INT:* Was there any repercussion for you telling her mum? Or?

*Victoria:* I think she (.) she didn’t speak to me for a little, for a few days after that (.) erm but I had to(.) I just sort of texted her saying look (.) I’m sorry I had to (.) erm (.) but she’s forgiven me now (.) so I think she’s getting a little bit better now (.) so her mum know and her mum’s now (.) putting less pressure on her now which was the main reason I think she was harming was because of her family.

*INT:* Yeah, that something has come from it (.) has it taken any pressure off you?
Victoria: Yeah (.) she hasn’t called me as much(.) I haven’t been as worried lately (.) but erm(.) it’s still(.) the worry never goes away though (Focus group 5)

Seeking support from family members or partners was normally done when the participants perceived an immediate threat to the welfare of the self-harmer. For example, Victoria sought help because she received a worrying call from the self-harmer. This was very common and other participants sought help following a concerning text or phone call from the self-harmer, or the self-harmer not answering their phone. This was particularly prominent when there was geographical distance between the participants and the self-harmers. In constructing seeking support as being an act of betrayal, the participants often reported feeling “guilty” when they did so. When the decision was made to seek out support, the participants routinely considered their decision as being positive and in the best interests of the self-harmer. Victoria understood the net effect of her help-seeking as being successful, and framed her help-seeking in terms of prioritising the welfare of the self-harmer. She also talked about feeling less worried, the responsibility she felt for the self-harmer had decreased. Consistently the participants only mentioned the positive impact help-seeking had on them as a consequence of the positive outcomes it had for the self-harmers. Thus to be able to seek help and maintain their position the participants relied on constructing their positive experiences as being a by-product of ensuring the wellbeing of the self-harmer.

In terms of seeking help for themselves, many of the participants talked about taking on excessive responsibilities. They talked about supporting the self-harmer as being “tiring” (Focus Group 4; Mel). Three of the participants discussed their own self-harm as being a consequence of being unable to cope with their friends’ self-harm; “it really affected my life and then after that it was really hard like, a few months after that was when I first self-harmed” (Focus Group 1; Flo). Although not all of the participants had self-harmed after supporting the self-harmer, others talked about the negative effect it had on them in terms of feeling powerless, stressed, and out of control. Some participants sought out support;

You need to take care of yourself as well (.) because if it’s hurting you and you’re struggling (.) like you’re not making anything better you’re not going to make them feel better (.) by (.) like working yourself up over it so if some part of its bothering you and you’re worried about no one knowing (.) or (.) like if you’re struggling with secrets or you’re struggling with it (.) you need to talk to someone else (.) ok try and keep it confidential not tell them who it is
but it’s a more important that you are actually up to the standard of being able to help them. (Focus Group 1; Flo)

The participants considered their sharing as a “betrayal” of the self-harmer’s trust. When they did seek help, they deemed the subsequent outcomes as solely beneficial for the self-harmers. The participants’ focus on maintaining the wellbeing of the self-harmers permeated their constructions of their own help-seeking. The participants constructed the maintenance of their own wellbeing, through support-seeking as ensuring that they were “up to the standard of being able to help them [the self-harmers]” (Focus Group 1; Flo). Thus, rather than the support benefitting them, their own wellbeing was framed in terms of how they could better support the self-harmer. In reframing a self-focussed act, the participants were able to preserve a selfless self-construction.

Antonia was one of the only participants who talked about being involved extensively in group therapy with her self-harming friend. The sessions focussed on encouraging her to establish her role as a friend, not carer, within the friendship; “you really do learn just to have that (.) that distance and knowing where you belong in that (.) relationship as well” (Focus Group 4; Antonia). For her, the group sessions were focussed on redressing her place and role within the friendship. Thus, prior to the group sessions, Antonia believed that she had inadvertently and inappropriately taken on an unsuitable position within the friendship and too much responsibility.

6.8. Theme: One-way friendship

The participants all talked about a change in their friendships after finding out about the self-harm. This change was characterised by deterioration of communication within their normal friendships. Prior to self-harm discovery the friendships were constructed as being mutually supportive and as having communication that was not focussed primarily on one area. However, when the self-harm became an issue within the friendships the support became distinctly one-sided:

John: I certainly struggled letting it go at its own pace and letting them come to me and I found myself getting so over-paranoid and aware of it (.) any little thing was sort of (.) what if that’s worse than it seems (.) what if that’s going to escalate (.) and it didn’t help at all because (2) you know (.) you can’t work that out from the outside (.) not (.) certainly I couldn’t and I don’t think a lot of people could unless they were really switched on
(2) It just made (.) it certainly (.) I found (.) that it just made them close up more (2) Erm and you know (.) if you’re constantly asking and on the lookout for it (.) it goes the other way (2) Certainly the only thing that I found that worked was sort of just taking a back seat an perhaps being a bit discrete (2) and if something persisted over time to bring it up (.) and that was very (.) very hard

INT: What was hard about it?

John: To suppress the urge to try and help (2) It’s very difficult

Mel: Yeah I think I completely agree (.) you do sort of have to (.) you almost have to have to change how you interact with them (.) because if it was just a friend who was fine and they you know said to you ‘Oh I’ve done this really crazy thing the other day’ (.) then you’d be really inquisitive and you’d ask them loads of questions because that’s just what friendship is (.) whereas if they share something like that with you then yeah it’s almost like this protective instinct (.) you have to look after them (.) and you can’t (.) yeah you can’t have that sort of selfish side to it (.) being like, your own curiosity (.) it’s very different (.) it’s (.) yeah it’s more just looking after them and making sure that they’re okay and your own needs sort of take a back step (Focus Group 4)

The participants constructed their interest in the self-harm as being selfish and only serving to further the participants’ own curiosity and need for information rather than being helpful for the self-harmer. Other participants talked about this change in communication being due to a fear of upsetting the friend if they were too inquisitive. Sasha from the third focus group stated that she felt she was “treading on egg shells” (Focus Group 3; Sasha). The change in communication was associated by the participants with not wanting to upset the self-harmer. Participants regularly constructed their ‘normal’ friendships and ways of communicating as being potentially triggering for the self-harmer; they had to overlook their own friendship preferences and prioritise the needs of the self-harmer.
In tandem with the change in communication style, many of the participants constructed their support within the friendship as becoming unidirectional. The self-harmers were receiving support without reciprocating.

*With like friendship you kind of (.) it becomes less of a friendship if that makes sense (.) because usually in a friendship you help each other it becomes quite a one-way friendship (Focus Group 3; Sasha)*

Participants saw normal friendship as being distinctly different to that of the friendship they had with the self-harer. This distinction was framed in terms of the support provided and received. The participants constructed ‘normal’ friendships as being mutually supportive, a friendship of equals. This stands in stark contrast to the participants’ understandings of their ‘one-way friendship[s]’ with the self-harer. In constructing their friendships as prioritising the needs of the self-harmers, the participants were able to ensure their selfless self-construction.

As discussed in Study One, the friends of self-harmers described a shift within their friendship. More specifically, their friendships moved towards a more caring relationship which superseded the roles and responsibilities of friendship. Throughout the focus groups in this study it was clear that the participants were similarly constructing themselves as having something other than a ‘normal friendship’. This second theme further explores how the participants made sense of their role within the friendship post-disclosure, and the responsibilities they took on. There are two subthemes within this master theme; Semi-Counsellor: Estimations of Responsibility, and Sacrificial Support.

The participants within these focus groups primarily constructed themselves as taking on a role akin to a counsellor. As participants took on this new role, they often took on too much responsibility for the self-harer’s welfare. This is discussed in the first subtheme, Semi-Counsellor: Estimations of Responsibility. As a consequence of prioritising the welfare of the self-harer’s, the participant’s often began to lose sight of their own wellbeing. This is explored in the final subtheme, Sacrificial Support. Many of the participants talked about a deterioration within the friendship. For some, there was a sense of sacrificing their needs within the friendship. Others were willing to sacrifice their friendships in order to ensure the well-being of the self-harer.

6.8.1 Subtheme: Semi-counsellor: Estimations of responsibility

When self-harm was discovered the participants began to negotiate their new role within their friendship as being a carer, or semi-counsellor. In particular, Connor, in the first focus group,
talked about there being a “less level playing field” (Focus Group 1; Connor) within his friendship. When asked to expand he stated;

Connor: I mean that (.) I think sometimes it made me (.) sort of turn into a err (.) kind of semi-counsellor rather than just (.) rather than just a friend and we’re sort of equals and can (.) yeah you know (.) we all look after each other (.) It was kind of like (.) this (.) this friend of mine needs (.) needs help in a way that I don’t (.) so it (.) sometimes (.) possibly puts me in a position of (2) not authority as such (.) but

Maddie: It’s like an uneq-unequal

Connor: Yeah

Maddie: Friendship (.) yeah (Focus Group 1)

Other participants repeated similar experiences, for instance, Lola considered herself to be a “24 hour carer” (Focus Group 3; Lola), someone who was always there for the self-harmer. The participants constructed the time they spent with the self-harmer, and their subsequent relationship, as doing something different to their friendship. The distinction between the two roles was characterised by deterioration in equal support.

Connor discussed his role as friend and semi-counsellor as being distinct roles;

I spent more time in the kind of (.) trying to help role (.) rather than the laid back friend sort of role. (Focus Group 1; Connor)

The two positions, friend and semi-counsellor role were distinct and all-encompassing, his role of carer took over his role of friend. When self-harm was introduced within the friendship Connor understood his role within the friendship to have altered; he talked about his “laid back friend” position within the friendship as being displaced by his “trying to help role”. Thus, when self-harm was introduced the participants understood their role as friend within the friendship to have transformed into that of a semi-counsellor, a caring and selfless position.

Alongside their new role within the friendship, the participants also discussed their increased sense of responsibility for the welfare of the self-harmer. In particular, most of the participants talked about taking on too much responsibility for the self-harmer within the friendship;

You shouldn’t have that much responsibility for someone if they’re like self-harming or anything like that (2) you shouldn’t have the full responsibility for
that person (.) and like (.) I had that for my friend and I found it really difficult (Focus Group 1; Flo)

Participants suggested that the level of responsibility they adopted was exacerbated by perceiving themselves to be the sole supporter of the self-harmer. They talked about the self-harmer "refusing to see anyone professional, or get any kind of help" (Focus Group 4; John). Furthermore, the sense of responsibility that the participants felt for the self-harmer was inflated by keeping the self-harm a secret and maintaining the self-harmers confidentiality;

*I think that's kind of the worst part about self-harm and friendship is when they say you can't tell anyone else because carrying that around (.) you feel responsible (.) if something worse happens (.) you feel responsible (Focus Group 1; Flo)*

Through maintaining the confidentiality of the self-harmer the responsibilities adopted by the participants were not often challenged. Thus, the participants were able to present their position as being out of their control and were able to remove their accountability for any over involvement in the care for the self-harmer.

In presenting themselves as being the only support that the self-harmer has the participants reframed their excessive adoption of responsibility as being necessary and therefore appropriate. As one participant stated;

*And you don't know what to do, and because you're the only person who they're talking to at that precise moment and it's like oh my god like someone's life is like on the line and you're the only person that they're willing to talk to about it (.) like the pressure from that is quite immense (Focus Group 3; Lola).*

The level of responsibility adopted was therefore considered to be unavoidable, for without their support the self-harm could become more severe. In constructing themselves as "the only person" supporting and listening to the self-harmer the participants were able to justify their over-involvement in their support of the self-harmer. Through understanding their presence and involvement as being essential, the associated responsibilities became a necessity. As Lola states; “You’d have to like come out of a lesson to answer the call to make sure she’s alright, because it got to that stage where you couldn’t like leave, you couldn’t not answer the call.” (Lola; 3). The participants seemed to be aware of the excessive nature of their involvement in hindsight, yet at the time were unable to see it as being excessive.

The participants’ excessive responsibilities increased slowly and incrementally;
I became far too involved, erm (.) and its only now sort of after that’s happened that I’m able to look back and think no! I got way too involved there (Focus Group 4; Mel)

I’d have killed to be part of one of the support groups and it’s just (.) well just to not have to bottle it all up and be able to find out what you’re actually supposed to do properly (Focus Group 4; John)

Across all focus groups the participants mentioned the scarcity of support available for the friends of self-harmers. Participants said they learned how to support the self-harmer as they went along; they “learn(ed) on the fly”. The majority of the participants considered their involvement with the care of the self-harmers as being a product of miss-calculating how involved they should become and not knowing what to do. In presenting themselves as blindly supporting, the participants were further able to distance themselves of any wrong-doing or misadventure that occurred when they supported the self-harmer.

6.8.2. Subtheme: Sacrificial support

In believing the self-harmer’s wellbeing to be the upmost priority within the friendship and providing unidirectional support, the participants began to neglect their own needs within their friendships. For some this escalated into the complete sacrifice of their friendship in the hope of helping the self-harmer recover.

Largely participants talked about their negative experiences in supporting a self-harmer;

They’ve said they’ve overdosed or something like that and it’s like constantly you know (.) just (.) it’s really tiring just having to be there (Focus Group 4; Mel)

The participants routinely considered the support they provided as “tiring” (Focus Group 1; Flo) and themselves as “completely out of control” (Focus Group 2; Holly). The participants consistently discussed the support they provided as being negative and having a detrimental impact on themselves. There were some participants, however, who found supporting the self-harmer rewarding and welcomed the opportunity to provide support.

I just felt like I was actually being able to do something and so like I felt that (.) yeah, it felt a lot (.) more helpful it just it just felt a lot better that I knew that they were able to talk to me about it and that I was able to help them out in some way or another (.) rather than having someone who’s just like completely closed off and wouldn’t talk about it (.) so yeah I did feel kind of
selfish because it felt good for me to have some way of helping. (Focus Group 2; Lyndsey)

Those who discussed the positives of supporting a self-harmer were quick to reframe this, like Lyndsey above, as “selfish”. In discussing their positive supportive experiences as being selfish, the participants understood that the support they provided should be a selfless act that should not benefit them.

Although participants reported feeling tired, out of control, and unsupported, they continued to provide support to the self-harmers.

Lola: It was a lot of pressure to like have to, go to lessons and then you’d get a text or like endless calls from her like just wouldn’t stop (.) like if you didn’t answer she’d just call again and again and again (.) the whole of my like you know previous calls log was just all from her (.) you’d have to like come out of a lesson to answer the call to make sure she’s alright (.) because it got to that stage where you couldn’t like leave (.) you couldn’t not answer the call.

Sasha: Yeah (.) my friend like called me like four in the morning sobbing down the phone to me (.) and like (.) the worst thing was most people sort of turned their backs and

Naomi: Yeah same

Sasha: And sort of like (.) was a constant from beginning to end sort of thing (Focus Group 3)

To avoid feeling “guilty” (Focus Group 5; Norah), and feeling that others were not accepting responsibility for the self-harmers, the participants made themselves constantly available to the self-harmer through the use of mobile phones. In so doing the participants reported occasions where they would be contacted “in the middle of the night” (Focus Group 5; Harriet). Others, similarly to Lola above, talked about coming out of lessons in order to support the self-harmer. In allowing themselves to become constantly available to the self-harmer and to become 24 hour carers the participants sacrificed their own well-being in order to safeguard the self-harmer’s.

Not only did the participants sacrifice their own wellbeing outside of the friendship, the participants also neglected their own needs within the friendship;
If I wanted to moan about something and offload like before I knew they were self-harming then maybe I would openly do that with my friends (.) but as soon as I know they’ve got those issues going on then I feel really guilty (.) if I’m, you know (.) just talking about something really petty and I know that they’ve got more important things going on basically (.) but I think it does change the dynamic, which (.) which I think is a (.) one of the hardest things for me (.) because part of me just thinks ‘oh I just, wish I could have my friend back, like when I had them before’ you know it could be almost like an equal friendship in that if you want to offload on them you can and (.) I think that if someone has got psychological issues like that or they’re going through a really hard time you can’t (.) you’ve got to wait for them to be okay again (Focus Group 4; Mel)

Like Mel above, the participants understood their position within their friendships as being the one to provide support without the need for reciprocation. The participants routinely prioritised the welfare of the self-harmer over their own need for support. As demonstrated by Mel, the participants often felt “guilty” seeking support for their comparatively “petty” issues. In neglecting their own needs within the friendship, the participants further present themselves as the selfless supporters.

The persistent commitment to prioritise the self-harmer’s welfare meant that some participants were willing to sacrifice their friendships to safeguard the well-being of the self-harmers.

They’d [self-harmer’s counsellor] say to me like how’s she been? She’d be there and you’d have to talk like she wasn’t there and you know (.) there was one week where it was really bad and I could see her looking like as if to say ‘don’t say it!’ Like, ‘don’t kind of do me in’ (.) and I had I felt like I had to for her own good and it kind of got to the point where I was just (.) I was willing to lose the friendship if it meant that she was ok (.) like I cared enough about her to just be like (.) I have to say something. (Focus Group 2; Nancy)

Nancy discussed being willing to lose her friendship with the self-harmer in order to ensure her friends’ wellbeing. Not only were the participants willing to sacrifice their needs within their friendships, they were also willing to sacrifice their entire friendships to ensure the self-harmer’s well-being. In understanding their role as carer as relentlessly prioritising the welfare of the self-harmers, even if this was at the expense of their own friendship, the participants solidified their position as the selfless carer.
6.9. Recommendations

Friends discussed their experiences of support from counselling or therapeutic services, or online, such as internet forums and support tools. The friends who sought support from formal support services, such as counsellors, had found the support they received to be useful, particularly in helping them to establish boundaries and re-establish their role as a friend within their friendship. In contrast, those who sought support online considered online resources to be inadequate, confusing or unhelpful; the messages and advice were either too vague or contradictory for them to be useful.

The participants recommended improvements in three key areas: *What self-harm is*, increasing awareness to self-harm and support services; *What the friends can do to support the self-harmer*, practical advice for supporting a self-harmer; and *What the friends may be experiencing & what they can do to help themselves*, outlining issues that the friends may face, and tips for friends to safeguard themselves.

Through discussing their experiences of support, the participants chiefly talked about the support they either found through: counselling or therapeutic services, or online, such as internet forums and support tools.

Participants’ experiences within therapeutic settings were widely considered to be useful;

*The uni made sure that I had support there and stuff like that so that was quite good because I probably would () had they not said you need to come in () like you have to come in () they kind of () well they didn’t make me but they were like it’s really important that you have support for yourself. (Focus Group 2; Nancy)*

Those who had sought support from counselling services had done so both for support for themselves as well as attending counselling sessions with the self-harmer. They generally found these experiences to be useful, particularly in re-establishing and understanding their roles and responsibilities as a friend.

The participants who had accessed online tools or forums, however, did not find them to be very useful;

*I definitely did a lot of research on the internet when I first came into contact with people with this kind of issues () yeah () but I think to be honest it wasn’t very helpful (Focus Group 4; Mel)*
Generally the participants found the online resources inadequate; they often considered them to be confusing and unhelpful. In particular they found that many of the messages and advice provided by the tools were contradictory, or too vague for it to be meaningful to them.

6.9.1. What self-harm is

The participants talked about there being a perceived lack of consistent information about what self-harm was and what support options were available. They felt that schools and universities should increase student awareness to self-harm, sources of support and honesty in how self-harmers could act.

*Sasha*  I’m not saying they should teach the whole ins and outs but maybe a bit more awareness of those sorts of things.

*Int:* So like increase awareness?

*Sasha:* Yeah (.) coz you talk about smoking (.) drugs (.) all the basic stuff (.) but things like that aren’t really taught through (.) because I didn’t really know what to do (.) I had never experienced anything like that (2) so it’s just really like (.) a lot to deal with (Focus Group 3)

Through increasing awareness of self-harm the participants suggested that those who supported them would have a better understanding of how they could best care for the self-harmer. Many of the participants accidentally took on too much responsibility for the self-harmers, often for fear of the self-harmer’s welfare. Additionally, the participants felt that support services could be better advertised;

*It’s quite difficult to know who to go talk to I had no idea like who could you tell (.) like call up anybody and say like actually my friends like (.) so I think it’s important for like schools to, not advertise but have some sort of information of who you could call. (Focus Group 5; Julie)*

The participants felt that there was a lack of support available or that if there were services available they were unaware of them. A key suggestion to develop from this was to advertise appropriate support services to the friends of self-harmers. The participants highlighted that the support should be not only for themselves, but also services that could be of support to the self-harmer. They talked about it being their “job” to seek out sources of support on behalf of the self-harmer (*Focus Group 4; Mel*).
The participants considered self-harm to still be a “taboo” topic (Focus Group 5; Norah), as such, they felt that the impact of supporting a self-harmer had been largely unconsidered. They regularly reflected on taking on too much responsibility, largely because they did not know how best to support a self-harmer. Through increasing awareness of self-harm and how it may affect the friends, the participants discussed how they would be better placed to support self-harmers. Indeed, the participants felt that their experiences supporting a self-harmer made them more prepared for the possibility of supporting friends later on; “dealing with the [friend with the] eating disorder was so much easier after going through it with the self-harmer” (Focus Group 4; Antonia).

6.9.2. What the friends can do to support the self-harmer

The participants also discussed practical advice they would give to a friend of a self-harmer. Primarily the participants suggested that the friends listen to the self-harmer;

Sasha: I’d say, be patient with the person, because sometimes it can be like talking to a brick wall () quite a lot like you’d give advice and they wouldn’t take it () that sort of thing () but I think just be patient and listen

Hazel: Yeah () and listen () and not be judgmental () don’t make them feel like they’re

Sasha: I think sometimes they don’t want advice () sometimes they just want people to just listen to what they have to say (Focus Group 3)

Much emphasis was placed on the friends “not be[ing] judgemental (Focus Group 3; Hazel), and just listening to what the self-harmer wanted to say. The participants discouraged other friends from trying to question the self-harmers, or give advice. Indeed, Edward stated that friends should endeavour to “keep your emotions in check as best you can when you’re talking to them [self-harmers]” (Focus Group 4; Edward). The participants felt that the friends of self-harmers were better placed in a passive role, one that discouraged intervening.

6.9.3. What the friends may be experiencing & what they can do to help themselves

The main recommendation that the participants had for friends, was that they prioritised their own well-being, and looked after themselves. This recommendation came from the participants’ own experiences in putting the self-harmer’s welfare above their own.
Mel: I think mine would be, don’t forget about your own sanity, so look after yourself and (. .) become familiar with the options that are available in terms of like mental health support groups and (. .) you know self-harm support groups (2) There are things in place to help people like that (. .) it’s hard to find (. .) it’s a minefield trying to navigate local mental health services (. .) but it is possible and I think as a friend (. .) it is (. .) that can sometimes be your job (. .) you have to do that hunting and be like (. .) right (. .) you can get help here (. .) so yeah (. .) that would be my advice

John: I’d echo that (. .) erm (. .) because unless you are some kind of super human (. .) then it (. .) I don’t think you’d be able to help on your own for one thing (. .) but even if you could staying on the level just when you’re trying to deal with it all on your own (2) I don’t know anybody who could do it (2) Erm (. .) so (. .) if I was going to say anything (. .) even if it’s just one other person that kind of half knows (. .) that’s a hell of a help (. .) trying to do it on your own is not a good idea (. .) just something else would be key (Focus Group 4)

The participants talked about themselves losing sight of their needs because of the amount of care they provided to the self-harmers. Thus, the participants readily suggested friends seek out other forms of support;

Melody: I would say involve a counsellor or a doctor as soon as possible (. .) it may not feel the right thing to do at the time (. .) but it will help in the long run

Norah: Yeah (. .) I’d agree (. .) I’d say don’t take on all the stress yourself because it’s really damaging because you feel that person you want to be there for them and you want to be (. .) want to (. .) you want to help them as much as you can but if you keep it all to yourself then it just (. .) it’s so so damaging (. .) so obviously getting help from a counsellor, doctor, other friends. (Focus Group 5)

There were two reasons that the participants suggested friends sought support. Firstly, to help provide support to the self-harmer, and secondly, so the friends would have someone for themselves to talk to. When discussing how to support the self-harmer, participants
recommended sharing out support with other friends so that one person was not left feeling responsible for the welfare of the self-harmer. As John noted, “even if it's just one other person that kind of half knows that's a hell of a help” (Focus Group 4). It was also widely recommended that friends should seek out support exclusively for themselves. In these instances the participants suggested both formal and informal sources of support.

6.9.4. Summary

In summary the participants felt that there was a lack of consistent information about what self-harm was and what the support options were. Through increasing awareness and understanding about self-harm, the friends felt that people would be in a better, more knowledgeable position to help understand and support those who self-harm. Additionally, the friends also discussed how information, and support services could be better highlighted in support tools. Linked to this, the friends also wanted practical advice for supporting someone who self-harms. Finally, participants in all three studies highlighted that in caring for the self-harmer, their own wellbeing was not prioritised. Therefore, the friends felt that anyone supporting a self-harmer should be advised to ensure that they also take care of themselves.

From the friends’ experiences, it was evident that they struggled with the information and support tools available to them, and what was needed was a resource that encapsulated their experiences whilst providing useful information, and advice for ensuring both their own, and the self-harmers wellbeing.

6.10. Conclusion

The aim of this study was to gain an understanding of the experiences of friends who were currently, or who had more recently supported a self-harmer. This study aimed to achieve this through answering this research question:

   How do friends make sense of the impact of self-harm on friendship?

Across these five focus groups one overarching theme, Secrets and Power, and three themes; The Chosen Ones, Sharing: Trust and Betrayal, and One-way Friendship, were identified. Within the two latter themes, four subthemes were also identified: Politics of Sharing, Sharing is caring, Semi-counsellor: Estimations of Responsibility and Sacrificial Support. In addition, the theme Recommendations, was also generated. This theme outlined the suggestions that the participants had for those who support a self-harming friend.

This chapter has highlighted that secret keeping and secret sharing are integral to the experiences of the friends. In being told about the self-harm, the participants understood the
self-harm to be a secret; this was both explicitly stated, and assumed. Through being involved in the secret, the participants constructed their position as one of trusted confidante and as such their priority was ensuring the welfare and confidentiality of the self-harmers. Participants considered sharing with those outside of the friendship, or friends that the self-harmer had already talked to, as being a breach of trust, an act of "betrayal". Thus their position as supporter went uncompromised. They constructed their support-seeking, both on behalf of the self-harmer or for themselves as being done in the best interests of the self-harmer. Only when they felt that the self-harmers were in immediate danger, or when they felt they were not "up to the standard of supporting, did the friends tell others. Regardless of whether the help was for the self-harmer or support for themselves, their secret-sharing was understood as ensuring the welfare of the self-harmer.

The participants constructed themselves as being selected by the self-harmers as being amongst the select few to know about the self-harm, they were 'the chosen ones'. Typically they compared themselves to other, closer friends of the self-harmers. They understood their new position as being a consequence of them being non-judgemental and therefore the superior friend to support the self-harmer.

Consistent with findings from Study Two, the friends of self-harmers reconstructed their friendship with the self-harmer and the role they played within the friendship. Specifically, participants talked about their friendships as being unidirectional in support; the participants provided the majority of support with little to no expected or actual reciprocation from the self-harmer. They discussed how their role of friend was superseded by their new role as carer, or "semi-counsellor". Alongside this new role the friends discussed the sense of responsibility they felt over the welfare of the self-harmer. Upon reflection, the friends reported miscalculating their level of involvement with the self-harmer and taking on too much responsibility. This was compounded by their tenacity in ensuring the confidentiality of the self-harmer.

Although useful, there are some issues that need to be considered when conducting sensitive research with those recruited from Research Participation Schemes. One of these issues is the potential for participants' anonymity to be threatened (Leentjens & Levenson, 2013). Through using these systems there is potential for students who know each other to participate in the same focus groups. This is not necessarily a problem; indeed, it has been well documented that focus groups that include friends or acquaintances may increase disclosure (Kitzinger & Barbour, 1999). In my case, when it was clear that focus group participants knew each other, I reassured them about confidentiality, reminded them that they controlled what was discussed.
and checked their understanding of the information sheet they had received (all standard good practice for conducting focus groups). In line with Finch, Lewis, and Turley’s (2014) guidelines, I was also watchful for any "shared views or assumptions” (p. 233) that these participants may have had. The disclosure of these participants, however, was not focussed on their experiences with shared friends. No shared assumptions arose other than usual shared assumptions (e.g. ‘you know what I mean?’); in these cases the participants were asked to elaborate or clarify.

Some participants talked about the deterioration with their friendships with the self-harmer. In particular, they understood this in terms of a sacrificial act. Either they felt that they had sacrificed their needs within the friendship and were providing unidirectional support. For some, the expectation that they should selflessly and relentlessly prioritise the self-harmers’ welfare meant that they were willing to sacrifice their friendship completely.

In addition to exploring the participants’ understandings of providing support to a self-harming friend, they also discussed the ways in which friends could be better supported. It was evident, from these discussions, that the friends felt the support that was available to them was lacking, and that a support tool that was tailored to the friends was necessary. The lack of perceived support tailored to the friends, alongside the findings from Studies One to Three which highlighted that friends struggled to support a self-harmer, led to the development of a prototype support and information tool tailored to the needs of the friends. The specifics of which is outlined in the next chapter.
Thus far three studies have been conducted. Study One was a focus group based investigation with counsellors that established that self-harm was an issue in friendship and highlighted the concerns of the friends within a counselling setting. Study Two explored the experiences of friends of self-harmers through interviews, and generated an insight into the impact of self-harm over the life-course of friendship. Study Three was comprised of a series of focus groups conducted with the intention of generating a deeper understanding of the experiences of friends who were currently, or who had recently supported a self-harmer.

In this chapter I will draw together the main results of the previous chapters, the findings of which fed into the development of materials for the focus groups, and outline the development of a support tool. From Study Three a series of recommendations were put forward by the friends. These recommendations, and the friends’ perception that information and support for friends was either absent, or lacking, instigated the development of the support tool.

7.1. The appropriateness of a support tool

Support tools have been identified as a useful outcome for those who are struggling. For example, Rodham, Gavin, Coulson, and Watts (2015) worked with patients to co-create resources for those who have Complex Regional Pain Syndrome (CRPS). They argued that the most effective way to address the concerns of a target population was to include them in the “co-creation of information resources that directly address the areas in which they have experienced the most difficulty” (p. 5). The importance placed on the co-creation of support tools has been noted by Pipon-Young, Lee, Jones, and Guss (2011) who developed a leaflet about early onset dementia which was co-created with those experiencing it. Pipon-Young et al. (2011) highlighted that often those who are the subject of information, or support tools are rarely included in the development of them. They argued that including the voice of the users is of prime importance to ensure that relevant, useful, and informative information is included. By way of an example, Sousa and Turrini (2012) found that information material written by medical professionals aimed at those undergoing orthognathic surgery often failed to address the issues and fears of the people undergoing the surgery.

The championing of co-created support tools within the literature highlights the importance of including the ideas of those who would use the support tool in its development. This chapter
presents the development of a support tool designed specifically for the friends of self-harmers through a series of focus groups with friends and support providers.

7.2. Method

The study was comprised of three phases as can be seen below in Figure 10. In Phase One focus group materials were developed based on the findings from Studies One to Three, and an evaluation of pre-existing support tools for the friends of self-harmers was conducted. In Phase Two these materials were presented in five focus groups, three with the friends of self-harmers, and two with support providers. The focus groups were then analysed and a draft support tool was developed. In Phase Three the draft support tool was discussed in three further focus groups and refined based on the participants’ suggestions. The final support tool was then printed, and disseminated to the support providers who participated. Finally, feedback was provided by the support providers on the usefulness of this tool.

![Figure 10: Outline of the phases of the support tool development](image)

7.3. Phase One: Developing

In Phase One, the focus group materials were developed from the collated findings of Studies One to Three. These findings were subsequently organised into thematic groups by the recommendations from Study Three. These key findings were integrated with an evaluation of the pre-existing support tools to develop the focus group materials.
7.3.1. Studies One, Two, & Three: Collated results

In this thesis I used focus groups and interviews to collect data, and Interpretive Phenomenological Analysis (IPA) and Thematic Analysis to analyse them. Each of these methods were appropriate to the research questions I was asking, what I wished to explore, and my epistemological, ontological, and theoretical frameworks. These methods created different types of data, explored different types of knowledge, and generated different understandings.

Although many have discussed the importance of having epistemological and ontological consistency in the integration of mixed methods qualitative research, very few have explained how results from qualitative mixed methods studies are integrated. Of those who have done so, mixed methods have tended to be used to triangulate findings to establish the “validity” of their research, resulting in a hierarchy of methods with one study normally holding a superior position (Dick & Frazier, 2006). As there was an absence of literature surrounding the integration of findings from separate qualitative studies, I looked to best practice for the synthesis of qualitative research, alternatively known as ‘qualitative meta-synthesis’ (Sandelowski, Docherty & Emden, 1997). Although those writing meta-syntheses are drawing on multiple studies conducted by different researchers, there remains a respect of the different purposes, research questions, and findings of each study. This stands in contrast to pluralistic qualitative methods researchers who integrate findings from one study that has aimed to answer one research question through either engaging with multiple perspectives (e.g. Mishna, 2004), multiple data collection methods (e.g. Lambert & Loiselle, 2008), or multiple analyses on the same data set (e.g. Frost et al., 2011). Thus, due to the absence of any clear protocol for integrating the findings of a body of research like those presented in this thesis, focus has been paid to the final stages of qualitative meta-synthesis, where researchers detail how they synthesised the findings from multiple studies.

Prior to integrating the findings, researchers have advised others to establish the compatibility of the research collected (Sandelowski et al., 1997). Typically, this is focussed in three areas; data collection, analysis, epistemological assumptions, and ontological assumptions (Barnett-Page & Thomas, 2009). In having a potentially incompatible data set, Walsh and Downe (2005) recommend that researchers may want to avoid trying to integrate studies which are theoretically mismatched, alternatively they suggested having reverence for the differences in writing up of the meta-synthesis. As outlined in Chapter Three, all studies in this thesis were approached using the same epistemological and ontological framework, that of social constructionism, and relativism, respectively. Thus, from a theoretical position, the studies
were fundamentally compatible. The main point of conflict within this thesis was the integration of results from studies that used either interviews and IPA, or focus groups and Thematic Analysis.

In using focus groups, and analysing them with Thematic Analysis, I generated data that was exploratory and reflective of consensual knowledge. Thus, I was able to produce an understanding of some of the key issues highlighted by both the friends and the counsellors. In integrating this with the results of an interview study that used IPA, I was also able to explore “the depths and nuances” of the friends’ experience (Reid, McKenna, Fitzsimons, McCance, 2009, p. 440). In drawing the results from studies with different methods together, Walsh and Downe (2005), suggest that researchers have a respect for the type of data they are integrating, and to reflect this in the write up. In essence, they suggest that researchers should not exclude, gloss over, or avoid different methods, but rather to make it a part of the synthesis. Thus, in the synthesis of the research I remained mindful of the different types of knowledge I was drawing together.

Although there are many proposed approaches to conducting a meta-synthesis (for more information see Barnett-Page & Thomas, 2009). I used a process based on that suggested by Walsh and Downe (2005), which focussed on drawing the thematic elements of Studies One to Three together. The process I used had three stages;

1: Re-reading & study summary

In the first stage I re-read the analysis for each study in turn. Whilst doing this I wrote an overview, or summary of each of the studies. This included what the methods and aims were, what the main findings were, and what each study added to the understanding of self-harm and friendship.

2: Mapping the studies

Key features of each of the summaries were then put on one mind-map (see Appendix G). In mapping out the studies, similarities and differences between the studies were considered (Barnett-Page & Thomas, 2009). This also included issues which had been discussed by the participants, but had been done so in a different way, therefore identifying different constructions (Sandelowski et al., 1997).

3: Identifying the issues

After identifying the relationships between the studies, a thematic overview of how the friends and counsellors talked about self-harm in friendship was put together. In mapping out the
studies, I focussed on what the friends and counsellors felt were the key issues facing the friends that were important in the development of a support tool.

The key results from Studies One to Three can be encapsulated into six themes: *Roles and Responsibilities, Secrets: Inclusive & Burdensome, Why me? The Presence of Others, Help-seeking,* and *Deterioration.*

*Roles and responsibilities*

It was clear that the friends of self-harmers took on roles and responsibilities that lay outside of what they considered to be a “normal” friendship. The counsellors considered the friends to be taking on a “parental” role. The friends, however, constructed their role as being analogous to being a “carer” or a “semi-counsellor”.

The way in which participants discussed acquiring this new role also varied. The counsellors felt that friends fell into two groups; those who lacked the skills to know what they should do, and as a consequence accidentally and incrementally took on an excessively supportive role; and those who refused to provide support or removed their “support” from the self-harmer. Ongoing support tended to be withdrawn when the friend encountered an external stressor which meant that they began to feel unable to cope with having a self-harming friend too. External stressors enabled the friends to construct their withdrawal of support as being something they had no control over.

Amongst those who took on excessive responsibility there was a consensus that this was exacerbated both by the perception they held that them were the only carer of the self-harmer, as well as the perceived need to protect the privacy of the self-harmer. In considering the self-harmer’s wellbeing as the upmost priority within the friendship the participants began to neglect their own needs. Essentially for this group, support involved sacrificing their needs within their friendships and an acknowledgement that the support they provided was unidirectional.

*Secrets: Inclusive & burdensome*

Across all of the studies it was clear that secrets and the acts of secret-keeping and secret-sharing were important in how the friends understood supporting a self-harmer.
The counsellors felt that secret-keeping was detrimental to those who were supporting a self-harmer and caused them to feel burdened. Prior to seeking formal support, some friends "shared quietly" with others in order to gain some social support of their own. Sometimes this helped the friends, on other occasions the counsellors felt that this meant that the secret was just being held by a bigger group of people. In keeping and maintaining the secret, the friends could normalise the self-harm.

Secrecy played a key role in helping the friend's position themselves in relation to others. Secrets acted as markers for a closer friendship; friends felt that they had been chosen above others and as such it was their responsibility to care for the self-harmer. Furthermore, through being involved in the self-harmers secrets, the friends felt that they had been afforded a level of trust by the self-harmer and believed that to tell others would be an act of betrayal. They either assumed, or were told explicitly that they could not talk to others about what they were experiencing. Thus being included in, and keeping the self-harmers' secrets, the friends held a unique bond with the self-harmer, and any disclosure by the self-harmer to other people threatened their special role.

Although the friends struggled to provide support whilst maintaining the confidentiality of their friend, they constructed this as something they had to do. In the focus groups it became apparent that the friends felt that if they were to tell, the self-harmer would no longer confide in them and would have no support which could lead to more dangerous or harmful behaviour. Similarly the counsellors also identified that the friends felt unable to discuss their experiences for the "fear" of losing the friendship.

Secrets played a key role in how the friends navigated their friendships with the self-harmers. They simultaneously denoted their special relationship with the self-harmer and also served to maintain their new role. In keeping secrets the friends' behaviour went unchallenged and ultimately meant that much of the 'accidental' responsibilities adopted went unchallenged.

Why me? The presence of others

In exploring why they were chosen by the self-harmer as confidante, the participants generally constructed themselves as being special, the "chosen ones" to support the self-harmer. In being selected they considered themselves as having qualities that made them superior to the self-harmers' other friends. This position, however, was contingent on the self-harmer not telling others.
Once the friends had established their new role, they then began to make sense of their experiences through comparing themselves to the other friends and family members of the self-harer. The participants negatively constructed these individuals through portraying them as being bad friends, or bad influences. They constructed the family members of the self-harmers as the ones who were closest to them, and consequently the ones who should have been responsible for their care. Through portraying the self-harer’s other relationships as inferior, and in some cases detrimental, the participants were able to establish a sense of purpose within their new caring role. Further, they were able to reinforce their position as the better friend, the most supportive friend, and the close confidante to the self-harer.

In summary, the friends felt that they had been selected above others and as such held a special and significant relationship with the self-harer. In solidifying their superior position the participants denigrated others who threatened their role and special bond with the self-harer. Doing so allowed them to further establish their special bond, status, and relationship with the self-harer.

**Help-seeking**

Typically, the friends reported seeking help from professionals when they were fatigued, or when there were other external pressures on their time, such as essay deadlines. The counsellors' accounts supported this.

The perceived secrecy around self-harm also hindered the help-seeking of the friends; they reported feeling more comfortable seeking support for themselves if the self-harer had condoned it, (seeking support, even for themselves, would be a betrayal of the self-harer's confidence). When they did seek help, however, this was constructed as being for the benefit of the self-harer, because in seeking help for themselves, they were better placed to support the self-harer.

**Deterioration**

Although the deterioration within the friendship was not discussed by all participants, it was an important issue. Those that did mention it constructed the friendship deterioration as being something that happened outside of their control. Many felt that they had grown apart from the self-harer, and that each had gone their separate ways. This was often associated with times of transition and change, such as going to different Universities. For others, the
deterioration began when they felt that they were no longer needed by the self-harmer, and that others had replaced them. This either occurred because the self-harmer had desisted self-harming, and as such no longer needed the support the self-harmer had sought out alternative sources of support.

7.3.2. Evaluation of pre-existing support tools

Google is the most popular search engine, particularly amongst young users looking for support or information online (Buhi, Daley, Fuhrmann, & Smith, 2009), therefore, I used this search engine to identify already existing free-to-access support and information tools for the friends of self-harmers. I used the search terms “my friend is self-harming/self-injuring” and “friend self-harm/self-injuring” in order to replicate the search terms that might be used by friends.

Inclusion and exclusion criteria

There were three inclusion criteria for the selection of support tools: they were focused on self-harm, they were freely accessible, and they were directed at the friends.

It was important that all of the support tools were freely accessible. It has been demonstrated that people are only more willing to pay for online information if they feel they can’t get the information anywhere else for free, or it is more convenient (Wang, Ya, Zhang, & Nguyen, 2005). As there were multiple tools that were accessible without having to subscribe to a website, or pay, tools that could only be accessed through subscribing to sites, or paying for the content were excluded from the tools selected.

There is a wealth of information on the internet about self-harm (Zahl & Hawton, 2004). The focus of this project, however, was on the support available to the friends of self-harmers. Therefore, only information or support tools that mentioned the friends were included. In focussing explicitly on the support currently available to the friends I was in a better position to understand what already existed, and what was missing in the support available to the friends.

To date there is no precedent, or guidelines set for the appropriate number of support tools to evaluate before developing a support tool. Although much of the research that has created a support tool has considered pre-existing literature (e.g. Sousa & Turrini, 2012), very few have considered pre-existing support tools, and those that do fail to provide information about how many they have evaluated. Due to limited guidelines about the number of support tools to
evaluate, I chose to include those that were freely accessible and evaluated fourteen support tools.

**Assessment criteria**

In line with the recommendations highlighted by the friends and counsellors, it was clear that the participants wanted information on *what self-harm was, how friends could support the self-harmer, what the friends may be experiencing, and what can be done to protect the wellbeing of the friends.* These four criterion were used to assess the support tools:

*What self-harm was:* Was there a description of self-harm, including what the behaviour is, who it affects, how many people self-harm, why people self-harm?

*How friends could support the self-harmer:* Was there provision of practical information that the friends could use to help the self-harmer? For example, the LifeSIGNS leaflet stated "*don’t be negative or accuse your friend of being an attention seeker*". Here the focus is solely on the self-harmer and what the friend can do to support them.

*What the friends may be experiencing:* Did the support tools make explicit reference to the feelings of the friend? For example, the LifeSIGNS leaflet stated; "*Discovering that someone you care about is hurting themselves can be overwhelming.*" Instances where the support tools had explicitly addressed the friend, or talked about how they might be feeling were identified. Attention was also paid to whether the friend’s feelings were explored independently, or whether they were used as a pre-say for information about the self-harmer.

*What can be done to protect the wellbeing of the friends:* Did the support tool offer suggestions for support for the friend (rather than the self-harmer)? For instance, the LifeSIGNS leaflet stated; "*remember to take care of yourself – it is difficult coping with the self-injury of someone you care about so don’t be afraid to seek extra support for yourself.*"

As an example, Table 1 outlines the evaluation of two of the support tools, for the full evaluation of all of the support tools, see Appendix H. If the support tools provided a lot of information it was marked with an "X". If, there was only a sentence or two throughout the support tool then it was marked with an "x". If there was no mention of it within the support tool, that box was left empty. General comments were also written about whether the tool was long or short, what it addressed well, what it addressed poorly, and how the friends were considered within the support tool (whether they were combined with family members, for example).
Most tools explained what self-harm was, who it affected, and for what reasons. Secondly, the tools also provided suggestions for supporting the self-harmer. These were usually presented in a list of “do’s and don’ts”. Detailed information about how the friends themselves may be feeling was rare. When the feelings of the friends were discussed it was done in passing, or written prior to giving advice on supporting the self-harmer. Comprehensive information about how the friends could protect their own wellbeing was missing. Typically, when a tool did do this, the friends were advised to seek out support and were provided with a list of helplines. In summary, the focus of these support tools was on the self-harmer and ideas for supporting them; minimal attention was paid to the impact on the friends and what they could do to look after themselves.
<table>
<thead>
<tr>
<th>Support Tool</th>
<th>Information about self-harm</th>
<th>What friend can do to help</th>
<th>What friends might be experiencing</th>
<th>What they can do to help themselves</th>
<th>General Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Befrienders, “How to support someone who self-harms” (website)</td>
<td>X</td>
<td>X</td>
<td>x</td>
<td></td>
<td>The support tool was short and provided a quick overview of what self-harm was and possible motivations. There were a few suggestions for how the friends could support the self-harmer. There was one sentence on what they might be feeling. There was no suggestions for how they should support themselves.</td>
</tr>
<tr>
<td>Helpguide “Cutting &amp; Self-harm: Self-injury Help, Support &amp; Treatment” (website)</td>
<td>X</td>
<td>X</td>
<td>x</td>
<td></td>
<td>The support tool was a general tool aimed for use for those who self-harm, their family, and friends. The information in it was aimed at the self-harmer and how they can help themselves. The information that was set aside for supporting the self-harmer was there for both friends and family. The information was written so that the self-harmers’ wellbeing would take precedence over the friends and family e.g. “Encourage your loved one to express whatever he or she is feeling, even if it’s something you might be uncomfortable with.” There was little mention of how the friends may be feeling, and only done so in relation to the self-harmer’s wellbeing e.g. “Acknowledging your feelings is an important first step toward helping your loved one.” There was no information about what the friends should do to help themselves.</td>
</tr>
</tbody>
</table>
7.3.3. Developing the focus group materials

From the issues highlighted in the recommendations in Study Three, four main areas were identified as important for the development of the support tool:

1. What self-harm is
2. What the friends can do to support the self-harmer
3. What the friends may be experiencing
4. What the friends can do to support themselves

Using these four issues, the key findings from Studies One to Three were encapsulated in a series of mind-maps, created in MindGenius (see Appendix I). These materials were designed to encourage discussion within the focus groups and to elicit content for the tool. Alongside these mind-maps, other resources were also used, and developed to encourage participants to talk about the design, layout, and presentation of the support tool. Examples of these are presented in more detail in section 7.4.3.

7.4. Phase Two: Creating

In Phase Two, the draft support tool was created through five focus groups with the friends and support providers.

7.4.1. Participants

In total, five focus groups were conducted. Participants were drawn from: University students (3), University Counsellors (1) and Local Support Services (1). In total, 17 people participated, 2 men and 15 women.

University students

Three focus groups were conducted with University students. One focus group was solely comprised of participants who had already participated in Study Three. Although fourteen participants who had provided their contact details were contacted, twelve were removed prior to focus group as they either; no longer studying at the university (8), were unable to attend the focus group (2), the email address was not recognised (1), or did not show up to the focus group (1). In total, two students participated.
The participants in the other two focus groups were recruited through the Research Participation Scheme (RPS), a full discussion of the appropriateness of this scheme is outlined in Chapter Six, as well as answering online adverts placed on University hosted websites. In total, fourteen individuals responded to the recruitment. Seven participants did not participate as they either: failed to respond to arrange a time (1), cancelled prior to focus group (4), or they failed to attend the focus group (2). In total seven students participated in two focus groups.

*University counsellors*

The counsellors who participated in Study One were invited to take part in Phase Two of the support tool development. In total, six counsellors participated.

*Local support services*

As those who self-harm and their friends do not always seek support from services provided by institutions, preferring to seek support from external support services (e.g. Fortune et al., 2008), a local self-harm support service was invited to take part. Two individuals participated.

7.4.2. Data collection

In total, five focus groups were conducted, three focus groups had two participants, one had five participants, and one had six participants. The focus groups lasted between 60 and 90 minutes. All participants were informed of the nature of the study prior to attending and were reminded in the focus group.

The participants were invited to give a pseudonym which was used in the focus group setting to encourage anonymity and was used in the write-up. This was followed by setting the ground rules for the focus group (Farquar & Das, 1999).

One focus group had six participants, one had five participants, and three focus groups had two participants. Recruitment in two of these was low due to attrition rates. As the other participants were still willing to participate, the focus groups continued. The other two-person focus group was intentionally planned with two people. As the participants in this group were recruited from an active support service with low numbers of staff it was difficult to recruit

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6 For the purposes of this study, the counsellors and the support services are jointly referred to as “support providers” in the results sections.
further participants. Although traditionally focus groups have more than three participants, considering the restrictions on the recruitment two was considered not only appropriate, but the only way that this service could be involved in the project.

7.4.3. Focus Group Materials

Section One: What self-harm is

Section one of the prototype focussed on what self-harm is, and addressed the participants’ wishes to raise awareness and understanding of self-harm, and highlighted what the self-harmer may be experiencing.

Firstly, participants were presented with an outline of this section. See Figure 11 below.

![Focus group material: What is self-harm?](image)

**Figure 11: Focus group material: What is self-harm?**

From this participants were asked a series of questions including:

*What do you think of having a section about what self-harm is at the beginning?*

*Are the images appropriate?*

*Are the colours appropriate?*
These questions were used to consider not only whether a section on self-harm would be useful, but also if it was how the participants would prefer it to be presented. This included exploring whether they felt that pictures were appropriate or whether they would prefer more written information. I also used this as an opportunity to discuss what colours would be most appropriate for the support tool, and whether there were any issues with this, or alternative colour schemes.

Section Two: What the friends can do to support the self-harmer

Section two addressed the need for the participants to have clearer guidance on what they can do to support the self-harmer. The focus on what the friends could do to support the self-harmer dominated the pre-existing support tools. This was included as, although it has been well-covered elsewhere, the participants wanted an all-inclusive support tool and more clarification on what they could do.

The findings of the previous studies consolidated the suggestions for how friends could provide support to a self-harmer were made into a mind map in MindGenius, as can be seen in Figure 12. This mind map was given to participants and they were encouraged to use it as a reference point and to write on it.

![Mind map](image.png)

**Figure 12: Focus group material: What friends can do to support someone who self-harms**

Initially I gave a general overview of what this area was focusing on;
My participants discussed that often they felt that they didn’t know how they should support someone who self-harms. These four strands highlight some of the ideas they suggested. Have you got any suggestions for what worked when your friend self-harmed?

If the participants were unwilling to engage with this question I focussed on one of them specifically, for example;

My participants recommended that friends should have patience when supporting a friend. Was patience something you had, or maybe something you struggled with?

By directing quieter participants to one of the strands of the mind map, they often found it easier to discuss the rest of the mind map. Prompts were used to encourage the participants to discuss some of their comments further, such as;

That’s really interesting can you tell me a little bit more?

Or if the participants went off topic they were refocused onto the mind map by me focussing on one of the other strands, such as;

What about being someone to talk to, an ear when they needed you?

Section Three: What the friends may be experiencing

Based on the results from the previous three studies, it was evident that the friends were struggling to cope with supporting their self-harming friends. This had received little attention in the pre-existing support tools. This section addressed what the friends may be feeling when supporting their self-harming friend.

Section three followed the same pattern as section two, the mind map used for this section can be seen in Appendix I.

Section Four: What the friends can do to help themselves

The absence of information or guidance on how to self-care was the main issue absent from the support tools, yet the most recommended action by the participants in Studies One to Three. Therefore, this section focussed on clarifying what sources of support might be acceptable to a friend of a self-harmer, as well as advice about what they could do to protect their own wellbeing.
This section followed the same pattern as Sections Two and Three, the mind map used for this section can be seen in Appendix I.

Section Five: The presentation of the support tool

Finally, it was also important that the support tool should be user-friendly, and attractive to the friends of self-harmers. In order to establish what would be the most appropriate format for the support tool, a range of general University information booklets and leaflets were presented to the participants, as can be shown in Figure 13. Participants were asked to comment on what they liked or disliked about the colours and designs, as well as the formats that they would find most attractive, appropriate, and user-friendly. Participants were also encouraged to make suggestions about formats not represented in the sample materials.

Figure 13: Focus group material: Leaflets used as examples for the participants

The focus groups ended on a question that aimed to address any areas that the participants felt had not been considered;

Is there anything that you wish to talk about that you don’t feel we have covered?

7.4.4. Data analysis

The focus groups were transcribed verbatim and analysed using Thematic Analysis (Braun & Clarke, 2013). The analytic procedure as set out by Braun and Clarke (2013) was followed (for
an in-depth outline of this see Chapter Four). A combination of both deductive and inductive analysis was used (Fereday & Muir-Cochrane, 2006). As the intention was to produce a support tool I coded the data within pre-established parameters. These were dictated by the four recommendations I had already established, as well how it should be presented. In particular I focussed on:

- What the participants thought about the section about self-harm
- How the friends supported the self-harmers
- What impact having a friendship with a self-harmer had on the participants
- What the friends did, or could have done, to support themselves
- How the friends wanted the support tool to be presented

These five issues were used as a “selective coding” framework (Braun & Clarke, 2013, p. 206), whereby the focus groups were considered in light of these five issues and data were selected that related to these issues. In using a selective coding framework I was able to focus my analysis on data that clarified the core issues for the support tool (Starks & Trinidad, 2007). For example, in the reading of the focus groups I selectively coded for when participants discussed the challenges they faced in supporting the self-harmer. How the participants talked within these codes, however, was data-driven. Thus, anything that the participants discussed that related to these issues was identified. This constituted the inductive data-driven element of the analysis. Using a combination of deductive and inductive analysis allowed me to focus on the issues raised by participants that would be most useful in the creation of the support tool.

As the focus of this support tool was to provide support and suggestions, I also sectioned the subthemes into problems and resolutions in an Excel spreadsheet. Aspects that the participants struggled with were identified as problems (e.g. feelings of responsibility). Actions, ways of thinking, or incidents that the participants found helpful were identified as resolutions (e.g. having other friends who were willing to provide support when necessary). In the excel spreadsheet I used quotes to illustrate the problem and the resolution, a worked example of this can be seen in Table 2.
Table 2: A worked example of problems and resolutions

<table>
<thead>
<tr>
<th>Problem</th>
<th>Quote</th>
<th>Ref</th>
<th>Resolution</th>
<th>Quote</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling Responsible</td>
<td>Rosie: Yeah (.) I think the bit about like be aware of your own feelings (.) one thing I had was kind of putting it all on my shoulders and like constantly worrying about her making sure she’s okay</td>
<td>FG1</td>
<td>Having other friends to help support</td>
<td>Rosie: I think having other friends (2) like who knew really was helpful just to talk about (2) but not with (.) her there but like a nice way Charlie: Yeah Rosie: Just trying to think of stuff to support her</td>
<td>FG1</td>
</tr>
</tbody>
</table>

7.4.5. Results

An overview of the results from a Thematic Analysis of five focus groups is presented. To avoid repetition, I provide an overview of the key findings, the complete analysis from this stage is detailed in full in Appendix J. The coding structure used to analyse the focus groups constitutes the key themes within this results section, What self-harm is, What the friends can do to support the self-harmer, What the friends may be experiencing, and What the friends can do to help themselves. Further, there is a final section outlining how the friends wanted the support tool to be presented.

What self-harm is

In the majority of the support tools, self-harm was introduced and explained. This included sections on what self-harm was, who self-harmed, and why people self-harmed. In exploring what was needed in this section of the support tool, participants were discussing the hand-out presented in Figure 11.

Types of self-harm

The participants generally found this section useful as a way to orientate themselves towards what self-harm is, and could be.

\[
\text{I think it’s good that you’ve got lots because I think people often (.) associate (.) I know I do (.) associate self-harm with like razor blades and not...}
\]
particularly with burning or like pinching of that sort of thing (.) so I think it's good that you've got like everything. (Focus Group 1; Sophie)

For some participants the listing of a few types of self-harm meant that they were able to identify behaviours, like punching, that fell outside of the more “obvious ones [forms of self-harm]” (Focus Group 1; Charlie). However, other participants felt that the list was not representative of the many forms that self-harm can take.

Well an interesting thing I thought of the current focus of the focus group before was whether we got to what was and what wasn't self-harm we talked a lot about that but just thinking about it now and reflecting there's nothing there about alcohol. (Focus Group 4; Ed)

Alcohol, drug use, and branding were amongst the suggestions provided by the participants for alternative forms of self-harm to the seven presented to them. It was also suggested that having a constricted list of forms of self-harm may mean that other intentionally harmful behaviours may encourage people to not see them as self-harm. Consequently, it was suggested that I include an “other” section with a sentence stating “this is not an exhaustive list” (Focus Group 3; Helen).

It was also discussed in a focus group with one of the support providers that people may try and equate certain types of self-harm with being more or less serious than the others.

“People will be like that's oh well they're just scratching themselves with fingernails that's not nearly as serious as someone who's used a kitchen knife but actually it's not it's the level of distress that matters and that if what you (.) and it's all to do with your frame of reference” (Focus Group 3; Helen)

As the support providers were concerned that people would try to rank types of self-harm, I included a sentence making it clear that certain types of self-harm do not reflect a more serious underlying problem than other forms of self-harm.

Participants also discussed the images. Some found them to be useful as “visuals are always really good because they are much easier ways to (.) convey information” (Focus Group 3; Helen). However, others felt that some were “unclear” (Focus Group 2; Summer) and they required the descriptions underneath. It was also identified that some of the images may be triggering, such as the razor blade image. As the participants felt that the images were either unclear, or may be triggering to a reader, these images were removed from the draft tool. As a substitute for the images, it was suggested that a word-cloud be used instead.
Who self-harms?

Largely the participants found the statistic of “one in ten young people self-harm” useful, especially in highlighting how common a problem it was.

The participants in focus group four, who were members of a support provider, felt that it is often difficult to put a specific number on how many people do self-harm.

Pat: I mean the one in ten young people self-harm thing you know we think I wonder how much we can ever know and of course we have to go on stats that are available but erm (2) I don’t know I think there’s always a risk of putting a specific number like that in just because it’s helpful in that its indicative I suppose but erm

Mary: Unless you changed that to one in ten who have disclosed (Focus Group 4)

The difficulties in specifying how many people self-harm, how many disclose that they self-harm, and which population is the focus of the statistics were discussed within this group. They felt that it was difficult to put a specific number on it, but felt it was a good way to indicate the levels of self-harm. The secrecy element of self-harm was also discussed as being influential in the numbers of people disclosing self-harm, rather than the statistics accounting for all that do self-harm. Thus, the section was amended to include the word “disclosed”, and to highlight that often people are unwilling to come forward or discuss their self-harm.

Why do people self-harm?

Generally, the participants liked the section providing reasons why. However, it was suggested by the support providers that these lists were not covering the range of motivations. One focus group highlighted that it did not cover some of the more sensitive issues, such as abuse.

I find it’s a really tricky balance between kind of acknowledging it that those kind of more extreme situations that people have found themselves in have really high linkages with self-injury (.) and then there’s the (.) kind of the more maybe everyday issues (Focus Group 3; Maggie)

Another focus group felt that the motivations should better reflect the different drivers behind self-harm.
What I think is they’re actually slightly different phenomenon (.) like this is a
generalisation but my broad experience is that when someone is self-harming
to relieve pain and suffering its often very private (.) it’s not communicate very
often to other people its often they cut (.) arrive in the common room and look
at this that’s a different phenomenon it’s about wanting to connect trying to
connect with someone so I think they’re actually (.) different phenomenon
(Focus Group 4; Carlyon)

Other suggestions regarding the motivations included putting sentences in that addressed the
potential that the self-harmers “don’t know themselves” (Focus Group 5; Antonia), or that
“there’s lots of reasons” (Focus Group 3; Maggie).

It was also suggested that care was needed to prevent conveying the message that some
reasons were more “valid” than others.

I really struggle with (.) the judgement people put in sometimes (.) like they’re
only worried about their exams that person’s been sexually abused that sort of
thing (.) well no wonder they do it really severely but she’s you know she’s got
a loving family and she’s worried about her exams and it’s that and people do
make that judgement and do say oh what’s she got to be worried about what’s
she got to be upset about. (Focus Group 3; Maggie)

Taking all of this feedback into consideration I felt that the reasons provided in the hand-
out did not cover the extensive reasons why people self-harmed. Therefore, I attempted to address
some of these issues and provide a more extensive list.

**What the friends can do to support the self-harmer.**

In this section, the participants were presented with the mind map in Figure 12. The
participants used this as a spring board to discuss ways that friends could support a self-
harmer without trying to stop the self-harm. From their discussion, seven subsections were
developed. To avoid repetition, one subsection is presented in full, and a brief overview of the
other six is given. For a full outline of the analysis, see Appendix J.

**My friend self-harms!**

Finding out about the self-harm and reacting to this discovery was a salient issue for the
friends. Some felt that they “panicked” (Focus Group 1; Sophie) when they found out. Whereas
others already felt that there was something wrong before the self-harmer told them.
She actually approached the other friend who was self-harming and erm (.) then that kind of made it a bit more open because my other friend is very open about it so that made her more able to talk to me about it as well (.) but I didn’t know how to go to her and say (2) what’s going on? (Focus Group 1; Charlie)

Many discussed feeling that they did not know how to approach the self-harmer, or address their concerns for their welfare with them. When discussing how to deal with finding out about the self-harm, the friends all reiterated that the friends should avoid “freaking out” (Focus Group 1; Sophie), they should remain calm, and have “patience” (Focus Group 5; Antonia). If the friends were to discuss their concerns with the self-harmer, they suggested that it should be done sensitively and by mentioning that they had noticed something was wrong.

Let them go at their own pace: The friends struggled when the self-harmers’ recovery did not go as quickly as they were anticipating. In this section, it was suggested that the friends have patience with the self-harmer, and to recognise that the self-harmers will still coming to understand their self-harm, and recovery may not always be a linear process.

I want to help them stop: Upon finding out about the self-harm, the friends’ immediate response was to try and get the self-harmer to stop self-harming. The support providers suggested friends identify self-harm as a coping strategy, and one that is difficult to stop immediately.

I can’t understand why they self-harm, their life is great!: Some of the friends struggled to understand why their friend self-harmed, as they felt that the self-harmers were doing well, i.e. were attractive, or were doing well in education. The support providers advised friends to look outside of their frame of reference; that for the self-harmers, self-harm was a coping strategy.

I don’t know how to support my friend without supporting the behaviour: Whilst supporting the self-harmer, the friends felt that they may be inadvertently supporting the self-harm. In tackling this, the friends suggested acknowledging the self-harm, yet explicitly stating that it was inappropriate.

I think my friend needs help!: A main challenge reported by the friends, was feeling unable to seek support for the self-harmer when they became concerned about their welfare. This was exacerbated when self-harmers would cancel, or not attend
appointments. The support providers advised friends to seek help for themselves if they were worried.

*Try to do normal activities with your friend:* In caring for the self-harmer, the friends felt that they were spending less time doing fun activities with the self-harmer. To address this, the support providers felt that the friends could make efforts to engage in the activities they shared before.

**What the friends may be experiencing.**

The previous three studies had demonstrated that the friends had experienced difficulty whilst supporting their self-harming friend. This third section aimed to explore and refine some of those experiences. The participants were presented with a mind-map outlining the key issues about the friends' experiences (see Appendix I for the mind-map).

Similarly, the participants used this mind map as a spring board for the friends to discuss how they felt supporting a self-harmer, and how the support providers had understood how the friends felt supporting a self-harmer. From the discussions, six subsections were developed. Again, one subsection is detailed in full, and a brief overview of the other six is given. For a full outline of the analysis, see Appendix J.

**Is what I’m feeling normal?**

Feelings such as guilt, anger, shock, confusion, isolation, upset, helplessness, worthless, useless were discussed. The friends also discussed how supporting the self-harmer would make them feel closer to them.

*I didn’t find so much with the change in relationships I found that we got closer erm (.) a lot closer erm and that was (2) nice nicer (.) and it’s not nice it sounds horrible (Focus Group 2; Alicia)*

The friends would discuss any positive feelings they had from supporting their friend as being horrible. In supporting their friend through something they felt was not nice, the positives they garnered from supporting their friend were considered to be inappropriate, or “horrible”. This was addressed by Helen, a support provider, who said that,

*I think yeah that whole thing of actually having a mix of positive and negative emotions in most situations is a part of being human and it doesn’t negate (.) negative experiences don’t negate positive ones and vice versa it doesn’t make*
you a bad person for thinking 'oh I really helped them but I’m kind of pissed off as well’ those are both okay (Focus Group 3; Helen)

The friends felt a range and mix of emotions in finding out about the self-harm, and this needed to be reflected in the tool. It was also important, as Helen states, the friends are not made to feel that their feelings are unnatural, or unusual.

I feel like the only one supporting my friend: As friends often took on too much responsibility for the welfare of the self-harmer, and others were not as willing, they felt that they were the only ones caring for the self-harmer. In response, the friends suggested using other friends as a source of support.

I don’t feel able to talk to anyone: Many of the friends felt unable to seek support for fear of breaking the confidence of the self-harmer. This further compounded their feelings of isolation. It was acknowledged that this was difficult for the friends, and the support providers felt that in making it clear that if the friends sought help it would be to help them, and would not breach the privacy of the self-harmer.

I don’t know if what I’m doing is right!: Many of the friends felt that the did not know how to support, and were unable to identify if they were being helpful. In response, the support providers suggested that the support tool should make it clear that by just listening to the self-harmer, the friends were being helpful, and they were not obliged to provide any further support.

My friend tells me one thing, but I’ve heard something else: In listening to the self-harmers’ stories, the friends felt that they were being told different stories to others, or that they were only being told half-truths. This was particularly difficult for the friends when they had been asked to keep the self-harm a secret. The support tool, the support providers suggested, should make it clear that inconsistencies could be a result of the self-harmer still getting used to talking about their self-harm.

I can’t tell my friend about my troubles, theirs are worse: As the friends provided more support to the self-harmer, they often felt unable to ask for advice because the self-harmers were not in a position to help them. As this was also identified as a significant change in the friendship, the support providers encouraged friends to still seek support from the self-harmer; this support did not necessarily have to be emotional. In
continuing reciprocity in support, the support providers felt that the friends were better able to maintain their friendships.

**What the friends can do to help themselves.**

What was largely absent from many of the pre-existing support tools was practical help about how the friends could protect their own wellbeing whilst supporting their self-harming friend. In this section, the participants focused on how the friends can make steps to support themselves and maintain their own wellbeing, and used a mind-map (see Appendix I) as a catalyst for conversation. From this five subsections were developed. As with the other two subthemes, one subsection is detailed in full, and the other four are briefly outlined. For the full analysis see Appendix I.

**Be aware of your own wellbeing**

What was very clear across all focus groups was that the friends were often supporting the self-harmer to the detriment of themselves.

*Sometimes is think friends get quite burnt out and they become the main source of support quite dramatically for a short space of time (Focus Group 4; Pat)*

The friends consistently took on more responsibility for the self-harmer than they were meant to, and in the process, as Pat states, they were not looking after themselves. A point raised across all focus groups was that the friends needed to take care of themselves.

*Someone saying to you that (.) at the end of the day like she’s very important but you’re also important as well you can’t forget that (.) you know you’re important as well like (.) you’ve got to kind of (.) work out a way where you’re both are have the best out of the relationship sort of thing (Focus Group 2; Alicia)*

The need to self-care was an important theme that I wanted to get across in the tool. Often the friends felt that in supporting their friend they were running out of energy, particularly when they had other constraints on their time, such as essays and exams. The focus of the friends looking after themselves was also framed as being beneficial for the self-harmer.

*If you look after yourself you’re more likely to stick with them (.) in the long haul and also have that more rounded friendship (Focus Group 3; Helen)*

The participants all identified that in friends caring for their own wellbeing they would also be more able to provide meaningful, and long term support for the self-harmer. In discussing self-
care as such, the friends are able to justify their own help-seeking whilst dealing with the fears of breaching the trust of the self-harmer.

*Set boundaries:* Both the friends and support providers had identified that the friends often took too much responsibility for the self-harmer, and had acted outside of the boundaries of ‘normal’ friendship. In particular, the support providers wanted the support tool to encourage the friends to understand the limits of what a friend could do, and set clear limits about what they were capable of doing for the self-harmer.

*Make some time for yourself:* In caring for the self-harmer, the friends often neglected their own well-being. The friends and counsellors wanted the support tool to encourage the friends to continue to do enjoyable activities, and to make time for themselves.

*Help-seeking:* As friends would often avoid seeking help for fear of breaking the confidence of the self-harmer, the friends and support providers advised friends to seek support for themselves. In particular, they wanted the support tool to reinforce that the support the friends would be seeking would be for themselves, and would not be breaching the confidence of the self-harmer.

*Their wellbeing is not your responsibility:* The friends routinely took on too much responsibility for the self-harmer. By addressing this directly in the support tool, the support providers felt that feelings of responsibility may be reduced.

*The presentation of the support tool*

Feedback was also provided about how the design of the support tool. The participants wanted something neutrally coloured, with a mixture of images and words, that was easy to navigate and was discrete, and that also provided specific suggestions for support.

*Colours*

The materials presented to the participants had a blue and green colour scheme (see Figure 11). All participants liked the choice in colour scheme, describing it as “plain, simple and effective” (Focus Group 5; Antonia), “fitting” (Focus Group 1; Sophie), and “calming” (Focus Group 1; Matilda). They also felt that colours such as red would be inappropriate as they are
“dangerous and aggressive” (Focus Group 5; Antonia). In the draft support tool I tried to keep the colours neutral, and stay within a blue-green palate.

Images & Words

A mixture of images and words was preferred by the participants, particularly because they felt that “visuals are always really good because they are much easier ways to (.) convey information” (Focus Group 3; Helen). In the focus group materials, the participants tended to not like some of the images used, mainly because they were unclear, or inappropriate. In the draft tool I incorporated some of the images and removed the ones that participants raised concerns with. I also included some stock pictures.

Format

The two main features that the participants were looking for in a support tool was that it was easy to navigate, and that it was discrete. Participants did not like large bodies of text, and did not want to be “scrolling through loads [of text]” (Focus Group 1; Matilda) to find what was relevant. Instead, they preferred smaller sections with clear headings. Participants also suggested the use of questions, or issues as sub-headings, such as “Am I wrong for feeling guilty?” (Focus Group 3; Maggie). Thus, information, and advice was put into sections and sub-sections to make it easier for people to navigate.

Overwhelmingly, the participants requested that the support tool should be “something you can like shove like sneakily in your bag” (Focus Group 1; Alice). The participants wanted the tool to be discrete so they “can pick them up and not have to flash it around” (Focus Group 5; Antonia). Largely the participants preferred the tools that would fold out, rather than leaflets or booklets. Maggie, one of the support providers suggested z-cards, which are concertina pamphlets that, when folded, are the size of credit cards. She felt they were subtle, clear and had enough detail on them to be useful. Therefore, z-cards were used as the basis for the draft leaflet.

Information & Specific Suggestions

The final suggestion from the participants was that many of the support tools gave limited, or unhelpful suggestions for support, they wanted something that was more directive and specific.
Alice: Yeah () like for more information go here () so it would be you can kind of

Sophie: And actually like numbers for like hotlines is another good thing

Matilda: If you say you know you can contact () instead of saying () use different sources of support you actually have () the sources there because otherwise you can sit there going oh I don’t know where to go (Focus Group 1)

Consequently, the section on seeking help was tailored so that more information was given about what types of support can be accessed through which support providers. Furthermore, the support services listed at the end were all given a description about what kind of service, or information they provided.

7.4.6. Expert consultation

The use of experts has been considered to be useful in the development of support tools (e.g. Roberte, Hoga, & Gomes, 2012). In their study, Sousa and Turrini (2012) used the Delphi technique, an assessment strategy that they used to help refine the content of their information leaflet through “expert judges” (p. 167). Through using experts, Sousa and Turrini argued that they were more able to refine, and validate the content of their information tool.

Experts were not only identified as being experts in the relevant field, but also by having the necessary skills and knowledge in producing the desired outcomes (e.g. Street & Ottmann, 2007). In their development of an information tool for new mothers Roberte et al., (2012) recruited experts who worked in prenatal care settings, had prior experience in health promotion activities, and those who had been involved in the validation of other information material. As Professor Rodham and Dr. Gavin who were experts in the field of self-harm, and had recently been involved in the development of a suite of information tools for health professionals, friends and relatives, and employers of those with Complex Regional Pain Syndrome, they were considered to be appropriate experts to consult in the development of the support tool.

The tool went through three rounds of consultation before the draft tool was finalised. Through these consultations the content was refined, and the support services section was made more specific. The main revision to the support tool was the amount of text on the resource. In creating the content for the support tool I had been writing in word and not on a template for
the resource, thus when the information was put into the template it was text-heavy and very difficult to navigate. The main revision suggested by the experts was to reduce the amount of text, delete areas of repetition, and generally streamline the content.

Through removing areas of repetition subsections were reduced in size, and in some cases two subsections were combined. For example, the subsection *I feel my friendship isn’t the same*, was removed as much of the information was addressed in the subsection *Try to do normal activities with your friend*. These included suggestions for maintaining activities, and the benefits this has for the friend and self-harmer.

Finally, in the support services section, it was also suggested that a few sentences should be given outlining what the organisations listed were, and what services they provided. In so doing, the friends would be able to navigate the services in a more target way. In the next section, the draft support tool prototype from the focus groups and expert consultation is presented.
7.4.7. Draft support tool prototype

Figure 14: Front of draft support tool
**Is What I'm feeling normal?**

- Worried
- Upset
- Lonely
- Angry
- Burdened
- Scared
- Confused
- Responsible

You might feel like you are the only one supporting your friend.

You might feel so worried for your friend that you think you always have to be there for them. It’s important to remember that you don’t have to support your friend alone and it is a good idea to make sure that you have trusted people to whom you can turn to for support.

You might not feel able to talk to anyone.

Your friend may have asked you to keep their self-harm a secret, or you may feel that it is not something you should talk about with others. You may feel that it would be a breach of their trust to talk to others. Remember, it is okay to seek a friend’s confidence and get help for yourself.

You might doubt whether what you are doing is right.

Just being someone who will listen to them can help a lot. It can be a good idea to ask your friend about what they actually want and remember. If you are worried, then you can talk to those who can give you practical advice about supporting a friend, such as a counsellor.

Your friend shares different things with different people.

Hearing that your friend has told different people different stories can leave you feeling annoyed, betrayed, confused, or angry. Remember that your friend may still be learning how to talk about their self-harm, particularly if it is something they’ve kept hidden for a long time. This may mean that they tell different people different stories.

You feel unable to talk about your own issues.

Finding out that your friend self-harm may make you feel that you can’t talk to them about your problems. If you feel comfortable in doing so, sharing your feelings may show your friend that they are not alone and others have difficulties as well. They may even be able to help. If you don’t feel comfortable, talk to those you feel you can support you.

**What can I do to help myself?**

- Be aware of your own wellbeing.
  - If you’re starting to struggle or feel it difficult to cope, talk to someone you trust (e.g., other friends, family, teachers, support lines, counsellors).

- Set boundaries.
  - Be clear about when you are and are not available. This will help you to decide time to look after yourself. In looking after your own wellbeing, you are also more able to provide meaningful and consistent support to your friend.

- Make some time for yourself.
  - It may feel counterintuitive but it is also important that you make time for yourself. Keep doing activities that you enjoy doing.

- Help-seeking.
  - There is nothing wrong in wanting support for yourself. If you do decide to seek help, focus on what support you want. If you want some more advice about self-harm, consider talking to services for self-harm, or look at online help pages. If you want someone to talk to and to vent at, consider contacting listening lines. If you feel overwhelmed or want advice about coping with your situation, consider contacting counselling.

**Sources of Support**

- Lifeline: User-led site providing information and leaflets about self-harm. [www.lifeline.org.uk](http://www.lifeline.org.uk)
- Mind: A charity providing mental health information & support. [www.mind.org.uk](http://www.mind.org.uk)
- National Self-Harm Network: Online support forum providing crisis support, information, and resources. [www.nshn.co.uk](http://www.nshn.co.uk)
- Samaritans: A confidential listening service, providing support for those in crisis. [www.samaritans.org](http://www.samaritans.org)
- Self-Harm UK: A site dedicated to young people affected by self-harm with information, support, and personal stories. [www.selfharm.co.uk](http://www.selfharm.co.uk)
- Self-Injury Support: A national service providing information and support via text and email for girls and young women who self-harm. [www.selfinjurysupport.co.uk](http://www.selfinjurysupport.co.uk)
- Young Minds: Online information & support for issues affecting young people. [www.youngminds.org.uk](http://www.youngminds.org.uk)

*And finally, remember, your friend’s wellbeing is not your responsibility.*

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**Figure 15: Back of draft support tool**
7.5. Phase Three: Refining

Phase three focussed on refining the support tool through three focus groups with those who would use the support tool; friends and support providers.

7.5.1. Participants

In total, three focus groups were conducted. Participants were drawn from: University students (2), and a Local Support Service (1). In total, 7 people participated, all were female.

University students

Two focus groups were conducted with University students. The first focus group was comprised of those who had been involved in Phase Two of this study. Seven participants who had provided their contact details were contacted. Five were removed prior to focus group as they either; did not respond (3), were unable to come to the focus group (1), or did not show up to the focus group (1). In total, two students participated. The second focus group was comprised of students recruited through the Research Participation Scheme (RPS). In total, three students participated.

Local support services

The local support service involved in Phase Two of the study were invited to participate in Phase Three. The same two individuals participated.

7.5.2. Data collection

The focus groups lasted between 30 and 70 minutes. All participants were informed of the nature of the study prior to attending and were reminded in the focus group.

The number of participants to have in a focus group has been outlined in greater detail elsewhere (section 6.3.2.). Customarily focus groups have consisted of between three and six participants (Kitzinger & Barbour, 1999). However, I had two focus groups consisting of two participants. One focus group was intentionally planned to involve two people due to the constraints of their organisation. The other two person focus group happened due to attrition rates. As these participants were happy to continue, the focus group continued as planned.
7.5.3. Interview schedule

The participants were presented with an A4 copy of the draft support tool, as can be seen in section 7.4.6. A loosely-structured interview schedule was used (Braun & Clarke, 2013), for a full discussion of this approach see section 6.3.3. The questions were based on the different sections of the support tool. Firstly, the participants were invited to read and write on the support tool;

This is the support tool that I’ve come up with based on previous focus groups, and I want to get your opinions of it. Please read through it, and feel free to write comments on it as well.

The participants spent between five to ten minutes reading and writing on the draft support tool. Afterwards they were encouraged to share their thoughts without much direction from myself. If the groups began to struggle I would direct them to different sections of the support tool and ask for their opinions on it;

What do you think about the pictures that have been used?

If the participants were not engaging well in the critique of the support tool, I tried to focus them on talking about what they did not like, or areas they felt could have been improved;

Is there anything you’re not so keen on?

Is there anything else you’d like to see or that worked for you?

Is anything you disagree with that’s been written?

Similarly to the previous studies the focus groups ended on a question which aimed to address any areas that have not been covered.

Is there anything that you wish to talk about that you don’t feel we have covered?

7.5.4. Data analysis

The focus groups were transcribed verbatim, these were analysed with Thematic Analysis (Braun & Clarke, 2013) alongside the written feedback that was provided on the hand-outs. This was the most appropriate analytic strategy as it allowed me to explore some of the key issues with the support tool. For a full outline of the process of Thematic Analysis see Chapter Four (section 4.3.4.).
7.6. Results

The draft support tool was generally well-received. The participants found it to be useful and informative. The friends particularly liked how a lot had been covered in the support tool, yet it was easy to navigate around.

It is quite good because it’s got the subheading and the sections and because they’re quite brief one topic it covers quite a wide (.) erm area so it’s quite good that way (Focus Group 8; Amy)

It was really important that the support tool was informative, and covered a lot of information without overwhelming the readers. The participants also commented on the general layout, in particular they felt that the use of quotes as headings made it easier for them to “relate” (Focus Group; Tiffany) to the content, and put the advice in context. During the creation of the support tool the participants had talked about the need for certain colours to be avoided, such as red, because it had associations with danger. The aesthetics of the support tool were well received. Indeed, the colours were considered to be appropriate and “hopeful” (Focus Group 7; Sophie,), and the font was described as feeling “friendly” (Focus Group 8; Tiffany). The images (word clouds, and one in ten image) were well received, in particular Maggie, a support provider, felt that it was a good way to represent information and break-up the information on the support tool. Similarly, the two pictures were liked and well-placed in the tool itself. Indeed, it was commented that the pictures told the story of finding out about self-harm, and the final picture made one participant feel that there was a “light at the end of the tunnel” (Focus Group 7; Summer).

A key issue discussed in the creation of the support tool was that many support tools “don’t make any suggestions” for supporting the self-harmer (Focus Group 2; Alicia). Thus, it was a key focus to include suggestions about how to support the self-harmer and themselves. These were welcomed by the participants;

Sally: And the fact that it gives you a lot of suggestions about how to do normal activities with your friend is quite helpful because it’s all very well saying yeah you need to support them but most people don’t (.) not many things tell you how you can help them

INT: So it’s having the how’s in there

Sally: Yeah suggestions about what you can do (Focus Group 8)
In creating the support tool, the friends felt that often support tools would give general advice without any specific examples of how they could support their friend, or what they could do to support themselves, such as who to contact for support. Consequently providing specific suggestions was important in the creation of this tool. Receiving the positive feedback about the suggestions highlights how providing more specific advice to the friends is important to them, and something they felt made this support tool unique.

A key finding of Studies One to Three was that the friends often felt responsible for the welfare of the self-harmer. Addressing these feelings was a key focus of this support tool.

Yeah it sort of says although obviously (.) they need support but it makes you not feel guilty yourself and lets you know that it's okay for you to feel a bit worried about it all (Focus Group 8; Sally)

Sally in particular felt that this support tool was very effective in reducing feelings of guilt. She repeatedly commented that in supporting her friend she had felt guilt for not preventing the self-harm, when she wanted time to herself, and when she sought help. As reducing feelings of responsibility and guilt were a key focus of this support tool, it was good to see that the support tool could be used to reduce these feelings.

Although the support tool was generally well received, and was praised as being “pitched really well” (Focus Group 6; Maggie), the participants did feel that a few issues needed revising before it could be finalised. The key suggestions were that the language should be softened and made more accessible to those outside of academia and the healthcare environment, comparisons should be avoided, the feelings of the friends should be woven throughout the support tool, and the tool could be made more navigable.

“Softening up” the language

A key suggestion was to “soften up” some of the language. For example, the support providers felt that certain parts were a little “harsh”;

Maggie: And finally remember that your friend's wellbeing is not your responsibility (.) I think that's a little bit harsh

Helen: Yeah (Chuckles)
Maggie: I thought something like you can only do so much and that’s okay you know something that’s accepting of your part of being one of many in their life (Focus Group 6)

In a couple of places in the support tool, the language was felt to be a little too academic. The support providers in particular felt that it was a little too blunt for the friends, and that it needed to be less direct, use more common phrases, and avoid language which is used by health professionals or academics. The places highlighted in the focus groups were rewritten with this in mind, I attempted to make the language more accessible, and reflect the language of the friends rather than that of health professionals or researchers.

Weave in the friends’ feelings

Although the participants felt that the experiences of the friends had been taken into consideration, it was suggested that the feelings of the friends could be interwoven throughout the tool;

I suppose I might although a lot of these might be leading with an acknowledgment of how the friend might (.) feel I don’t know I suppose that’s more in line with how we do stuff that kind of validation so almost leading with my friend self-harms you might if you find this out you might find it really it might be a really shocking or upsetting or difficult thing to to know and it’s okay to feel like that whatever you feel alright that kind of thing but to me that’s the only thing that kind of that validation of their feelings (Focus Group 6; Helen).

The support providers suggested the inclusion of “validating sentences” in the earlier sections of the support tool. They felt that this would make the focus on the friends more salient throughout the tool, and would mean that the friends would not have to wait until the section about their feelings before they were addressed. This was mirrored in the friends’ suggestions, Sophie felt that something needed to be put in the “introductionary [sic.] bit or something kind of making it clear that it’s not your fault at all like that”.

As a more constant focus on the friends’ feelings was a key concern, the redraft of the support tool focussed on including how the friend may be feeling, and validating these feelings. For example, in the section titled I don’t know how to support my friend without supporting the behaviour, the section starts off with “Their self-harm may upset you, and this is understandable.”

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The participants felt that this weaving of friends' feelings into the support tool was good, and simply adding "and okay", to the end of it would validate their feelings. Thus, the sentence would read "Their self-harm may upset you, and this is understandable, and okay." It was suggested that these sorts of sentences were reiterated throughout the tool. Although this may seem repetitive, the support providers felt that issues, such as help-seeking are issues which are "okay to be said twice as it's a really important point" (Focus Group 6; Maggie).

**Context appropriate**

In particular, the support providers felt that some of the information that had been presented in the support tool was not suitable for a written resource;

> I think the next one the sort of equating to erm (.) going for a run and going out for a drink and things I'm not sure if that's great as a direct (.) a comparison because I suppose its I think in training we might talk about that in terms of if someone took that away how would you feel to get people to get the sense of oh I would find that really hard to kind of I wouldn't know what to do I would look for other things but I don't think it's quite the (.) I wouldn't equate them in that way because there's that sort of emotional distress and erm much deeper emotional distress level around self-harm (Helen)

In the creation of the support tool, the support providers had suggested the use of comparisons to make self-harm a more understandable behaviour, giving the suggestions of going for a run. In this focus group, however, they felt that it did not translate well in a written resource. Instead, they felt that this issue was a good way to generate discussion in a group setting. In a written format, however, they felt that it may cause friends to make comparisons, or may encourage friends to try and suggest alternatives to self-harm. In order to avoid this, I removed any comparisons drawn between self-harm and other behaviours.

**Navigation**

Generally, the tool was considered easy to navigate and read. However, the participants suggested that the sections, particularly in the *How can I support my friend* section, could benefit from being reordered.
Yeah it’s like my friend self-harms I think they need help I want them to stop I can’t understand why they self-harm their life is great (.) and then it’s like it’s their perceptions and then what’s helpful (.) they’re all really good paragraphs but it just they’re not flowing for me (.) in the natural transition of the natural flow (Focus Group 6; Maggie)

The support providers suggested reordering the subsections in order to reflect the “natural flow” of the friend’s feelings. They suggested front-loading the section, How can I support my friend, with subsections that focussed on the feelings and initial reactions of the friends, such as My friend self-harms!. Then going onto subsections which provided practical solutions, such as Let them go at their own pace. In restructuring the sections I hoped to make the information in the tool reflect the experiences of the friends.

Each of the support services had an explanation about what kind of organisation it was and what support it offered. Friends, such as Sophie found the information helpful; “I think sources of support are good as well (.) erm (2) it kind of like the information what the charity does”. However, they also suggested that changes could be made to how the support services were talked about;

At the bottom of each block or something with the sources of support say so you can link so being aware of your own wellbeing you can go to the young minds or whatever like that so almost direction where they can go on to which kind of sources of support for each question (Focus Group 7; Sophie)

Generally, the friends felt that although the list of support services were useful, they wanted further direction about which support service would be more appropriate for each issue raised in the support tool. This was also discussed by the support services. They suggested that friends would find it easier to identify an appropriate support service if they were sectioned up according to what they provided, such as “helpline text line” (Maggie). Doing so, they argued, would stop friends feeling overwhelmed and help them chose what support service would be most appropriate.

7.7. Final support tool prototype

From these focus groups the final support tool was developed and disseminated. A copy of this can be found on the back page of this thesis.
A guide for the friends of those who self-harm

What is this leaflet about?
This leaflet is for people who have found out that their friend is self-harming or they suspect they are. This leaflet can help you answer:

What is self-harm?

Self-harm is a behaviour that is done to intentionally cause harm to the self. There are many different forms of self-harm. The most common are cutting and overdose, but it can take other forms too.

How can I support my friend?

"My friend self-harms!"

Your friend may already have told you that they self-harm or you may suspect it, if they do confide in you, be calm and listen to what they have to say. Ask where they want to go from here and what you can do to best support them.

"I think my friend needs help!"

You might find that your friend does not want to seek help. This is their choice and you cannot force them to do so. What you can do is be clear with them about your concerns and explain why you think they need help. If you are very worried about your friend’s safety, it is okay to ask for help from someone else (see sources of support).

Try to do normal activities with your friend

Try to keep doing the normal things you and your friend have always done. This will help to show your friend that they don’t just have to get support from you, but they can also have fun and enjoy themselves. It may take time for you to feel comfortable with this, but it may help maintain your friendship.

Let them go at their own pace

You may feel like you want them to tell you exactly how they’re feeling and get them to stop self-harming, and this is normal. Be aware that this may be the first time that they’ve spoken to anyone about their self-harm. It is important to let them go at their own pace, and not push them to talk or change their behaviour. It may take time, and it’s normal that you may find it difficult.

Figure 16: Front of final support tool prototype
Figure 17: Back of final support tool prototype
Studies One to Three established that the friends struggled to support a self-harmer, and that the written support tools available were inadequate, and often provided confusing or unhelpful advice. Therefore, the aim of this final stage of the thesis was to co-create a support tool tailored to the needs of the friends with friends, and support providers.

This tool contains information on what self-harm is, how the friends can support the self-harmer, what the friends themselves might be experiencing, and how the friends can ensure their own wellbeing.

Although the prototype support tool was well received in the focus groups, the opportunity for participants to write on the hand-outs in Phase One (i.e. mind-maps) was not taken up very often. Although it was evident that these hand-outs acted as a good springboard for participant discussion, very few were written on. In the later stages, participants were more inclined to annotate the draft support tool, to change wording, or to write general comments. The preference for writing on the draft support tool suggests that participants may feel more comfortable writing on something that is more specific, and represented something more finalised.

In summary, this support tool has been developed through “360⁰ feedback” (Rodham et al., 2015, p. 11), in that the friends of self-harmers, and those who support them identified the lack of information and support, and whose experiences inspired the development of the support tool. Further, friends and support providers were involved in the co-creation of the draft support tool which was then piloted, and further refined through further series of focus groups. Due to the friends and support providers presence throughout the development of the support tool, their voices, experiences, and knowledge are reflected in the final output. Thus, the
information, and guidance detailed in the prototype support tool is a product of the co-created knowledge generated between myself, the friends, support providers, and experts.

In the following chapter I will discuss where this thesis sits with the current research on self-harm, friendship, and support. I will also discuss some of the limitations of the research and what questions this project has raised, and where future research could go. I will also consider relevant issues that have been highlighted through this project, such as the importance of using the language and ideas of those who deal with self-harm daily, and the appropriateness of using research participation schemes for focus groups. I will also reflect on my role as a researcher within this project, what I have brought to it, and how this directed the trajectory of the thesis.
Chapter Eight

Discussion

In the self-harm literature attention has only been paid to the friends of self-harmers if they can provide information about the self-harmer, or they themselves go on to self-harm. Considering friend self-harm is the highest predictor of own self-harm in young people (e.g. DeLeo & Heller, 2004), the lack of attention paid to the friends, and their experiences of having a self-harming friend is concerning. I set out to redress this imbalance by exploring the impact of self-harm upon friendship and identifying how those who support self-harmers make sense of, and understand this impact.

The overall research question was: How is the impact of self-harm on friendship understood? This was achieved through three sub-questions that were addressed in the studies within this thesis:

1. What are the key issues facing the friends of self-harmers?
2. How do friends make sense of the experience of being a friend of a self-harmer?
3. How do friends make sense of the impact of self-harm on their friendship?

In order to address the aim and research questions, three studies employing a range of qualitative data collection and analytic methods were used. A key outcome from the three studies was the identification of the lack of tailored support for the friends. In response to this, a prototype support tool was also developed.

8.1. Overview of empirical chapters

In this thesis I conducted three studies, and produced a prototype support tool. In order to contextualise the findings prior to discussing how I answered each of the research questions I provide an overview of each of the empirical chapters, as detailed below.

In Study One, I conducted a focus group with University counsellors to identify the key issues facing the friends of self-harmers. Due to their position as sources of support for students dealing with intrapersonal and interpersonal issues (e.g. Fox & Butler, 2007), counsellors were identified as being well placed to gain an initial understanding about some of the issues facing self-harmers and their friends.
Study Two explored the lived experiences of the friends. I conducted semi-structured interviews with friends who were retrospectively looking back on their experiences of having a self-harming friend. Through using IPA, and Positioning Theory, I generated an insight into the life-course of the friendship, and how friends came to understand their experiences of being a friend to a self-harmer.

In Study Three, I conducted a focus groups with friends in order to gain an understanding of how those who have more recently provided support to self-harmer made sense of their experiences.

Across Studies One to Three it was evident that the friends struggled to support the self-harmers, and that support options available to them were often lacking, confusing, or vague. Therefore, using a series of recommendations from Study Three, existing support tools were evaluated, and key findings from Studies One to Three were drawn together to begin the process of co-creating a support tool. Through three phases, and eight focus groups, a support tool was created that provided information, support, and advice, designed specifically for the friends of self-harmers.

8.2. Answering the research questions

The knowledge generated within each of the studies helps to piece together how the impact of self-harm on friendship is understood through emphasising shared, similar, and competing constructions held by participants. Through listening to the multiple voices, a layered understanding of the impact of self-harm on friendship has been established. Each study gives a different insight into the experiences of supporting a self-harmer. In such a novel area of research, attempting to understand this experience using a range of techniques has promoted the multiplicity of experience and sense-making. Doing so has produced results that confirm (e.g. that friends' role does change), advance (e.g. that secrets may have different purposes), and challenge (e.g. how the friends negotiate the change in their friendships) each other.

The synthesis presented below builds on the synthesis outlined in Chapter Seven (see section 7.3.1). In addition, I also considered how the studies answered the research question, built upon each other to provide a more nuanced picture of self-harm and friendship, and where the findings sat in relation to existing literature. The process I used had five stages;

1: Re-reading & study summary

In the first stage I re-read the analysis for each study in turn. Whilst doing this I wrote an overview, or summary of each of the studies. This included what the methods and aims were,
what the main findings were, and what each study added to the understanding of self-harm and friendship.

2: Mapping the studies

Key features of each of the summaries were then put on one mind-map (see Appendix G). In mapping out the studies, similarities and differences between the studies were considered (Barnett-Page & Thomas, 2009). This also included issues which had been discussed by the participants, but had been done so in a different way, therefore identifying different constructions (Sandelowski et al., 1997).

3: Answering the research questions

After identifying the relationships between the studies, a thematic overview of how the friends and counsellors talked about self-harm in friendship was put together. This was then subjected to a deconstruction in terms of the research questions. Attention was paid to identifying 1) the key issues for the friends, 2) how the friends constructed their experiences 3) how the friends constructed their friendship.

4: Furthering the understanding

Through mapping out the synthesis, some researchers have taken the opportunity to further interpret the results, and to "go beyond" the constituent studies (Barnett-Page & Thomas, 2009, p. 66). In this stage, attention was paid to where studies advanced, contradicted, and supported each other. Thus creating an account of the impact of self-harm that although retains the multifaceted nature of the studies, also moves beyond an aggregation of findings towards the generation of a novel insight (Walsh & Downe, 2005).

5: Reflecting on current research

Although not included in the protocol surrounding meta-synthesis, in order to further explain and situate the findings, I considered how the findings mapped onto existing research on friendship, care, and support as outlined in Chapter Two.

8.3. What are the key issues facing the friends of self-harmers?

Through this research question I aimed to identify what the general concerns were for the friends of self-harmers across Studies One, Two, and Three. This question was useful in providing an overall picture of self-harm and friendship, and identified issues that were able to be explained in more detail in the subsequent two research questions. Three main issues were identified; how the friends negotiated the introduction of self-harm into their friendships,
how the friends and counsellors made sense of the change in the friendships, and how the friends negotiated seeking support.

8.3.1. Introduction of self-harm in the friendship

Across all of the studies it was evident that when self-harm became an issue in the friendship the friends were faced with the opportunity to provide more care and support to the self-harmer. How friends responded to this differed; the friends would refuse to provide support, they took on the responsibility of care, or they would reluctantly support the self-harmer.

In the focus group with the counsellors it was evident that those who identified themselves as housemates would reject supporting the self-harmer. In these situations, the rejection of support was almost instantaneous, and demonstrated a complete rejection of responsibility over the welfare of the self-harmers. The act of rejection was also discussed by the friends in Studies Two and Three. Those who did not want to support the self-harmer identified someone else who they felt was better suited to take on the burden of responsibility.

For those who did take on the responsibility of care over the self-harmer, the counsellors identified that often the friends would slowly and incrementally take on responsibility for the self-harmer. This is reflected in the friends' accounts, particularly those who passively took on the role of carer; often they could not identify when their friendship had transitioned to include the care of the self-harmer. How the friends made sense of these transitions is discussed in more depth in section 8.4.1.

8.3.2. Roles and Responsibilities

In taking on responsibility for the self-harmers' welfare, the friends were then faced with the changes in their friendship. By supporting the self-harmers, the friends took on excessive responsibility for the self-harmers' welfare. These responsibilities were identified by both the counsellors and the friends as lying outside of what was expected of 'normal' friendship.

How the friends and counsellors constructed this involvement differed. The friends felt that their care was essential, and without their involvement the self-harmer would deteriorate. For the friends who did identify that they had taken on too much responsibility, they blamed their young age and lack of knowledge for making them unsuitable to provide care. The counsellors, however, felt that the friends accidentally and incrementally took on excessive responsibility, and it was the limitations of being a friend that made their care inappropriate.

As a consequence, of taking on responsibility for the self-harmer, the friends had to renegotiate their role within their friendships. Across Studies One, Two, and Three, friends were described
as being something other than friends. The friends in Study Two likened themselves to family members, and did so as a way to demonstrate their special role to the self-harmer. The counsellors also likened the friends to the family members, feeling that the friends had taken on a parental role. Unlike the friends, where these comparisons seemed to demonstrate their special relationship, the counsellors used the comparison to try to communicate the inappropriate responsibilities that the friends had taken on. In a similar vein to the counsellors, the friends in Study Three drew on constructions of caregivers in an attempt to convey the extra responsibilities that they had taken on. Thus demonstrating an attempt to consolidate and integrate their new place within the friendship, through the use of alternative social roles.

It has been discussed elsewhere that in order to demonstrate a special relationship, people will liken themselves to others who hold a special status (Phal, 2002). For instance, Pahl and Spencer (2004) found that roles such as friend (being the actual relationship) and sister (the comparison relationship) were integrated to communicate the perceived special bond held between two people.

Across all of the studies it was evident that the friends were doing something other than friendship. The responsibilities that they had taken up were constructed in a similar fashion by the counsellors, and the friends in Studies Two and Three. The counsellors felt that the friends had taken on a parental role, the friends in Study Two drew comparisons between themselves and the family members of the self-harmer, and the friends in Study Three felt that they had taken on a role akin to a counsellor. Although each construction differed slightly, it demonstrates that the friends and counsellors struggled to explain the friends’ behaviour, and responsibility for the self-harmer as being something that exists within a “normal” friendship.

In trying to explain the change in behaviour, and maintain a consistent understanding of what the friends were doing (Gergen & Gergen, 1988), the friends and counsellors both turned to social positions that had an element of care attached; parents, family, and counsellors. Using the linguistic and relational tools that different social roles come with (Gergen, 2011), the friends and counsellors were looking to explain the behaviour of the friends that lay outside of the traditional role of ‘friend’ (Burr, 2003). Thus suggesting that, for the counsellors and friends, the responsibilities and roles that the friends were taking on were incongruent with expectations of friendship, and that the friends were doing something more than the expected practice of friendship.

Drawing the findings from the counsellors and the friends together it is evident that there is an understanding that the friends were doing something other than being a friend; they were taking on responsibilities that were more akin to either a family member or a professional
caregiver. How the friends made sense of this change in their friendships is detailed more fully in Section 8.4.2.

8.3.4. Breaking confidence

In feeling like they were the only person who knew about the self-harm, the friends often maintained the self-harmer’s secrets, even if they were struggling as a result. Across Studies One, Two, and Three it was evident that friends felt constrained by the perceived and actual fear of losing the friendship, or worsening the self-harm if they sought out support. Consequently, although they were struggling with supporting the self-harmer whilst also maintaining their own wellbeing, the friends would delay seeking support. When the friends did break the confidence of the self-harmer, and sought support, help-seeking for themselves was constructed in one of two ways.

Both the counsellors and the friends in Study Two seemed to identify external pressures, such as exams and essay deadlines as being a motivator to seek out support. In these situations, the friends either withdrew support, or sought out support services. The increase in help-seeking around stressful periods has been well documented, with incidents of self-harm peaking around exam period (e.g. Hawton et al., 2012a). With the potential increase in the severity of self-harm at a stressful time for both the self-harmers and the friends, the friends seemed to be less able to cope with the demands of supporting the self-harmer. In using their situation, the friends could also have been looking for a way to decrease the amount of care they were providing whilst still maintaining their unselfish self-construction. In effect, breaking the self-harmers’ confidence at a time of stress was an opportunity for them to “opt out” of caring (Watson and Fox, 2014, p. 31).

Alternatively, the friends in Study Three also sought out support for themselves when they felt that without getting personal support they would be unable to continue to provide meaningful care to the self-harmer. Across all studies, when the friends decided to seek support for the self-harmer, however, it was always constructed as being in the self-harmers’ best interests. The counsellors found that often friends were worried about losing their friendship if they decided to seek help on behalf of the self-harmer. This reflects the sentiment of the friends, who sought help for the self-harmer as a last option, and presented themselves as being willing to lose the friendship in order to ensure the wellbeing of the self-harmer. From the accounts of the counsellors it is clear that the friends struggled to seek support for both themselves, and on behalf of the self-harmer. From looking at the friends’ accounts we can see that they framed their help-seeking as being necessary, because they were unable to cope or to increase their ability to care. Feeling better able to cope with their situation, was only identified by young
carers when they either fully accepted the role of carer, and we able to use it as a frame of reference to make sense of their experiences (Smyth et al., 2011), or when they moved out of the situation and out of the role (Van Parys et al., 2014b). The findings from the friends and counsellors suggest that friends who care are unwilling to completely accept the role of carer, yet are unwilling to completely reject it. The findings from this thesis suggest that once friends feel overwhelmed with the support they are providing they look for ways to still provide support, whilst decreasing the intensity of it.

The friends presented their help-seeking on behalf of the self-harmer as a last resort. This finding sits neatly with much of the research about young people’s formal help-seeking; it has been documented that young people postpone seeking support (e.g. Gulliver, Griffiths, & Cristensen, 2010), and will often wait until a crisis point before doing so (e.g. Murray, 2005). The reluctance to seek help could be further exacerbated by the secretive and taboo status of self-harm (Adams et al., 2005). As discussed by the counsellors and the friends, it was clear that the friends felt an element of risk in seeking help on behalf of the self-harmer. The friends in Study Three presented this help-seeking as a threat to their friendship, yet they were willing to lose the friendship in order to ensure the wellbeing of the self-harmer. Thus the friends presented themselves as the dutiful friend who was willing to risk the friendship if it meant that they ensured the self-harmers’ wellbeing. Interestingly, this construction was mainly evidenced in the focus groups with the friends; when interviewed the friends were more likely to try and protect the self-harmer from external intervention. The tendency for the friends to promote themselves as being so caring that they were willing to lose the friendship could have been a consequence of the focus group setting, and the presence of others who had provided care.

8.4. How do the friends make sense of the experience of being a friend of a self-harmer?

My overall aim was to explore how the friends understood their experiences, and how they constructed themselves in response to these issues and challenges. This research question was answered by Studies Two and Three, however, the comments from the counsellors were also used to add context, or to highlight points of conflict.

8.4.1. Acceptance & rejection of supportive role

Upon self-harm being identified as an issue in the friendship, the friends were faced with the opportunity to either accept or reject providing support, and consequently become the carer to the self-harmer. The friends who accepted being in the supportive role constructed this
transition as either easy, difficult, or something they were naturally good at. Friends who rejected the role of carer presented themselves as being unsuitable to provide support.

**Acceptance**

Some friends passively adopted the role of carer, and they felt there has been little change in their friendship with the self-harmer. Similarly, Hughes et al. (2013) who explored the experiences of carers of people with MS found that carers talked about their role of carer being "concordant" (p. 81) with their previous role as child. Thus, the transition to carer was something that happened with ease, and was not something that fell outside of the remits of the relationship they already had. Using this notion of concordance, the friends and counsellors may have felt that some friends were better suited to take on the responsibilities of care, and some friendships were more amenable to the changes associated with this inclusion. Further, feelings of obligation to protect the self-harmer were also discussed; the counsellors highlighted that caregiving by the friends would escalate in shared accommodation, and the friends in Study Two talked about taking on the burden of care because they felt someone had to. This sense of duty over the self-harmers' welfare is reflected in research conducted by Van Parys et al. (2014a), who explored how people retrospectively made sense of being a young carer to a parent with depression and found that often young carers would take on the responsibilities out of a sense of obligation. Thus indicating that the passive up-take in roles seen in the caring literature is also present for supportive friends. Unlike the findings from the caring literature, however, taking on a supporting role out of a sense of obligation was considered by the counsellors, and the friends, to be temporary in nature.

Rather than feeling like the transition from friend to carer was an easy transition, some friends felt that they had been pushed into the role of carer by others, and that this was a role that they neither wanted nor felt was appropriate for them to take on. This is consistent with research conducted by Watson and Fox (2014) who explored the experiences of young carers; they found that many of the participants tried to resist the role of carer. They found that often young carers would draw on constructions of youth and childhood as a way to demonstrate their resistance to the role, and their unsuitability for it. This was also reflected in the accounts of the friends in Studies Two and Three, for some they found consolidating the role of carer and friend difficult. For instance, one participant talked about how she felt pushed into the role of carer, and that she was too young to be in the position she was placed in. The tendency to focus on age as a marker for why the participants should not have been supporting the self-harmer was used a rhetoric throughout the studies, particularly with the friends who struggled the
most with their friends’ self-harm. Watson and Fox (2014) argued that competing constructs of youth and caring were used to demonstrate how the young carers had struggled to provide support in the face of adversity (their young age), and provided them with the "option to ‘opt out’ of caring (p. 31). Thus, by drawing on constructions of youth, the young carers could legitimately decrease the level of care, or alternatively could manage the impressions that others had of their ability to care. Similarly to the young carers in Watson and Fox’s research, the friends in Studies Two and Three used constructions of youth in order to emphasize the excessive responsibility they had taken on. Youth was further used as a tool to demonstrate the vulnerability of the friends, not only did they feel that they took on excessive responsibility, but that they did so because of those who should have taken responsibility, such as parents and teachers, failed to do so. Consequently, the friends presented themselves as selfless supporters who had taken on responsibility because of the failings of others. Thus confirming the findings of Watson and Fox, that when providing care, people will draw on multiple and sometimes competing constructions in order to communicate certain aspects of their experiences.

Other friends actively embraced the role, and felt that they were capable of supporting the self-harmer because of their natural caring tendencies. This positive account of role acquisition is rare in the caring literature, positive accounts are normally focussed on the skills developed through caring and the subsequent impact caring has had on career options (Bolas et al., 2007; Earley & Cushway, 2002; Heyman & Heyman, 2013). In a movement beyond this, the accounts of friends, particularly evident in Study Two identified that some friends also felt positive about becoming a carer; in particular they framed themselves as being naturally supportive people. Despite the friends presenting themselves as natural caregivers, the counsellors’ accounts suggested that the friends seemed to struggle. Watson and Fox (2014) suggest that positive accounts are often used as a way to positively restructure a difficult situation. In positively framing themselves as natural caregivers, the friends could have been trying to rationalise the difficult situation of becoming a carer.

Rejection

Those who rejected the role of carer, however, usually identified a more suitable other to take on the responsibility of care. The person was normally identified as holding a closer relationship with the self-harmer, such a partner. For the friends who rejected supporting, they normally denigrated their own ability to care in favour of the other person. For those who rejected the role of carer there was a constructive distancing of themselves from the self-harmer; they were either not close enough to provide care, or they identified someone else that
they felt was better suited to the position. When there was a lack of a suitable other and the friends felt obliged to care for the self-harmer, they provided as minimal support as possible, and considered themselves to being temporary until they identified someone more appropriate to provide support. Similar findings of role rejection, or avoidance, have been identified within the young carer literature surrounding gendered expectation of care. In their study of young carers, Bolas et al. (2007) found that often male relatives would be unwilling to take on the care of the relative if there was a, usually older, female relative to do so instead. Bolas et al. (2007) attributed the withdrawal to societal expectations around gender and care provision. In a similar vein, the friends who withdrew their support appeared to be motivated by the understanding that someone else was better able, or better suited to provide care, such as the partner of the self-harmer, or counsellors.

*Theoretical Explanation*

In looking at how the counsellors and friends talked about the shift from friend to carer, or indeed, the rejection of the shift, an insight is gained into how people take up roles within society. This is particularly applicable to positioning theory, as outlined in Chapter Two. Drewery (2005) focussed on how people come to acquire social roles, she argued that people are not passive recipients of social roles, rather they interact with it and can either reject it, accept it as it is, or alter it. From the counsellors and the friends it appears that friends negotiated their supportive role; some accepted the role or carer with ease, others tried to resist it, this was both successful and unsuccessful, and others changed the role, and only provided superficial support. In support of Drewery's work it is evident that the friends do actively engage with role acquisition. In advancing the current understanding of role acquisition in young people, this thesis has highlighted that friends put a lot of effort into making sense of becoming a carer. Indeed, it is evident that it is not simply a change in activity, but rather caring for a friend comes to dominate the friendship, and their place within that friendship. Further, this thesis confirms the work of Drewery (2005) and demonstrates that people are actively involved in their role acquisition; it is not simply something that is placed upon them. The transition from friend to carer was a complex process for the friends, and one that they often had difficulty doing. In part, this was owing to the multiple constructions that the friends drew from in order to make sense of their experiences. In particular, it was clear that friends drew on constructions of friends, and caregivers, such as family members and support providers, to make sense of supporting a self-harming friend.
8.4.2. Friend-carer: Understanding the role

Through incorporating care into their shared activities with the self-harmer, the friends challenged their previous role within the friendship. As a result, the friends looked to establish a coherent “self-narrative” (Gergen & Gergen, 1988, p. 18) through drawing on multiple social roles including friend, youth, family, and caregivers.

What friendship is, and what a friend is, was a nebulous concept across all studies. ‘Normal’ friendship was usually identified by what the caring friendships were lacking, namely the lack of mutual support, and an ease in the time spent together. The counsellors drew comparisons between the friends’ behaviour, and what ‘normal’ friends should be doing, to highlight their inappropriate behaviour, and excessive up-take of responsibility.

The friends similarly used comparisons to show difference; however, they often used these comparisons to show how their friendship had changed, or how their relationship with the self-harmer was unique. The tendency for friends to use comparisons to show their unique bond advances research conducted by Smyth et al. (2011) who found that young carers would compare themselves to others their age to demonstrate how different they were. In negatively constructing similar others, and drawing comparisons, the young carers made themselves feel “exceptional” (p. 151) in order to generate meaning and see benefit in the light of bad experiences. The friends in Studies Two and Three similarly marked themselves as different, but instead of using youth they used constructions of friends, and expectations of what friends should do. In doing so, this thesis demonstrates that, when faced with a difficult situation that transgresses expectations, people will favourably compare themselves to similar others to show difference.

Similarly, research conducted by Watson and Fox (2011) showed that young carers would draw on constructs of youth as a way to “opt-out” of caring (p. 31), meaning that through reiterating their child-status they could legitimately decrease the level of care they provided. Youth played a more complex role for the friends in Studies Two and Three. It was used to firstly accentuate the difficulties they faced in providing support, and then to remove themselves from blame. The friends who did refer to their relative youth tended to do so when they were critiquing the behaviour of others whom they felt should have taken responsibility for the self-harmer’s wellbeing. Thus the friends present themselves as passive actors, ones who should not have been caring, and only supported the self-harmer because of the failings of others. In drawing on concepts of youth, the friends presented themselves as the vulnerable party, and the ones who took on responsibility for the self-harmer when they perceived other, more appropriate others, failed to do so. Furthermore, in accentuating their ‘youth’ status they
are removing themselves from blame, a child cannot be held responsible for another person’s welfare.

In addition to youth, the friends, particularly in Study Three drew on constructions of family and caregivers to explain their experiences, and convey the extra responsibilities that they had taken on. In doing so, it was evident that the friends acknowledged that they were doing something other than being a friend; they were taking on responsibilities that are more akin to either a family member or a professional caregiver. In looking to the young carer literature, Smyth et al. (2011) found that young carers reported feeling better able to cope with their extra responsibilities, and make sense of their experiences once they were made aware of the young carer identity. Indeed, Salgado and Hermans (2005) argued that alongside each social role comes a set of behavioural expectations and linguistic repertoires that can be used to make sense of experience. Through using alternative social constructions, particularly those that included an element of care, the friends used these to try to understand their behaviour and experiences.

Understanding the friends’ position as a carer was also raised in Study One by the counsellors, who felt that the friends were taking on responsibilities more akin to a parental role. Through using alternative social constructions to understand the friends’ behaviour by both the friends and the counsellors, it is clear that a concrete understanding of a friend-carer is lacking. Unlike young carers, who have a social identity to explain behaviour, and a framework through which experiences can be understood, the friend-carer identity is lacking and as such no lens exists through which to explain behaviour and experiences. Without this guide, it is evident that the friends who provide care reside in an intersection of constructions; friend, youth, family, and caregivers. Salgado and Hermans (2005) proposed that when a person’s self-narrative, or understanding of themselves, is threatened they struggle to make sense of their experiences and as such look elsewhere for social roles and constructions that appropriately communicates something about themselves or the position they hold in relation to others. In the absence of a concrete identity, the friends are therefore left to scabble at what social roles they are able to access. The understandings around the friend-carer, therefore, become a patchwork of different available constructions used in order to help the friends and counsellors explain or understand the extra responsibilities that the friends had taken on. What this thesis adds to this area is that the role of friend-carer needs to take more of a place within research. It is evident that the friends are doing something unusual, and something considered to sit outside of the remits of normal friendship. With there being no other direct frame of reference, however, their actions are understood through available societal frameworks.
8.4.3. Unique people

In coming to make sense of their experiences, the friends tried to understand why they had been chosen above others. The friends in Study Two, felt that they had been selected because they were the self-harmers’ best friend. The friends in Study Three, however, felt that they were chosen by the self-harmer because they would react in a better way. Thus, the friends identified themselves as the chosen ones, those most appropriate people to provide care to the self-harmer.

This special status was reinforced by being included in the self-harmers’ secrets. For the friends, being trusted with secrets by the self-harmer was indicative of being special, as it meant they held a unique position with the self-harmer. Looking at how secrets were used in the young carer literature, it is evident that they were largely considered necessary to protect the family member they were caring for (e.g. Bolas et al., 2007). This is similarly identified in the accounts of the friends in my research who talked about not wanting to tell others for fear of losing the friendship, and protecting them from the judgement or interference of others.

Unlike the young carers, however, the friends in Studies Two and Three also seemed to use secrets as social markers; secrets both established, and maintained their special role. This was particularly evident when the self-harmer told others about the self-harm, and the friends would denigrate both the self-harmer, and those they told. Thus suggesting that secrets were a powerful social factor in how the friends negotiated their position, and understood their own experiences. Indeed, it has been evidenced elsewhere that secret-keeping can be used in order to maintain a personal sense of power (Kelly & McKillop, 1996).Thus, when the self-harmers included the friends in their secrets, the friends felt like a person of special and trusted significance.

As the friends struggled to make sense of their experiences and invested a lot in the development of a coherent self-narrative, they also began to differentiate their role through making comparisons with others. Doing so allowed the friends to demonstrate the special status that they held. A particular focus of the comparisons were the other friends and family members of the self-harmers. The young carer literature has looked at how young carers compare themselves to the generic “other”, in this case, other young people. Watson and Fox (2014) found that young carers would often discuss other young people as being “immature” (p. 30), and themselves as mature. They argued that in presenting similar others negatively, the young carers are able to positively present themselves as being different. Similarly to the carers in Smyth et al.’s (2011) study, the friends in Studies Two and Three used comparisons to reinforce their position as being better friend and carer. Unlike the carers in Smyth et al.’s
(2011) study, however, the friends in this thesis made comparisons within a complex network of relationships, and compared themselves to known others, specifically targeting the self-harmers other friends and family, those who could be threats to their position.

Seeking to explain this, in their discussion paper, Harré and Slocum (2003, p. 109) theorised that people engage in "strategic positioning", meaning that through unfavourably presenting someone else, an individual maintains their superior position. Through denigrating known others, such as friends and family, the friends in this thesis were able to maintain their position as the better friend and carer. By reinforcing their position as the better friend and carer through comparisons, the friends were able to maintain a consistent self-narrative that they were special; they held a unique bond, and status with the self-harmer that rose above all others. Therefore, comparisons held a dual purpose for the friends, not only did it identify them as being different, and unique, but it also established them as being superior to others.

8.5. How do the friends make sense of the impact of self-harm on their friendship?

As established by the first research question, it was evident that self-harm had a profound impact on the friendship between the friends and self-harmers. In this question I aimed to explore how the friends talked about their friendship with the self-harmer, and made sense of the relational changes across the course of their friendships. This question is predominantly answered by the findings from Studies Two and Three, where appropriate, findings from Study One have also been included to contextualise the findings, or to further the discussion.

8.5.1. No ordinary friendship

Once the friends were established within the caring role, the relationship between the friends and the self-harmers changed; the support they provided came to encompass their whole being with the self-harmer. A key aspect of friendship change discussed by the friends was the decline in reciprocal support, particularly for those who had taken on the majority of care for the self-harmer. As the friends were often unwilling to seek support from the self-harmer, the friends often provided unidirectional support. This appears to be a common trend in those providing support. In their study Bor et al. (2004) found that friends were more comfortable giving, rather than receiving support from the person they cared for, particularly when they felt they had been in receipt of support previously. The findings from this thesis confirm that supportive friends will avoid seeking support from the person they are caring for. Similarly to Bor et al. (2004), the friends in Studies Two and Three felt that they had been helped by the self-harmer previously, that the self-harmer would do the same for them if the situation was reversed, or they did not need help from the self-harmer at all.

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In becoming the friend-carer and integrating care into their friendship, the friends no longer practised friendship in the same way as they did prior to the self-harm disclosure. Indeed, as stated in section 8.4.2., references to ‘normal’ friendship were used to demonstrate how the friends were taking on too much responsibility and not acting as a friend. The change in relationship demonstrated by the friends in this thesis has also been identified in other supportive friendship literature. For example, Hill et al. (1998), who looked at the experiences of friends and relatives caring for someone with bipolar disorder, stated; "caring was not simply an activity, but a relationship" (p. 618). Thus, when the practices of a friendship changed for the friends, such as taking on excessive support for a friend, the relationships changed also.

As a means of explanation, social constructionism theorise that friendships are active social structures that are co-operatively constructed between individuals (Green & Singleton, 2009), have a set of practices, expectations, and behaviours (Digester, 2013), and are developed through experiential and societal knowledge (Digester, 2013). As the friendships are active, the friends are engaged in the practices and rituals of being a friend, meaning that people “do” friendship (Green, 1998, p. 179). Approaching the studies from a social constructionism, it is clear that the friends began to do friendship differently once they began to care for the self-harmer; the friends no longer practised friendship as a friend, but rather as a friend-carer. Thus, the qualities that made the friendship identifiable as a friendship faded, and became confused with those of a carer.

**8.5.2. Special bond: secrets**

As established previously, the friends used secrets to establish their status, and maintain a coherent self-narrative. Secrets, however, were also used as a tool to demonstrate their special relationship with the self-harmer. Secrets were used as social currency. In keeping secrets, the friends, particularly in Study Three, felt that they were closer to the self-harmer, and used secrets as a means by which to distinguish their friendship as special. In other words, the act of secret-keeping and secret-sharing were important to how the friends came to understand their relationship with the self-harmer.

In trying to explain this, Merten (1999) explored how junior high school girls were “enculturated” (p. 108) into secrecy. What Merten means here is that people learn how to use secrets and understand the social power of them through socialisation. He argued that secrets are powerful social tools that are used by people to gain status, power, and solidify and advance friendships. In some cases, the secrets were used as “social currency” (p. 132), whereby people would use the secrets of previous friends to win favour with a new friend. Indeed, in secret-
sharing, Merten argued, friends were able to create a “reality of trust” (p. 132), wherein the disclosure of secrets acted as a way to formalise and solidify their friendship.

Although this research outlines the social rewards of secret-sharing, for the friends in this thesis the act of secret-keeping also played an important role. Looking at secret-keeping, it is evident that power is negotiated through secret-keeping; keeping secrets can be used in order to maintain relational power structures (Brown-Smith, 1998; Vrij, Paterson, Nunkoosing, Soukara & Oosterwegel, 2005). Thus, when the self-harmers included the friends in their secrets, the friends felt a sense of inclusion, and social power.

This special relationship, established through secret-keeping, however, was questioned by the counsellors. The counsellors reported that they suspected that they had supported multiple students who they felt had sought support individually about the same self-harm. These students had been under the impression that they were the only person to know about the self-harm, and they felt obligated not to tell anyone else. Consequently, when the self-harmer began to disclose the self-harm to others, the friends felt that the self-harmer had transgressed expectations of secrecy, and as such they inadvertently threatened the special relationship held between themselves and the friends. When the self-harmer transgressed the perceived secrecy that the friends had about the self-harm, the friends felt distanced from the self-harmer and began to denigrate those that the self-harmer had told. Indeed, other friends were constructed as being bad friends or bad influences. The finding that the friends were unhappy with the disclosure of the self-harm stands in contrast to much of the literature surrounding friendships and secrets. There is a general consensus that friends feel betrayed when their secret had been told. For example, in her ethnographic research on the friendship practices of working-class girls, Griffiths (1995) found that secrecy was incredibly important, and sharing these secrets with others was the ultimate act of betrayal. What seemed to be happening with the friends in this thesis was that the secrets became part an integral aspect of the bond binding them to the self-harmer. Thus disclosure by the self-harmer threatened their bond. This reflects the research of Merton (1999) who suggested that secrets held a functional role in friendships and became entwined in the friendship itself. In an attempt to reinstate their special relationship with the self-harmer, the friends began to denigrate those that the self-harmer had told. As a consequence of feeling betrayed the friends then looked to critique others, including the self-harmer, as a way to psychologically preserve their role.

The results from Study Three, however, further complicate the role that secrets play for the friends. In the focus groups the friends sometimes considered the inclusion of other friends in the self-harmer’s secret as an opportunity to reduce the burden of care. The friends, however,
often perceived the other friends as avoiding care provision, and instead distanced themselves from the self-harmer. In these situations, the friends begrudged the other friends for not supporting the self-harmer to the same extent that they had. This was particularly evident in friendships which were presented as being smaller, and closer-knit. For the friends, the avoidance by the other friends was considered to be a missed opportunity to decrease the amount of support they were providing, without withdrawing support altogether.

The discrepancy between the friends in Studies Two and Three could be explained by the wish to change the situation. The friends in Study Three may have been looking for opportunities to reduce the burden of care, and as such the other friends provided an, albeit false, opportunity to decrease their level of involvement with the self-harmer. Consequently, other friends, who were seen as threats by the friends in Study Two and negatively constructed, were seen by the friends in Study Three as missed opportunities who refused to take on the level of responsibility that they should have taken on. These findings highlight an important educational message for the friends. Those who did turn to each other seemed to benefit from the additional support available. Many of the friends, however felt that they could not, or should not, seek support from friendship groups, or other friends. In not using these social networks, the friends are closing off possibly routes of support.

Drawing all of the studies together it is clear that friendships, and bonds are established, maintained, and damaged through secret-keeping and secret-sharing. Although it is evident that secrets play an important social function in the negotiation of social roles, what is less clear is a consistent understanding of how friends cope with the secret-sharing of the self-harmer. The counsellors were under the impression that many friends were being told about the self-harm whilst also being told to keep it a secret from others. Some friends felt that the secrets made them closer and disclosure by the self-harmer threatened their special bond, other friends felt that the self-harmers secret-sharing was an opportunity to get additional support, support that rarely materialised.

8.5.3. Deterioration

Due to the retrospective nature of Study Two, and the focus on the life course of the friendship, how the friends constructed their friendship deterioration has mainly been drawn from the findings of Study Two. In discussing the deterioration of the friendship with the self-harmers, the friends made efforts to distance themselves from the blame of causing the deterioration; they constructed their role in the deterioration in one of three ways. Either the friends talked about their friendships deteriorating because they grew apart, with the inference that growing apart was a natural part of friendship.
Alternatively, the friends felt that the self-harmer would find other friends who would either support the self-harm behaviour, or would take over the responsibility of care. As has been demonstrated elsewhere, particularly developmental research, potential rivals to the attention of a friend can lead to distancing and friendship deterioration (Parker, Kruse & Akins, 2010). In looking at how the friends in Study Two talk about the role of others, it is clear that with the self-harmer having other friends who were willing to take on the role of carer, the friends felt obsolete, and removed from not only their role, but also the friendship.

In both of these situations, the friends identified the transitions in education as being key factors, such as the move to, or away from University. This confirms research identifying times of transition, such as those like the transition in to, and out of, University act as a prime situation for friendships to deteriorate (Oswald & Clark, 2003). Transitions such as this have been attributed to the decline in friendship due to geographical distance (Feld & Carter, 1998), differences in interests (Oswald & Clark, 2003), and the making of new friendships (Buote et al., 2007).

Finally, some friends reported that the self-harmers had stopped self-harming. In these situations the role of carer was no longer necessary, and friends seemed to struggle to be able to make the transition back to being a friend without the element of responsibility. Considered together, the findings from this thesis relating to friendship deterioration lend support to the theoretical understanding of the relational self (Gergen, 2009a), in that through the friends changing their role within the friendship, and becoming a carer to the self-harmer they are constructing an alternative sense of self. The self that the friends constructed was that of someone who provided support without expectation of reciprocation, they became friend-carers. Thus, when the factors that lead to that type of relationship were no longer there (i.e. someone else began caring for the self-harmer, self-harm was no longer an issue, or they were not close enough to continue the same level of care), their role was no longer necessary and the relationship they held deteriorated. Suggesting that, for those friends who completely shifted their role to that of carer, they were unable to reassert the friendship that they had held previously, and their role as friend. Indicating that for some of the friends, through changing their role was irreversible.

8.6. Contributions to knowledge

My studies have increased awareness of the previously unheard voices of the friends of self-harmers, and how they come to understand themselves within this new relational context. Additionally, I have also produced a prototype support tool for the friends of self-harmers, co-created with friends and support providers.
Prior to this research, friends had been established as a marginal group within self-harm research. Friends only became the focus of research if either they went on to self-harm themselves, or if they could tell researchers or clinicians about the life of the self-harmer. Indeed, previous research has established friends as either being triggers to self-harm episodes (e.g. McMahon et al., 2010), sources of support (e.g. Evans et al., 2005) and as such are identified as being useful in the therapeutic support of self-harmers (e.g. Klingman & Hochdorf, 1993). Their experiences are only listened to when they go on to self-harm themselves (e.g. Hawton et al., 2003).

This suggests that for too long the friends have been placed on the periphery of self-harm research. Thus an understanding of how the friends cope is lacking. This is particularly concerning as they are often the main source of support to self-harmers (e.g. Evans et al., 2005), and having a friend who self-harms is the biggest short and long term predictor of own self-harm (e.g. Hawton et al., 2003). This thesis has addressed the current lack of the friend’s voice in self-harm research by placing them at the forefront of the research. Through using a range of perspectives, and methods I have built up a layered understanding of how self-harm in friendship is made sense of, and how the friends’ negotiation of roles and responsibilities is comprehended, understood, and explained. In particular it has highlighted that friends are taking on responsibilities that lie outside of their role as friend, and in attempting to make sense of their actions, the friends and counsellors draw on a range of social identities. What resulted was a patchwork identity, one arising from the selective use of available social roles. Reflected in the young carer literature, the focus on identity construction as a by-product of supporting a self-harmer is an important finding as it tells us more about how the friends are coping with their experiences. Through firstly identifying their behaviour as being something that falls outside of ‘normal’ expectations of friendship, and then drawing on alternative identities to help them make sense of their experiences, the friends demonstrate that they are doing something different to simply supporting a friend.

Furthermore, my findings have highlighted the difficulties that friends face in seeking help in three key areas: barriers to help-seeking, what sparks help-seeking, and the paradoxical relationship held between help-seeking and struggling to cope. The friends, and counsellors in this thesis felt that the main barrier to friends seeking help both for themselves, and for their friend was the potential risk this posed to their friendship. Previous research looking at why people fail to seek support has identified that people may feel that they can cope with providing support because of similar prior experience (e.g. Dunham, 2004), or because they felt that the support would not be useful (e.g. Bor et al., 2004). My findings, however, suggest that the main
barrier was potential for friendship-loss. Thus, the loss of relationship is a key barrier that has currently not been considered within the friend support literature.

When the friends did decide to seek help, it was often at a point of crisis, the counsellors identified that this was often around the exam period, or when students had other external constraints on their time. In these cases the self-harm had become too much to manage alone. When the friends did seek help, they considered it to be in the best interests of the self-harmer (rather than for themselves). Alternatively, the friends, in concordance with the counsellor’s accounts, sought help when they felt overwhelmed with external pressures and were unable to provide support to the self-harmer. Looking at how the friends framed their help-seeking it was evident that they were uncomfortable seeking support, particularly for themselves.

Although the friends postponed seeking support and struggled as a result, when asked about advice they would give to others in their situation, they all recommended seeking help. The conflictual relationship the friends held between their behaviour and their recommended course of action for others has been found by others. Fortune et al. (2008), in their study looking at how adolescents felt self-harm could be prevented, found that often the young people would know that seeking support was beneficial, yet were unwilling to do so because of fears of stigma, or lack of confidentiality. Further, research has also suggested that young people felt that seeking support from older adults would be unhelpful (Berger et al., 2013). The accounts of the friends in Studies One and Two go to demonstrate that the help-seeking around self-harm is a complex, and confusing act for young people to do. In seeking out support, even for themselves, they risked losing the friendship with the self-harmer by exposing their secret. This adds to the current understanding of support seeking in young people, particularly help-seeking that includes self-harm. Indeed, many of the friends in this thesis felt that they were not entitled to seek support because it was not them who was self-harming. As a consequence of this additional complication, the friends put a lot of effort into explaining their decision to seek support. Either they framed it as being so that they could support the self-harmer, or that they themselves were struggling because of external pressures.

Much of the research surrounding friends has looked predominantly at the impact of disclosure (e.g. Ahrens and Campbell, 2000), how friends cope (e.g. Banyard et al., 2010), how comfortable friends feel in providing support hypothetical situations (e.g. Dunham, 2004), and has often included friends’ responses with the responses of family members (e.g. Bor, du Plessis & Russell, 2004). Very little research has looked at how, particularly young, people come to understand and make sense of their experiences of supporting a friend. The findings from this thesis have demonstrated that friends who provide support to self-harmers occupy a peculiar
social position, one that not only the friends struggle to understand, but also those outside of the friendship, such as counsellors, struggle to understand. In so doing the friends and counsellors drew on a range of social constructions in order to create a coherent understanding of the friends’ behaviour.

A further contribution to knowledge, and practice, is the development of the prototype support tool. Prior to this thesis, many of the support tools available to the friends were focussed on educating the friends about self-harm, and identifying ways that they could help the self-harmer. Very few of these support tools identified how the friends may be feeling, or provided advice that focussed on ensuring their wellbeing (for the full evaluation see Appendix H). From the accounts of the friends, counsellors, and support providers represented in this thesis, however, it was evident that the friends were struggling, and did want additional information and support.

When seeking to create resources, researchers have emphasised the importance of including the target population throughout the stages of development (Pipon-Young et al., 2011; Rodham et al., 2015). Thus, through a collaborative project with the friends, and support providers, a co-created support tool was developed, piloted, refined, and disseminated. Through including the friends and support providers in the decisions throughout its development, the support tool remains faithful to their understandings, and is informed through the experiences of those most affected by self-harm and friendship.

8.7. Limitations

In this thesis I used a range of data collection and analytic methods, as such there are strengths and limitations to the methodological decisions that were made. In this section I will discuss and evaluate some key methodological issues that arose including, recruitment (the use of research participation schemes), the use of quantitative criteria for assessing focus group recruitment, and the interviewing of those who have self-harmed.

8.7.1. Recruitment

Throughout this thesis I used a range of methods of recruitment, including traditional methods such as putting up posters around the university, posting online advertisements, and using professional connections. I also used the Research Participation Scheme (RPS), a modern and increasingly popular form of participant recruitment. I used the RPS alongside traditional methods in Studies Two and Three. In the development of the support tool I relied more heavily on the RPS.
In Chapter Six (Study Three) I provided a justification for using participation schemes for sensitive research. The main concern I had prior to using these systems was the ethical implications for the participants, such as the participants' right to anonymity (e.g. Leentjens & Levenson, 2013), and the possibility for participants to have been friends who may have had shared assumptions (Lewis et al., 2014), or may have affected disclosure (Kitzinger & Barbour, 1999). However, a bigger problem for me concerned participant attrition. In my studies, the highest rates of attrition, and no-shows were from the participants who had been recruited through the RPS.

The research that has explored the appropriateness of using RPS has critiqued the ethical implications of using them (e.g. Ferguson, Yonge, & Myrick, 2008), and their educational value (e.g. Moyer & Franklin, 2011). Very little attention, however, has been paid to the impact of these schemes on attrition rates. In their study, Elicker, McConnell, and Hall (2010) explored students' resistance to using RPS. Students cited timing clashes, that the available time slots did not fit in with their timetable, and a lack of motivation to participate as feeling that the research was "not worth" the credits they would be afforded (p. 185).

In terms of timing, typically qualitative researchers are flexible and arrange times for interviews and focus groups at mutually convenient times (Barbour and Kitzinger, 1999). To be advertised on the RPS, however, a time and a location had to be set prior to advertising the study. Thus, in using the RPS decisions had to be made prior to recruitment about the time and location of the focus groups, meaning that often available slots for focus groups would be empty. In order to counteract this, I included a note telling students to contact me if none of the times advertised were appropriate and I would arrange a time that was more convenient; none of the students responded to this.

Similarly to Elicker et al. (2010), the students lacked an interest in participating in the research in exchange for course credits. Further, Elicker et al. (2010) also noted that students preferred to take part in online studies due to the flexibility of being able to participate at any time; at the time there were a lot of online studies open to students which could have seen as more attractive than my study.

Although RPS appear to work well for experimental, or online studies; for sensitive face-to-face qualitative research I feel that students were 'put off', both by the time commitment and by the inflexibility this type of scheme offered them. Overall, these schemes are useful, but there are flaws in the system that disadvantage qualitative researchers who rely on face-to-face data collection methods. With the increasing reliance on these systems in Psychology Departments,
attention needs to paid to whether these schemes are always appropriate, particularly for qualitative studies that have to be more flexible, or are more likely to discuss sensitive issues.

8.7.2. Sample size

In this thesis, I conducted six interviews and fourteen focus groups across Studies One to Three, and the development of the support tool, justifications for each of these can be found at the beginning of each study.

In qualitative research, sample size has been a focus of criticism, and debate; whether more data is better, or whether more data makes a project unwieldy (Sandelowski, 1995). It is left to qualitative researchers to decide how much data is needed. In trying to decide the appropriate sample size, Morse (2000) identified several influential factors, concluding that:

“The number of participants required in a study is one area in which it is clear that too many factors are involved and conditions of each study vary too greatly to produce tight recommendations. We must spend as much time considering why we make certain decisions about our methods as we do about our analysis per se.” (Morse, 2000, p. 5)

The difficult decision, outlined by Morse above, was further compounded in this thesis by the multi-method, and multi-analytic design. Due to the exploratory nature of this research I wanted to make research-informed decisions about the subsequent stages of this thesis. Ensuring the quality of the findings, meant that the level of analysis, the scope of the research question, and the quality of the data were at the forefront of my methodological decisions.

Throughout this thesis, decisions regarding sample size have been explained (Sections 4.3.2., 5.2.2., and 6.3.2.), all had comparable sample sizes to similar research (e.g. Wilstrand et al., 2007), were adequate in answering the research questions, and were appropriate considering the practical limitations, such as attrition rates and reduced participant pools. Through conducting research in an under-researched area I made decisions about sample size that were appropriate to the type of information I was seeking to gather, using specific data collection methods and analyses. In placing importance on the requirements of the research question, the participants, and the quality of the data, I used sample sizes that were appropriate for the purpose, and methods for each study, and produced a sufficient amount of data to answer the research questions.

8.7.3. Self-harmer or friend

As self-harm in a friend is the biggest short and long term predictor of own self-harm (e.g. DeLeo & Heller, 2004), there was always a possibility of interviewing people who had
themselves engaged in self-harm. Further, due to the taboo status of self-harm within society (Adams et al., 2005), those who had participated and self-harmed may have not felt comfortable in revealing their previous self-harm.

In recruiting for this Studies Two, Three, and the support tool development, I made it clear to potential participants that I was aiming to recruit the friends of self-harmers. I framed the research in terms of exploring the experiences of being a friend, and not the experiences of being a self-harmer. Although the focus was on their experiences as friends, there were some participants who talked about their own self-harm behaviour. They discussed this in three key ways, either they "had a go" at self-harm to see if it worked for them, they self-harmed because they felt unable to cope with the self-harm of their friend, or they self-harmed to show the person how "silly" it was.

Although including those who had previously self-harmed may have affected the data, in deliberately removing them, I would have intentionally ignored some of the key experiences of being a friend to a self-harmer. Additionally, due to the stigma attached to self-harm (Adams et al., 2005), the friends may not have been willing to disclose their self-harm, and I may never have been able to remove them.

Through including the friends who have self-harmed within this thesis it has been interesting to see how they constructed their own self-harm, and presents an opportunity for further research to explore how young construct their own self-harm in comparison to how they construct, and make sense of their friends self-harm. Thus, rather than the inclusion of those who self-harmed being a detriment to the thesis, I feel that it has enriched it. Not only does it reflect the landscape of self-harm for young people, it also confirms research demonstrating the clear influence friends have over personal self-harm, and how important it is to address the needs of this population.

8.8. Reflections

This thesis has also highlighted the importance of paying attention to those "on the ground". This thesis highlights the need to listen to those who are involved with self-harm on a daily basis with particular focus on how this information can shape definitions.

8.8.1. Importance of grass-roots knowledge

In talking with the friends and support providers, it was clear that the term self-harmer held a controversial space within research and practice. Those who provided professional support to those who self-harm were uncomfortable using the term, and often preferred to call them "a
person who self-harms”. The friends, however, used the term self-harmer, and felt at ease calling their friend a self-harmer.

There has been a movement towards a person first approach, as advocated by Braun and Clarke (2013), who suggested that researchers avoid incorporating a mental or physical health status into the identity of a person. A full discussion of this can be seen in Chapter One. What was interesting was that the friends of self-harmers were happy to refer to them as self-harmers. This mismatch between the terminology that the literature suggests is appropriate, and the terminology that the friends used, created a challenge for me as a researcher. In particular, it was difficult to consolidate the person-first argument (Braun & Clarke, 2013), with the commitment to using the language and terminology of the participants (e.g. Rodham et al., 2013).

In-keeping with my commitment to staying close to the language of my participants I made the decision to use the term self-harmer in the write-up of this thesis. I did so with the full understanding of the implications this may have for those who do self-harm. Furthermore, I made efforts not to use this phrase whilst conducting the studies, therefore, it was all the more interesting to hear my participants freely use the term.

Throughout this research, it was also clear that how the participants conceptualised self-harm lay in stark contrast to the clinically accepted categorisation. As identified in Chapter One, there has been controversy concerning the type of behaviours that are identified as being self-harm. The current clinical definition outlined in the DSM conceptualises self-harm as Non-Suicidal Self-Injury (NSSI), an intentional self-inflicted injury towards the surface of the skin that falls outside of socially sanctioned behaviour (APA, 2013). This definition has been criticised for being too narrow in focus, and ignoring other types of self-harm behaviour (Kapur et al., 2013). Similarly, the evidence from the studies in this thesis indicates that self-harm is done both directly and indirectly, and using a range of techniques. For example, some participants talked about the banging of the ankles, turning the heating off, and the misuse of alcohol, to name but a few. The clinical definition of self-harm would not include behaviours such as turning the heating off, or misusing alcohol as there was no intentional damage caused to the surface of the skin (APA, 2013).

Gender is a particularly good example of where this classificatory structure falls down. It has often been demonstrated in research that females are more likely to self-harm than males (e.g. Hawton et al., 2002). These results, however, are often based on definitions of self-harm that are positioned more in-line with self-harm behaviours that are more likely to be used by females, such as cutting (e.g. Laye-Gindhu and Schonert-Reichl, 2005). There has been a shift
within the research that demonstrates that males are more likely to use more externally focussed forms of self-injury, such as punching, or putting themselves in risky situations, which are not included in more traditional definitions of self-harm (e.g. Taylor, 2003). Consequently, in confining the definition of self-harm to the restrictive definition of damage to the "surface of the skin", the experiences and struggles of those who self-harm using different methods are ignored.

This research highlights the need to listen to those who are in the midst of supporting self-harmers. In looking at the classificatory parameters set by the APA, self-harm behaviours such as ingestion, overdose, self-poisoning, drug and alcohol misuse, under and over eating, and deliberate self-neglect would not be included. The movement towards a classification structure that systematically ignores much of the range of self-harm behaviours described by those self-harming or those supporting self-harmers, means that many people may not be getting the support they need.

8.8.2. The particularities of self-harm

Self-harm is one of a number of mental health vulnerabilities that affect young people such as drug and alcohol misuse (Foxcroft & Tsertsvadze, 2012), eating disorders (Belfer, 2008), and depression (Merry et al., 2012). It has been found to co-occur with these and other issues (Welch & Fairburn, 1996). There is evidence to suggest similarities between these issues, such as secrecy in eating disorders (Reslan & Suales, 2011), self-esteem in drug misuse (Ball, Carroll, Canning-Ball, & Rounsaville, 2006), and lack of perceived control in depression (Emslie, Ridge, Ziebland, & Hunt, 2006), to name but a few. There are, however, specific aspects about self-harm that distinguish it; its links to suicide, its often visual event-based nature, and its association with attention-seeking.

Self-harm has been more strongly associated with suicide than many other vulnerabilities (Hawton et al., 2003). Although research (e.g. Harris, 2000), and current clinical guidelines (APA, 2013) suggest that suicide is not a motivation to self-harm, community research still suggests a lay understanding of self-harm as a suicidal behaviour (Klineberg, Kelly, Stansfeld, & Bhui, 2013). Although the friends never explicitly stated a fear of suicide, they did fear "escalation", or the self-harm "getting worse", and discussed the resultant pressure they felt to keep the self-harmers secrets. With self-harm holding a complex and unclear relationship with suicide, the responsibility felt by the friends was compounded. Either they risked losing the friendship, and leaving the self-harmer without any support, or they continued to support whilst the behaviour escalated.
Unlike other mental health vulnerabilities, self-harm has the potential to be immediately visual. Indeed, those who cut or burn can create an instantly visible injury (Laye-Gindhu & Schonert-Reichl, 2005), whilst those who overdose or ingest poison are likely to seek medical intervention (Berger et al., 2013). Indeed, the accounts in this thesis suggest that friends were aware of when their friends would self-harm. They were involved in their friends wound management, cleaning up after self-harm episodes, and following ambulances.

Lastly, self-harm holds a precarious position in that it can be perceived as a form of attention-seeking behaviour. In community studies, young people have associated self-harm with a form of attention-seeking (Klineberg et al., 2013), and conceptualised ‘authentic self-harmers’ as those who self-harm in private and attempt to keep the behaviour hidden (Scourfield, Roen & McDermott, 2011). Reflecting this sentiment, the perceived secrecy of the self-harm was important in how the friends understood the self-harmers behaviour. Indeed, more support was offered to self-harmers who were perceived to be doing it for "real reasons" (e.g. body issues). Support and friendship were also withdrawn when self-harmers began to share more with others, or were open about their self-harming, particularly to people that the friends felt were not interested in the welfare of the self-harmers.

8.8.3. Theoretical evaluation

I approached this thesis from an ontologically relativist perspective and an epistemologically social constructionist perspective. Doing so proved successful in exploring how friends came to understand supporting a self-harer.

In using relativism as an ontological framework for this thesis I was able to engage more with the culturally and historically mediated accounts of my participants (Krausz, 2010), and treated them as accounts of meaning-making, rather than accounts of one tangible, and accessible truth (Harré & Krausz, 1996). Using this perspective I did acknowledge that there was a social object for the participants; for the friends this was the friendship they had with the self-harer, for the support providers, it was the interactions they held with their clients. How these social relationships were understood, however, was formulated through the participants’ cultural and experiential frameworks (Krausz, 2010). I was interested, not in identifying a true and universal account of supporting a self-harming friend, but rather in finding out what this supportive relationship meant for the friends, and their relationships. Thus, using a relativist approach was advantageous for exploring how they came to understand their experiences.
Through using social constructionism as an epistemological framework, I was well placed to explore how participants understood both their experiences and themselves within socially produced understandings (Gergen, 2003). One of the key results of this thesis was the identification of friends adopting roles, and coming to understand their position within their friendship as being a socially situated activity. Without taking a socially constructionist approach, these findings may have gone unaccounted for. I was able to give precedence to the cultural and linguistic practices that the participants drew on in order to make sense of their experiences (Shotter, 1997).

As friends had been an under-researched group within self-harm research, and only considered in light of the stories of self-harmers, they had been conceptualised as an ancillary group, a category of individuals only made meaningful when they could provide information about the self-harmer. In taking a sceptical approach to how understanding is developed (Martin, 2003), I was able to consider some of the tacit knowledge that young people may draw upon when supporting a self-harming friend. This demonstrates that the friends struggle to consolidate their acts and experiences with their cultural understanding of what being a friend is, as such they draw on constructions of those who provide care to young person, such as family and counsellors.

In summary, this thesis holds a unique position in self-harm research. Prior research that has considered the friends has focussed on them solely as secondary to the self-harmers. In focussing on their experiences and placing them as the focus, I have shone, an otherwise dim light on those who are indirectly affected by self-harm. It is important to note the value of this thesis in the movement away from a positivist understanding of friends and self-harm, and the focus on making their meaning-making the focal point of research.

8.8.4. Multiple methods: Multiple voices

Using multiple methods was appropriate to answer the research question about how the impact of self-harm on friendship is understood. Through using a multiple qualitative methods design I was able to explore a range of perspectives, knowledge, and insights, and to build up a layered understanding of self-harm (Lambert & Loiselle, 2008). In using multiple methods, as opposed to mixed methods, I was also able to conduct independent studies, and assign equal significance and weighting to each of the studies, without reifying one data collection method, one perspective, or one analysis (Morse, 2012). Although using multiple methods allowed me the opportunity to take a flexible approach to study self-harm and friendship, and to explore different types of knowledge, insight, and perspectives, it also was a challenging enterprise.
In ensuring that the findings were able to be integrated, I not only had to ensure epistemological and ontological consistency, but also ensure that I could draw the findings from different data collection and analytic strategies together. For instance, I combined focus groups analysed with Thematic Analysis with interviews analysed with IPA. In using Thematically Analysed focus groups I was exploring consensual knowledge, and looking for broader patterns in people’s understandings (Barbour, 2007). In using interviews analysed with the tools of IPA, however, I was looking to explore, and explain the individual experiences, and sense-making of friends (DiCicco-Bloom & Crabtree, 2006). Thus, in drawing the two types of insight together I had to remain mindful of the type of insight I was considering, and to ensure clarity when different methods had generated conflictual understandings. There were points at which the two approaches had cross-over, and confirmed the findings of one another, such as identifying that the friends’ role did change in the friendship. There were also instances where each method served a unique function in exploring different aspects of sense-making and understanding, such as describing and identifying the role that friends played.

A further rationale for using multiple methods was the opportunity it gave me to explore a range of perspectives. In using multiple methods I hoped to build up a layered understanding of self-harm and friendship. Researchers have advocated the integration of multiple perspectives. Very few, however, have attempted to integrate multiple perspectives that have been developed from multiple data collection methods, and forms of analysis. Indeed, much of the multiple methods research focusses on either a consistent use of one data collection method and analyses to explore multiple perspectives (e.g. Mishna, 2004), multiple analyses on the same data set (e.g. Frost et al., 2011), or multiple data collection methods on the same target population (e.g. Lambert & Loiselle, 2008). As none had used multiple data collection and analytic methods on different populations, with different research questions, I struggled to figure out how to bring all of the knowledge, insights, and understandings I had generated together in a meaningful way that told a coherent narrative whilst also remaining sensitive to the type of data I had. The articles about conducting meta-synthesis lent itself well to addressing the problem of different research questions, different data collection methods, and different analyses, as researchers had detailed how they had synthesised the findings from multiple studies that all had different research questions, used different data collection methods, and analytic strategies. In using this approach I was able to systematically draw the findings of the studies together to tell the overall story of self-harm and friendship using an innovative technique.

In reflecting on my experiences of using qualitative multiple methods, it is clear that using multiple methods provided me with the opportunity to explore different types of
understanding, from different populations, and to different extents. It gave me the opportunity to consistently reflect on the results and to refine the focus of the next study. Each study illuminated the results from the other studies, and consequently developed a multifaceted, and diverse insight into the impact of self-harm on friendship. Although challenging both theoretically, and practically, without the range of methods I would not have had the opportunity to engage with the phenomenon as I had in this thesis.

8.8.5. Using positioning theory

In Studies Two and Three, positioning theory was used as an analytic tool to assist in the interpretation of the friends’ experiences and understandings. Positioning theory asserts that people interactively construct social roles (Harré & van Langenhove, 2008) that are flexible (Jones, 2006), and have their own associated responsibilities and expectations (Harré & Slocum, 2003). Through using positioning theory I was able to engage more in the mediated and co-operatively constructed understandings that the friends had of themselves, the self-harmer, and others around them. One of the key findings of this thesis was the identification that friends assimilated themselves in a range of social roles, and used these as frameworks to make sense of their experiences. These roles were also applied to the self-harmers, friends, and family members. By way of an example, through comparing and equating themselves to the self-harmers’ family members, the friends positioned themselves in a caregiving role. Doing so surreptitiously and “strategically positioned” themselves above others as the closest, and most selfless person to the self-harmer (Harré & Slocum, 2003, p. 109). In using positioning theory, the relational sense-making of the friends’ experiences that came to shape how the friends understood others, themselves, and themselves in relation to others were able to be identified.

Although positioning theory has commonly been used in combination with a discursive approach (Harré, Moghaddam, Cairnie, Rothbart & Sabat, 2009), it has also been used in IPA studies (e.g. Emiliussen & Wagoner, 2013). Indeed, in their exploration of masculinity and health behaviours, De Visser and Smith (2006) wove positioning theory into their IPA in order to further explain how a participant positioned himself in relation to discourses of masculinity. Through using positioning theory alongside IPA they were able to explore the meaning behind his comparisons with different types of masculinities, and the men that embodied them. De Visser and Smith’s (2006) study demonstrated the importance of blending theory and methodology to explore in more depth how individuals construct understandings, and make sense of experiences. In Studies Two and Three, positioning theory was used as an interpretive tool. It was particularly useful in explaining how the friends made sense of their position, and friendship with the self-harmer in relation to others.
8.8.6. Co-creating a support tool

Whilst looking at what the friends had available to them at the start of this thesis, it was evident that much of the information was focussed on the self-harer, with little to no consideration of the experiences of the friends. When the friends’ experiences were mentioned, it was often fleeting and they were normally directed to a series of support services (a fuller evaluation of this can be seen in Appendix H). The dearth of support specifically for the friends, coupled with the advocating of co-created leaflets with the target population (Rodham et al., 2015), it was decided to create a support tool tailored to the needs of the friends.

In setting out to co-create the support tool, I underestimated the amount of effort required to develop a co-created output. In order to ensure that I was creating something that was informed by the stories of the friends, I conducted a series of focus groups at two different stages. To make sure that the content was suitable, and to get an insight into what advice would be appropriate for the friends, I also conducted focus groups with the support providers. Both populations were incredibly informative; they were willing to share experiences, understandings, and advice readily. However, in running focus groups with the friends there was a consistent difficulty in retaining participants; many focus groups were conducted with smaller numbers because of having participant attrition. Although the participant numbers in some of the focus groups were small by comparison to other focus groups (Kitzinger & Barbour, 1999), the quality of discussion in these focus groups was not hindered by the small number.

Although, there were difficulties in the implementation of focus groups, the overall experience was incredibly rewarding. One of the most rewarding aspects of the project was the positive feedback from those involved. In a follow-up, one organisation stated;

"Taking part in this project was a really valuable exercise for our organisation - it gave us a chance to share our expertise and spend time thinking about new areas and other aspects of our work. The process was very relaxed and informal and it was helpful that the researcher came to us and understood our work."

As a consequence of their involvement with the creation of the support tool, I turned the tool into a pdf, and it has now been made available to their users through their website. Additionally, I was also invited to talk on a community radio show that featured local research being conducted on healthcare issues. Through this project, the importance of conducting collaborative research with those experiencing the topic of study has shone through.
drawing on the expertise of both the friends, support providers, and experts in the field, I feel that the support tool reflects well the “voices” of those involved (Rodham et al., 2015).

8.9. Directions for Future Research

Whilst providing a preliminary insight into the impact of self-harm on friendship, this thesis has also raised questions for the presence of friendship in self-harm research, to explore how (if at all) the friend-carer identity manifests in other supportive friendships, and options for the development of the support tool developed in Study Four. These will be discussed in turn.

8.9.1. Friends and self-harm: what is left to know?

This thesis has provided an insight into the impact of self-harm on friendship, and has shone a light on how friends, and those who support them make sense of this impact. However, it has also raised a lot of questions. In particular, secrets played a multifaceted role in the friends and counsellors’ understandings. Across all studies there was an agreement that secrecy was integral to how the friends understood their place within the friendship, and bound them to keeping secrets despite the harmful impact they had on the friends’ ability to cope. How the participants in each of the studies understood this, however, differed. The complicated role that secrets play in friendships has been well documented, particularly from a gendered perspective (Griffiths, 1995; Hey, 1997; Merton, 1999). However, this thesis highlights that secrets can, to some extent, bind the friends together, and establish roles both in relation to the self-harmer, and those around them. As self-harm is considered to be a taboo subject (Adams et al., 2005), it often has an added shroud of secrecy (McAllister, 2003). Thus, the role that secrets play for the friends seems to be exaggerated by the need to keep the self-harm a secret because of its personal, and potentially stigmatising nature. In order to develop a better understanding of how friends negotiate their friendships with a self-harmer, more attention needs to be paid to building up a more comprehensive map about the place, and role of secrets in supportive friendships.

8.9.2. The friend-carer

This research has highlighted that friends who take on a supportive role to a self-harmer struggle, and take on responsibilities that lie outside that of ‘normal’ friendship. In light of the lack of a concrete social identity that supportive friends could occupy, the friends, and those who support them attempted to make sense of their actions through a range of socially constructed roles. As self-harm features amongst many issues currently facing young people, including eating disorders (Belfer, 2008), drug and alcohol misuse (Foxcroft & Tsertsvadze, 2012), depression (Merry et al., 2012), and social anxiety (Bessdo-Baum et al., 2012), to name
but a few, further research needs to explore how young people cope with the problems of their friends.

Furthermore, across this thesis, care within friendship held a complex role for the participants. When friends either cared too much, or too little for the self-harmer, their role as friend was questioned by both the friends and counsellors. In so doing, an ill-defined ‘golden band’ of friendship and care developed. This band characterised the idealised integration of care into the friendship, whereby care was appropriately adopted and the friendship was maintained. In looking to the accounts of the participants in this thesis it was evident that those who fell below the expectation of care were considered by the participants to not be a friend; the counsellors identified them as “housemates”, and the friends identified them as being “bad friends”. Whilst those who exceeded expectations of care were considered to be friends, but were deemed to be doing something other than friendship in practise; they were likened to “parents”, “semi-counsellors”, and “24 hour-carers”. What constituted too much, or too little care, however, was a nebulous concept that was only identified when the friends either fell below, or exceeded expectations.

In recent years there has been a rise in campaigns encouraging young people to support their friends who are experiencing mental health issues, such as ‘Mind Your Mate’ (2016) and ‘Look After Your Mate’ (Studentminds, 2011). These campaigns are primarily developed to help increase social support, and break down stigma around mental health issues, and they use friends to help achieve these aims. Whilst these campaigns have been heralded as an effective route through which to access and support individuals with mental health vulnerabilities, the accounts of the participants in this thesis demonstrate that placing friends in such a pivotal position has potential pit falls. Indeed, friends can find themselves losing friendships, gaining too much responsibility for their friend, or isolating themselves from their own support networks. Currently, friends, and the impact that caring has on them has been a neglected aspect of mental health research. Therefore, future research should look to consider the experiences of young people who support to a friend within a variety of contexts, in order to explore whether the tropes used in this thesis are used elsewhere, and to provide a better understanding of what is considered to fall within a ‘golden band’ of care and friendship.

8.9.3. Interactive platform for support

As the friends consistently felt unable to cope with their self-harming friend, a support tool was developed designed specifically for the friends of self-harmers. The focus of this tool was to provide practical and tailored support to the friends. Included in this tool was information
about what self-harm was, what the friends could do to support the self-harmer, what the friends may be experiencing, and what the friends could do to protect their own wellbeing.

Due to the lack of focus on friends in existing support tools, the support tool was particularly well placed to address the at-risk status of friends in developing personal self-harm. The final support tool created was targeted at the student population. However, as self-harm affects those of all ages there is opportunity for the tool to be redeveloped with different populations in mind.

Further, as much of help-seeking is conducted online (Buhi, Daley, Fuhrmann & Smith, 2009), there is scope for this tool to be integrated into an online presence. A similar project called self-harm: parents' experiences developed in conjunction with Health talk online has been set up by Oxford University. The website is interactive and is aimed specifically at the parents of children aged up to 25 who self-harm. The website includes information about self-harm, and ways that the parents can support their child and themselves. It also has areas set up that include videos, audio clips, and transcripts aimed to make the information more accessible. This website has been heralded as a useful tool in helping parents understand self-harm and the impact it has on them (Smith & Durman, 2009). As the internet has been identified as a good environment to disseminate information and support resources, the support tool created from this thesis would be well-situated to provide a foundation in the development of an online, and interactive resource tailored specifically to the friends.

8.9.4. Explore the needs of self-harmers and friendship

Research that has looked at friendship from the self-harmer’s perspective has largely found that friends either act as a trigger for the self-harmers in terms of friendship conflict (McMahon et al., 2010), wellbeing concerns of the friend (Madge et al., 2011), the friend self-harmers (Mars et al., 2014), or a friend has committed suicide (Fortune & Hawton, 2005). Alternatively, the friends are also used as a place of support, and help-seeking (Evans et al., 2005). All of this research provides us with an understanding of self-harm and friendship that predominantly focusses on pre-cursors to self-harm behaviour, very little research has explored what friendship means for self-harmers. If we are to gain a better understanding of how self-harm is made sense of within a friendship, and support young people who both self-harm and support a friend who self-harms, the experiences of those who self-harm need to also be considered.

8.10. Conclusion

In conclusion, it is clear that the friends who provided support were doing something other than friendship, they took on responsibilities that lay outside of what’s expected of them as
friends. In doing so, the friends also took on a new role in the friendship, and transition out of being a friend, to a friend-carer. As the friend-carer was not a socially established role, however, the friends and counsellors drew on a patchwork of constructions, including friends, caregivers and family members to try and make sense of the friends’ behaviour. In taking on this role, investing time in their identity, and attempting to maintain a consistent self-narrative, the nature of the friendships also changed. In being a carer and providing unidirectional support, the friends used secrets as a way to guard their unique role, and special bond with the self-harmer.

Through using a multiple qualitative methods design, and drawing understanding from a range of perspectives, I have been able to develop a layered understanding of the impact of self-harm on friendship (Lambert & Loiselle, 2008). In beginning to understand what young people do when faced with a self-harming friend, my research demonstrates that friends do struggle to integrate care into their social identity. The findings from this thesis, further illuminate the experiences of a population who were only considered important when they either could provide information about the self-harmer (Klingman & Hochdorf, 1993), or they themselves went onto self-harm (McMahon et al., 2010). Further, there are implications for how support is provided to the friends. This thesis has gone some way in addressing the issues of the friends through developing a support tool that was created alongside the friends, and is tailored to their needs. Most importantly, this thesis demonstrates that friends are more than just “gatekeepers” to self-harmers (Klingman & Hochdorf, 1993, p. 123), they are people of interest in their own right.
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Appendices

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Appendix A

Mind-map of generated themes in Study One
**Appendix B**

**Transcription conventions**

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>Inclusion of extra information, e.g. to clarify what was meant by 'they'</td>
</tr>
<tr>
<td></td>
<td>To correct grammatical errors in speech e.g. be[ing]</td>
</tr>
<tr>
<td>[[ ]]</td>
<td>Overlapping speech</td>
</tr>
<tr>
<td>(1.0)</td>
<td>Numbers in brackets indicate length of time of a silence in seconds</td>
</tr>
<tr>
<td>(.)</td>
<td>Pause of less than a second</td>
</tr>
<tr>
<td>Name:</td>
<td>Speaker name followed by colon indicates name of speaker when multiple participants have spoken</td>
</tr>
<tr>
<td>(Name)</td>
<td>Speaker name in brackets indicates name of speaker</td>
</tr>
<tr>
<td>( )</td>
<td>Brackets filled with descriptors about extra verbal utterances, e.g. ((giggles)).</td>
</tr>
</tbody>
</table>
Do you know a friend who has self-harmed?

Would you be willing to take part in a focus group talking about your experiences?

I am a current PhD student interested in hearing about the experiences of those who has had a friend who has self-harmed. If you know or have known someone who has self-harmed and would be interested in talking about these experiences or want more information, feel free to contact me on the address listed below.
Appendix D

**Study exploring the experiences of people who have known someone who has self-harmed**

Do you know someone who has self-harmed? Are you interested in talking about these experiences?

Hannah Heath (PhD researcher) is looking for participants for a study which aims to explore the experiences of those who have known someone who has self-harmed.

**Participate in this study**

Participants must have known someone who has self-harmed.

This study involves taking part in an interview which will be approximately 45 minutes to an hour long.

Anonymity and confidentiality is guaranteed for all participants; your name and any details specific to you will be anonymised. This research has been approved by the Department of Psychology Ethics Committee.

**Contact**

If you would like to know more about this study feel free to contact Hannah Heath on H.E.S.Heath@bath.ac.uk
Project title: An exploration into the experiences of students who have, or who have recently, had a friend who self-harmed.

What is the purpose of this study? This study aims to explore the experiences of students who have, or who have recently had a friend who has self-harmed, focusing upon the impact upon the friendship.

Who is organising the study? The present study is being run as part of a PhD project at the University of Bath by Hannah Heath and supervised by Dr. Jeffrey Gavin and Dr. Karen Rodham.

What will happen to me if I take part? This study will require you to discuss a few issues and explore your experiences of being a friend of a self-harmer. Your responses will be recorded via Dictaphone.

What are the possible risks of taking part? There are no known risks from participating in this research.

Will my taking part in the study be kept confidential? Yes. All personally identifiable information such as names or locations will be kept confidential and anonymised. Only authorised persons directly involved in this study will be able to access this information. Information from this study may be published in a journal, but you will not be identifiable in any way.
Appendix E

Who has reviewed this study? This study was reviewed by the Research Ethics Committee of the Department of Psychology at the University of Bath.

Who do I contact for more information? If you require further information, please do not hesitate to ask the researcher at any time using the details above.

Thank you for taking part in this study and supporting our research.
Example of master & sub-themes: Study Two, Katy

Defined 'role'
- Functional
- Supportive
- Unique

Superior Relationship
- Established through comparisons with...
- Self-harmer's friends
- Self-harmer's family

Process
- Vague recollections
- Denied/failed to recall
- No defining disclosure

Sense of responsibility
- Helplessness
- Ill-equipped to support

Maintained via secrecy...
- ‘Protector' from professionals
- Deterioration in closeness

Grow apart
Counsellors (Study One)

Focus Groups & Thematic Analysis: Collective understanding.

- Firstly, it was an issue.
- University is a difficult and often triggering time for young people.
- Some friends rejected the self-harmer before providing support.
- Others incrementally took on responsibility for the self-harmer.
- Those who did so were considered to be taking on a parental role, and there was a change in friendships.
- As the friends have been asked to keep the self-harm a secret, they felt burdened and unable to seek help.
- The counsellors often found it difficult to juggle the expectations of, and obligations to, multiple interested parties.

Overall, this study generated an initial understanding of what the issues were facing the friends, and friends do struggle with having a self-harming friend.

Friends (Study Two)

Interviews & IPA: In-depth experiential and individual sense-making.

- Friends took on the role of carers, both passively and actively.
- In explaining their experiences, the friends equated themselves to the family and drew comparisons between themselves, and the family and friends.
- These comparisons strengthened their status with the self-harmer.
- There was a deterioration in the friendship, either when the self-harm stopped, or when they found new friendships.
- This deterioration was always due to other factors and not the friends.

Overall, this study explored how friends made sense of providing support, and identified the process of how friends came to provide support. It highlighted that friends' roles are subject to change, how the friends navigate this, however, differs.

Friends (Study Three)

Focus groups & Thematic Analysis: Collective understanding.

- In order to understand their status as the chosen ones, the friends used secrets (sharing and keeping) as a means to solidify it.
- As they felt that they have been imbued with a sense of trust if they told the self-harmer secrets they would be breaching confidentiality of the self-harmer.
- When the friends did seek help, they considered it as necessary, other than their own self-harm (external stressors), they were in a better place to provide support if they themselves sought support, or because the self-harm had escalated.
- The friends felt that they were providing one-way support, had taken on a semi-counsellor role, and had sacrificed their own well-being.

Overall, this study explored the friends' understandings in more depth, and highlighted the important role that secrets play for the friends, and how important their role is to them.
<table>
<thead>
<tr>
<th>Support Tool</th>
<th>Information about self-harm</th>
<th>What friend can do to help</th>
<th>What friends might be experiencing</th>
<th>What they can do to help themselves</th>
<th>General Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Befrienders, “How to support someone who self-harms” (website)</td>
<td>X</td>
<td>X</td>
<td>x</td>
<td></td>
<td>The support tool was short and provided a quick overview of what self-harm was and possible motivations. There were a few suggestions for how the friends could support the self-harmer. There was one sentence on what they might be feeling. There was no suggestions for how they should support themselves</td>
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<tr>
<td>Helpguide “Cutting &amp; Self-harm: Self-injury Help, Support &amp; Treatment” (website)</td>
<td>X</td>
<td>X</td>
<td>x</td>
<td></td>
<td>The support tool was a general tool aimed for use for those who self-harm, their family, and friends. The information on it was aimed at the self-harmers and how they can help themselves. The information that was set aside for supporting the self-harmer was there for both friends and family. The information was written so that the self-harmers' wellbeing would take precedence over the friends and family e.g. &quot;Encourage your loved one to express whatever he or she is feeling, even if it's something you might be uncomfortable with.&quot; There was little mention of how the friends may be feeling, and only done so in relation to the self-harmer's wellbeing e.g. &quot;Acknowledging your feelings is an important first step toward helping your loved one.&quot; There was no information about what the friends should do to help themselves.</td>
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<td>Source</td>
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<td><strong>Harmless</strong></td>
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<td>&quot;Factsheet 2: Advice for friends and family&quot; (downloadable booklet)</td>
<td>X</td>
<td>X</td>
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<tr>
<td>The support tool provided information about self-harm. There was also information about how the friends and family could support the self-harmer. There was no reference to how the friends may be feeling or what they can do to help themselves. The friends and family were combined.</td>
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<td><strong>LifeSIGNS</strong></td>
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<tr>
<td>&quot;LifeSIGNS Self-Injury Factsheet for Friends&quot; (downloadable information sheet)</td>
<td>X</td>
<td>X</td>
<td>x</td>
<td>x</td>
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<tr>
<td>The support tool was short and provided a quick overview of what self-harm was and possible motivations. There were suggestions for how the friends could support the self-harmer. The information was written so that the self-harmers’ wellbeing would take precedence over the friends. There was one sentence on what they might be feeling. The only advice for the friends to help themselves was to seek help if they needed it.</td>
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<tr>
<td><strong>Mind</strong></td>
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<td>X</td>
<td>X</td>
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<tr>
<td>&quot;Self-harm: What can friends and family do to help?&quot; (website)</td>
<td>X</td>
<td>X</td>
<td>x</td>
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<tr>
<td>There was no information about self-harm. The support tool was short and provided suggestions for how the friends and family members could support the self-harmer. There was one sentence on what they might be feeling. There was a small section suggesting friends and family members look after themselves, set boundaries, identify other areas of support, and get support for themselves.</td>
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<td>Resource</td>
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<td>Description</td>
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<tr>
<td>Mind</td>
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<td>Comprehensive explanation of self-harm. The information specifically for the friends was also combined with the information for the family members. The content was the same as what had been put on the webpage for the friends.</td>
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<tr>
<td><strong>National Self Harm Network</strong></td>
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<td>The main body of the website was dedicated to how the friends and family could support a self-harmer. This included a list of do's and don'ts, as well as a downloadable list of distractions. The feelings, or fears of the friends and family were discussed in a few sentences. The main focus of this was how others could support the self-harmer. The friends and family were put together.</td>
</tr>
<tr>
<td>ReachOut</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>The support tool was short and provided a quick overview of what self-harm was. There were suggestions for how the friends could support the self-harmer, including what to do in an emergency. There was one sentence on what they might be feeling. The only advice for the friends to help themselves was to seek help if they needed it, or to take time out.</td>
</tr>
<tr>
<td>ReachOut</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>The support tool was short and provided a quick overview of what self-harm was. It was aimed at friends who had either just found out about their friends self-harm, or they suspected it. The advice was focused on helping the self-harmer to &quot;open up&quot; about their self-harm. It also included a section including practical advice for the friends e.g. &quot;encourage them to talk to someone&quot;</td>
</tr>
<tr>
<td>Rethink Mental Illness</td>
<td>X</td>
<td>X</td>
<td>x</td>
<td>x</td>
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<td>“Self-harm”</td>
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<td>(downloadable booklet)</td>
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<td>The main focus of this booklet was about providing information about self-harm, and predominantly aimed at those who self-harm.</td>
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<td>There was a small section encouraging the friends and family to also take care of themselves.</td>
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<td>Talked about how the self-harer may be feeling in opening up to the friends.</td>
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<td>The support tool provided suggestions for how the friends and family members could support the self-harer.</td>
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<td>There were a few occasions where the feelings of the friend were considered, but this was often in reference to how they should try to work around those feelings.</td>
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<td>There was no advice on how to help themselves, but a list of avenues for information and support were provided</td>
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| TheSite                        |   |   | There was no information about self-harm.  
|                              | X | x | There were sections on how it might be to find out that different people self-harm e.g. friends, parents, or siblings.  
|                              |   |   | The experiences of the friends was woven into the suggestions for how to help the self-harmer and themselves.  
|                              |   |   | There was some advice about how they could help themselves, and a list of avenues for information and support were provided.  
| ULifeline                     |   |   | This support tool was solely designed to provide advice about supporting a friend, and giving practical suggestions about supporting the self-harmer.  
|                              |   | x | There was no focus on the friend, their thoughts of feelings.  
| "Coping with their self-harm" |   |   | (website)  
| "Tips to help a friend who may be self-injuring" |   |   | (website)  

Appendix I

Mind-maps created in Phase One which were used in Phase Two

What friends can do to support someone who self-harms
- Be aware of your own feelings
- Be someone they can talk to
- Have patience

What friends may be experiencing
- Changing relationships with the friend who self-harms
- Feeling like you should be doing something
- Feeling responsible for their welfare
- Changing relationships with others
Appendix I

What can you do to help yourself?

- Sources of Support
- Look after yourself
- Talk to trusted others
- Be aware of your own feelings
Appendix J

Results: Phase Two, Chapter Seven

Presented below are the full results from the Thematic Analysis of the five focus groups conducted in Phase Two of Chapter Seven.

What the friends can do to support the self-harmer.

In this section, the participants were presented with the mind map in Figure 12, section 7.3.3. The participants used this as a spring board to discuss ways that friends could support a self-harmer without trying to stop the self-harm. From their discussion, seven subsections were developed, My friend self-harms!, Let them go at their own pace, I want to help them stop, I can’t understand why they self-harm, their life is great!, I don’t know how to support my friend without supporting the behaviour, I think my friend needs help!, and Try to do normal activities with your friend.

My friend self-harms!

Finding out about the self-harm and reacting to this discovery was a salient issue for the friends. Some felt that they “panicked” (Sophie, Focus Group 1) when they found out. Whereas others already felt that there was something wrong before the self-harmer told them.

She actually approached the other friend who was self-harming and erm () then that kind of made it a bit more open because my other friend is very open about it so that made her more able to talk to me about it as well () but I didn’t know how to go to her and say (2) what’s going on? (Focus Group 1, Charlie)

Many discussed feeling that they did not know how to approach the self-harmer, or address their concerns for their welfare with them. When discussing how to deal with finding out about the self-harm, the friends all reiterated that the friends should avoid “freaking out” (Focus Group 1, Sophie), they should remain calm, and have “patience” (Focus Group 5, Antonia). If the friends were to discuss their concerns with the self-harmer, they suggested that it should be done sensitively and by mentioning that they had noticed something was wrong.

Let them go at their own pace

It was evident that the friends also struggled with how slowly their self-harming friend helped themselves.

My friend (2) we got her to the GP but she went for one session like () and was like they’re useless they just gave me some leaflets () I’m never going back ()
Appendix J

I was like (sucks teeth) great like (giggles) (.) so (.) yeah (Focus Group 1, Sophie)

Like Sophie, other friends also discussed feeling annoyed that the self-harmer was not helping themselves. This was usually discussed when the self-harmer would make, and then break doctor, or counselling appointments. Having patience with the self-harmer when this was going on was something that the friends found difficult.

The support providers also discussed how supporting a self-harmer can be quite a difficult task, and often those who support them want them to stop self-harming quickly. They highlighted that often the self-harmers were “practicing talking about it” (Focus Group 3, Maggie), and were still getting used to talking about the self-harm and as such did not always want to, or know how to, talk about their feelings. As highlighted by Maggie, the participants felt that giving the self-harmer space to discuss what they wanted and when they wanted to often was more useful than pushing them to talk.

I want to help them stop

When the friends recalled finding out about the self-harm, they wanted the self-harmer to stop self-harming.

Because I think like the (.) like (.) the first time she told me I sort of a little like a little bit of a meltdown can you just stop please stop (Focus Group 1, Sophie)

The friends discussed feeling responsible for the self-harmer’s welfare, they felt they were “putting it all on [their] shoulders” (Focus Group 1, Rosie). However, the support providers highlighted that self-harm was often used as coping strategy, and this often made it difficult for the self-harmer to stop completely. They discussed self-harm as being a similar coping strategy to punching a wall, and that it was an individual’s “framework” (Focus Group 3, Helen) that affected how they coped. They felt that if the friends were able to accept the self-harm, and not try to challenge it, the self-harmer would be better supported.

I can’t understand why they self-harm, their life is great!

The friends found it difficult to understand why their friend engaged in self-harm.

On reflection like she had a perfect lifestyle she had everything she could have possibly wanted and more but she couldn’t see it and like things like that I was like but why can’t you see it like come on and you find yourself well I found myself getting quite worked up (Focus Group 5, Antonia)
Appendix J

It was suggested by the support providers that friends should not try and assess the self-harmers’ behaviour from their perspective, but to try and understand differences in individual frames of reference or make self-harm more relatable.

Some people have been either brought up with more healthier resilient coping strategies so like if your family does exercise you’re into loads of sport or anything you’ve probably got quite a good outlet if you like sport but then again if you’ve been brought up in an environment where you’re not allowed to talk about your emotions then you’ve gotta find somewhere and I think that’s the thing people often have coping strategies but because it’s such an inherent part of who they are they don’t see that (Focus Group 3, Helen)

In making the self-harm more relatable, the support providers felt that the friends may be able to understand the behaviour, or at least accept their decision to self-harm. In accepting, or seeing how their behaviour related to that of the self-harmer’s, the friends would be better placed to support their friend.

I don’t know how to support my friend without supporting the behaviour

A challenge discussed by the friends and support providers was the difficulties in supporting the self-harmer, without encouraging the behaviour.

I think that’s a really difficult sometimes a difficult line to walk I find myself (.) you want to normalise it to the degree of you know this doesn’t make you an awful member of society and you shouldn’t be banned from society but at the same time you need to keep making the point well it’s not something that’s particularly useful and it’s something you want to stop doing it (Focus Group 4, Pat)

This challenge was considered by the support providers to be exacerbated by those who did not fully understand self-harm, or those who attributed it to suicide. This was also discussed by the friends, such as Matilda who discussed how she dealt with this challenge;

For me it was never saying what you’re doing is right it was always kind of being this is harming you all this is dangerous but (2) I’m here to listen and help you but never (.) making them feel that it’s (2) it’s kind of (.) not that it is accepted that’s the wrong word but almost that it’s not it’s not a good thing to be doing being careful that you’re not supporting them getting worse. (Focus Group 1, Matilda)
Appendix J

As Matilda highlights, the friends should try to support the self-harmer, and acknowledge the self-harm, but avoid making it an acceptable behaviour. From both accounts, it’s clear that both reminded the self-harmer that the behaviour was not always appropriate, and that it was not a healthy coping strategy. In not judging the self-harm, the participants felt that they would be more willing to seek support, and be open about their feelings.

*I think my friend needs help!*

The friends struggled to seek support on behalf of the self-harmer, particularly when the self-harmer was resistant to external support.

*Charlie:* You feel like you should go to someone but you also feel like they’re going to feel like you’ve betrayed them

*Alice & Sophie:* Yeah

*Charlie:* Because they’ve put their trust in you and you’ve just gone and told someone else (.) even though you feel you should tell someone else (Focus Group 1)

The self-harmers making, and breaking appointments, or only going to them if the friends or others went along were common issues for the friends. Friends also talked about situations where the support had been sought by others on behalf of the self-harmer. For example, Sophie, a friend, discussed how other friends of the self-harmer sought out support from their head of year because they were concerned about the self-harmer. She felt that this act “created more like negativity generally and more stress” than if they had gone directly to the self-harmer and expressed their concerns. The friends felt that any help sought should be discussed with the self-harmer.

The support providers, however, discussed the need for the friends to seek help for themselves if they were worried.

*If they’ve got absolutely shed loads of (.) feelings they want to talk about they want to talk about they self-injury they can do that with us which is (.) kind of a way of offloading a whole loads of stuff they might be feeling but it might still exist that actually they’re still worried about their friend and they might feel that they still need to talk to somebody about the safety of their friend and (.) and that’s (.) that’s a way they could actually offload some of the stuff (Focus Group 3, Maggie)*
Appendix J

An important message was that the help-seeking of the friend does not necessarily have to lead to an intervention. Rather, the friends can seek support for themselves, to help them “think a bit more sort of rationally”, to gain a bit of “clarity about it”, or to direct them onto services as a “safe space to unload and unpick”.

**Try to do normal activities with your friend**

The friends routinely found that they were spending less time doing fun activities with their friends. The support providers attributed the change in friendship to changes in roles within the relationship.

> It could also be that both of them have inadvertently shifted the relationship and you’re like oh right okay I can’t possibly suggest that you come to the cinema with me when you want to hurt yourself that would be an ordeal a terrible thing to suggest it would be really offensive and insensitive whereas in fact it’s quite possible that the (.) friend they’re supporting is very happy (.) to do those things so I think something along those lines where actually it’s okay to still do the normal things that you don’t have to stop doing those things (.) it’s not insensitive to still want to be their friend because that’s why you know each other in the first place (Focus Group 3, Helen)

The support providers felt that the friends should try to keep doing the same activities they did with their friend before the self-harm. In so doing, they felt that it would subdue any changes within the friendship, and would encourage a more “normal” friendship. They also felt that in doing normal activities, the friends were also well-placed to ask for support from the self-harmer,

> You can ask for help but not on an emotional if you feel unable to ask on an emotional level you could ask on very practical things like actually I really need to buy a new dress for my brother’s wedding can you help me choose something or yeah can you help me move house or can you cook dinner so these are not emotional demands but they’re still means asking for something so it keeps it on a reciprocal level (Focus Group 3, Helen)

Through including the self-harmer in more practical activities, the support providers suggested that the self-harmers may also be able to feel positive, and feel that they are able to provide reciprocal support to the friend.
Appendix J

*What the friends may be experiencing.*

The previous three studies had demonstrated that the friends had experienced difficulty whilst supporting their self-harming friend. This third section aimed to explore and refine some of those experiences. The participants were presented with a mind-map outlining the key issues about the friends’ experiences (see Appendix I for the mind-map).

Similarly, the participants used this mind map as a spring board for the friends to discuss how they felt supporting a self-harmer, and how the support providers had understood how the friends felt supporting a self-harmer. From the discussions, six subsections were developed, *Is what I’m feeling normal?*, *I feel like the only one supporting my friend, I don’t feel able to talk to anyone, I don’t know if what I’m doing is right!*, *My friend tells me one thing, but I’ve heard something else, and I can’t tell my friend about my troubles, theirs are worse.*

*Is what I’m feeling normal?*

Feelings such as guilt, anger, shock, confusion, isolation, upset, helplessness, worthless, useless were discussed. The friends also discussed how supporting the self-harmer would make them feel closer to them.

*I didn’t find so much with the change in relationships I found that we got closer erm (.) a lot closer erm and that was (2) nice nicer (.) and it’s not nice it sounds horrible (Focus Group 2, Alicia)*

The friends would discuss any positive feelings they had from supporting their friend as being horrible. In supporting their friend through something they felt was not nice, the positives they garnered from supporting their friend were considered to be inappropriate, or “horrible”. This was addressed by Helen, a support provider, who said that,

*I think yeah that whole thing of actually having a mix of positive and negative emotions in most situations is a part of being human and it doesn’t negate (.) negative experiences don’t negate positive ones and vice versa it doesn’t make you a bad person for thinking ‘oh I really helped them but I’m kind of pissed off as well’ those are both okay (Focus Group 3, Helen)*

The friends felt a range and mix of emotions in finding out about the self-harm, and this needed to be reflected in the tool. It was also important, as Helen states, the friends are not made to feel that their feelings are unnatural, or unusual.
Appendix J

I feel like the only one supporting my friend

One of the main issues discussed by all participants was that the friends often took on too much responsibility for the self-harmer. Frequently this would happen because the friends felt overly concerned for the welfare of the self-harmer.

Rosie: Yeah (.) I think the bit about like be aware of your own feelings (.) one thing I had was kind of putting it all on my shoulders and like constantly worrying about her making sure she’s okay and she’s’ there like worrying that I’m worrying about her

Sophie: It’s like a constant circle of never-ending worry

Rosie: Yeah you can’t do that because that’s just not helpful for her or you (3) so that like could be added maybe (2) so don’t erm (3) put it all on your shoulders like don’t hold yourself accountable (Focus Group 1)

The participants discussed feeling that nobody else was able, or willing, to support the self-harmer, because of this they felt it was their responsibility to ensure the wellbeing of the self-harmer. This was particularly evident in them feeling like they had to always be available to the self-harmer should they need to talk to anyone, regardless of what time this was. Many participants talked about sleeping with phones next to them,

Alicia: You’d go to bed but you wouldn’t want your phone (.) like you’d have to have your phone right near you just in case

Summer: Yeah and you’d have to have it turned on

Alicia: Turned on yeah

Summer: Yeah and you’d check it in the middle of the night (Focus Group 2)

The friends felt that they should be constantly available to the self-harmer. Many of the friends talked about feeling more able to cope supporting their friend when they removed the phone from their room when they slept, or by turning it onto silent or off. The purposeful avoidance of the self-harmer communicating with them via the phone at night was considered to be an effective way to manage feeling overwhelmed.
Appendix J

One of the main suggestions that the friends discussed to help alleviate their feelings of responsibility was to use others as support,

*I think having other friends (2) like who knew really was helpful just to talk about (2) but not with (.) her there but like a nice way (Focus Group 1, Rosie)*

The friends routinely identified other friends and their parents as being their preferred source of support. It was also clear, however, that often this support was not always appropriate. For instance, some participants felt that those the friends turned to “*might be trusted but they’re not well informed and then that can set up another drama*” (Focus Group 4, Ed). Instead, the support providers felt that the friends would be better suited seeking support from those who are trusted, as well as informed and knowledgeable about self-harm. However, it was also clear that many did not feel able to talk to anyone.

*I don’t feel able to talk to anyone*

A further issue concerning support, was that often the friends felt that they were unable to seek support.

Charlie: *You feel like you should go to someone but you also feel like they’re going to feel like you’ve betrayed them*

Alice & Sophie: Yeah

Charlie: *Because they’ve put their trust in you and you’ve just gone and told someone else (.) even though you feel you should tell someone else like their parents or someone who can do a bit more for them than you (Focus Group 1)*

Largely attributed to the secrecy participants imbued in the disclosure of the self-harm, or being told explicitly that they should not tell anyone, the friends felt that they could not, and should not seek help. Predominantly they feared that in seeking support, even for themselves, they were betraying the confidence of the self-harmer. This left them feeling trapped and further exacerbated feelings that they were the only ones supporting the self-harmer.

The support providers discussed the role that secrecy plays in supporting someone who self-harms. They felt that managing the conflicting feelings of being overwhelmed and in need of support, whilst still maintaining the confidentiality of the self-harmer, is a “*really hard place to be*” (Focus Group 3, Helen), and the friends should seek support for themselves.
Appendix J

People email our referral inbox concerned about a friend and I often come back to them and say this is what we can do for the friend but do you want to come in (.) because they don’t realise that they’re actually really distressed by it (Focus Group 4, Pat)

The friends’ need to seek support for themselves, was a key suggestion across all of the focus groups. Often the friends felt that in seeking support for themselves, they were breaking the trust of the self-harmer. In this support tool I wanted to make it clear that they could seek support for themselves, and it was alright to do so. As Matilda in focus group one, deftly stated, “you have a right as a person to also seek support”.

I don’t know if what I’m doing is right!

One of the big concerns for the friends was that they felt that what they were doing was unhelpful, or potentially making their friend more upset. The friends’ concerns about not being able to adequately support the self-harmer often came from them feeling they “should have done something but I don’t know what” (Focus Group 5, Antonia). Often, when they were involved they reported feeling “scared [they] might say something” (Focus Group 1, Charlie) that would upset the self-harmer or lead to something more dangerous.

This was discussed by the support providers, who suggested that the friends try to understand the power of listening.

I think that might be something to incorporate is just the power of things like listening an you know taking time (Focus Group 3, Maggie)

It became apparent that the friends felt that they should become involved, or provide suggestions for supporting the self-harmer. However, the support providers discussed that often just listening to the self-harmer will mean a lot to them. Chiefly, they highlighted that it was not the responsibility of the friend to give suggestions, but only to listen as a friend.

My friend tells me one thing, but I’ve heard something else

The friends also discussed how they would feel betrayed or deceived by the self-harmer, either because the self-harmer had withheld details from them, or they felt that different stories had been told to different people. The support providers associated these feelings of betrayal with secrecy,
Appendix J

I'd held this secret for you and you haven't actually told me everything and you've told me other bits to other people and that adds another difficult dynamic to the whole friendship group (Focus Group 3, Helen).

The support providers suggested that the friends may struggle more with feelings of deceit because they were the ones who were trying to keep the self-harmers’ secrets. The self-harmers, however, were not doing the same. This made it difficult for the friends to be able to trust what their self-harming friend had told them.

A key issue highlighted by the support providers was that the friends were often some of the first people that self-harmers would talk to about their self-harm, and as such may be still learning how to talk about it. As a result, there may still be inconsistencies in their accounts. The friends suggested that the best approach a friend can take in this situation is to give the self-harmer time and patience.

I can’t tell my friend about my troubles, theirs are worse.

Most of the friends felt that often their friendship with the self-harmer was unequal. Consequently, many felt uncomfortable seeking support from the self-harmer, or discussing their own problems.

Alice: I kind of felt like if you turned round to them and like go what you’re doing is making me feel (.) however then they’re just going to be like who’s the one with the problem

Sophie: You get it’s the it’s not about you but it is as well like

Alice: Yeah in relation to me theirs is so much bigger and you’re there like oh no I don’t have problems kind of thing but you have to be careful (Focus Group 1)

The main reason friends avoided discussing their own feelings was that they feared their friend would think them to be insignificant. Other participants felt that it was not fair to ask for support from their self-harming friend, because they were not in a position to help them.

The support providers associated this type of thinking as being linked to the change in role from friend to carer,

It’s once they started taking on their role of supporter they didn’t feel that they could go in the opposite direction because my stuff is never...well if I’m not self-harming my shit can’t be nearly as bad as yours (Focus Group 3, Helen)
Appendix J

In taking on the role of carer, the support providers suggested that the friends no longer felt that it was appropriate to ask the self-harmer for help. In order to try and maintain a more equal friendship, the support providers suggested that the friends do try and ask for help “on very practical things” (Focus Group 3, Helen). It was suggested that the friends should ask the self-harmer for support. Highlighting that this does not need to be in the form of emotional support, but also practical support. They further went on to discuss that maintaining reciprocal activities would not only be beneficial to the friend, and maintaining a more friendship-based relationship, but it would also demonstrate to the self-harmer that they can be supportive, and engage in fun activities.

_I feel my friendship isn’t the same_

Many of the friends felt that through supporting their self-harming friend, their friendship had changed. In taking on responsibility for the welfare of the self-harmer, the friends often talked about feeling that their friendship had deteriorated and they were taking on more responsibility for the welfare, or protection of their friend. When this was discussed in the focus groups, both the friends and support providers felt that the friends should try and do normal activities that they did with the self-harmer;

_Sophie:_ Just spend time with them (.) like (2) you wouldn’t normally because if they’re

_Rosie:_ Yeah just act normal (Focus Group 1)

In acting normally with the self-harmer, the participants felt that more normal aspects of the friendship could be maintained. Indeed, the support providers felt that maintaining normal activities, such as going to the cinema, or shopping would be beneficial for both the self-harmer and the friends.

_What the friends can do to help themselves._

What was largely absent from many of the pre-existing support tools was practical help about how the friends could protect their own wellbeing whilst supporting their self-harming friend. In this section, the participants focussed on how the friends can make steps to support themselves and maintain their own wellbeing, and used a mind-map (see Appendix 1) as a catalyst for conversation. From this five subsections were developed, _Be aware of your own wellbeing, Set boundaries, Make some time for yourself, Help-seeking, and Their wellbeing is not your responsibility._
Appendix J

Be aware of your own wellbeing

What was very clear across all focus groups was that the friends were often supporting the self-harmer to the detriment of themselves.

Sometime is think friends get quite burnt out and they become the main source of support quite dramatically for a short space of time (Focus Group 4, Pat)

The friends consistently took on more responsibility for the self-harmer than they were meant to, and in the process, as Pat states, they were not looking after themselves. A point raised across all focus groups was that the friends needed to take care of themselves.

Someone saying to you that (.) at the end of the day like she’s very important but you’re also important as well you can’t forget that (.) you know you’re important as well like (.) you’ve got to kind of (.) work out a way where you’re both are have the best out of the relationship sort of thing (Focus Group 2, Alicia)

The need to self-care was an important theme that I wanted to get across in the tool. Often the friends felt that in supporting their friend they were running out of energy, particularly when they had other constraints on their time, such as essays and exams. The focus of the friends looking after themselves was also framed as being beneficial for the self-harmer.

If you look after yourself you’re more likely to stick with them (.) in the long haul and also have that more rounded friendship (Focus Group 3, Helen)

The participants all identified that in friends caring for their own wellbeing, they would also be more able to provide meaningful, and long term support for the self-harmer. In discussing self-care as such, the friends are able to justify their own help-seeking whilst dealing with the fears of beaching the trust of the self-harmer.

Set boundaries

The participants, particularly the support providers, discussed that often friends would accidentally take on responsibilities that lay outside of friendship. Often the friends reported that only geographical distance stopped them from being more involved in the care of their friend.

If you were half an hour away from your friend and would up sticks and go to her (2) like on reflection I don’t think I ever offered to go home to see her (.)
partly because I was four and a half five hours away from her at the time.  
(Focus Group 5, Antonia)

Across the course of the focus groups, the friends often discussed points at which they felt they had gotten too involved in the support of their friend, and engaged in behaviour that lay outside of what they expected from a normal friendship.

This was also raised by the support providers, who felt that a key focus of theirs is to encourage friends to get a balance between being supportive and not feeling overly responsible.

For me the most freeing up thing that seems to work for my clients (2) is that sense of not needing to feel overly responsible it’s not about not caring its balancing with compassion and caring (Focus Group 4, Carlyon)

In putting in boundaries within the friendship, the support providers wanted the friends to acknowledge “their limitations” of being a friend (Mary, Focus Group 4). One of the key suggestions support providers suggested was “telling them [the friends] it’s okay to limit their contact with that person” (Focus Group 4, Pat).

Make some time for yourself

In encouraging friends to be aware of their wellbeing and to self-care, it was also suggested that the friends also make time for themselves and do activities that they enjoy doing.

Make sure you do something for you whatever you may be and you can put a whole load of suggestions (.j) just take some time out (.j) and have some fun and relax and (.j) look after yourself (Focus Group 3, Maggie)

The friends and support providers suggested a range of techniques that friends can do to help themselves, including going for a run, going out drinking with other friends, or writing down how they were feeling. What all of the suggestions had in common was the focus on allowing, and encouraging the friends to make some time for themselves.

Help-seeking

Due to friends often feeling that they would be breaching the confidence of the self-harmer by seeking help, the friends often reported not seeking help, or only seeking help once they began to struggle. Thus, a key recommendation by the friends and support providers was that the friends seek help for themselves.
Appendix J

Have someone to talk to even if it’s not the friend you know it’s not your friends friend if it’s someone you trust it can be an anonymous way of saying look I’ve got this friend she’s doing x y and z but what can I do or even having I know you can call there’s lots of support lines I’m sure there will be someone who’ll listen to you just for because sometimes when you get so worried about someone it can kind of take over and that can impact on your mental health (.) so it’s having someone to talk to and not keeping it up don’t feel like you have to keep it all to yourself. (Focus Group 1, Matilda)

Although this was a key suggestion, it was also something that the participants often struggled doing, or only did when they felt unable to cope; one friend suggested seeking help “before it gets out of control” (Focus Group 5, Nelly). As discussed by Matilda above, the friends mainly suggested speaking to those that the friend could trust, such as other friends, parents, and in some cases, support lines.

The friends also felt that support services were more useful when they were well advertised. A section of the support tool, therefore included what type of service could offer what type of help, as well as providing the friends with a list of contact details for a range of national, and local support services.

Their wellbeing is not your responsibility

The main piece of advice that the participants felt was important to relay to the friends to recognise that their friends’ wellbeing was not their responsibility.

Not feeling overly responsible not feeling that they have to do what the mental health services aren’t doing for example so I think that’s a key issue recognising that you’re not responsible. (Focus Group 4, Carlyon)

As discussed previously, the friends often took on excessive responsibility for the self-harmers’ wellbeing, and reducing this sense of responsibility was one of the main concerns for the support providers.