“I’m not the same person I was, she’s not; none of us are”: The experience of mothering self-harming adolescent daughters

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ABSTRACT

Self-harm is a pervasive phenomenon, with an increasing number of adolescents using such behaviours in response to their distress. Much research has been undertaken to establish the aetiology and management of self-harm, as well as the impact on those that self-harm. However, little research has been completed with a focus on the impact of self-harm on the primary caregiver, most often the mother. As many adolescents who self-harm do not connect with clinical services, how the primary caregiver is affected, challenged and able to cope is vital to their own wellbeing as well as the recovery of the child.

Semi-structured interviews were completed with six participants, all mothers of daughters who self-harmed between the ages of 15 and 18 years. Their accounts were analysed using Interpretative Phenomenological Analysis (IPA), a qualitative methodology that explores the lived experience of a particular phenomenon using a small sample.

Two main superordinate themes emerged from the data: 1) Impact of self-harm on the mothers' self (with a focus on their ideology of mothering, destabilisation and loss) and 2) The existence of self-harm as an omnipresent phenomenon (with a focus on self-harm as relentless, isolating and creating fear). Additionally, this study supports the primary position that mothers may have to support and manage their child's self-harm, thus indicating the vital requirement for greater practical and emotional support for the mothers themselves.

INTRODUCTION

There are many complexities of parenting (Janssens et al., 2015) and many parents today find themselves in unfamiliar territory as their adolescents introduce behaviours and ideas into the family system that are quite different to adolescents of their generation (Sheridan, Peterson, & Rosen, 2010). In addition to this, adolescents with mental health difficulties may often place a significant burden on families, becoming a source of immense family distress (Kuhn & Laird, 2014; Oldershaw, Richards, Simic, & Schmidt, 2008). Studies exploring how the parents of adolescents receiving treatment for mental health disorders make sense of, and respond to, their children's problems, found that over one third of parents indicated that they found it difficult to comprehend and cope with the symptoms displayed by their adolescent (Ferrey et al., 2016; McDonald, O'Brien & Jackson, 2007; Moses, 2011); displaying what researchers termed, a kind of *emotional anomie* (Karp & Tanarugsachock, 2000) - a form of instability resulting from a breakdown of expected norms. Alternatively, the term *cognitive anomie* may also be used due to the confusion in conceptualising the meaning of their child's problems (Moses, 2011).

When we consider the parenting role, it may be postulated that mothers are generally considered the primary caregiver of offspring (Everingham, 1994; Galbo, 1984; Liat, 2004; Moon& Hoffman, 2008) and have greater responsibility for the more emotional 'caring' aspects of parenting (Everingham, 1994; Moon & Hoffman, 2008). This suggests value in a closer inspection of the intricacies of this parenting role at a time when not only is the transition from childhood to adulthood already producing challenges enough (Janssens et al., 2015), but in addition to the adolescent presenting with complex behaviours beyond the parents' understanding. Therefore, this study aims to explore parents' experience, and their sense making of their adolescent's psychological distress demonstrated through the behaviour of self-harming, with the lens focused on giving a voice to mothers and mothering. The specific aims are to:

a) Give voice to a seldom-heard group within the phenomenon of adolescents' self-harm; the mothers
b) Introduce the focus specifically toward the mothering experience for a woman
c) Outline the serious and pervasive nature of adolescent psychological distress and its symptoms, specifically with regards to self-harm, and how a mother makes sense of this
d) Explore the impact of adolescents who self-harm on the wider family, as experienced by a mother
e) Highlight how networks and relationships outside of the family are experienced when an adolescent daughter is self-harming

To gain a comprehensive understanding of the individual dynamics involved in addressing the aims outlined above it would be beneficial to explore the distinctions within adolescence, adolescent psychological distress, self-harm, parents' responses to these and more specific features of mothering as a woman, as well as cultural aspects of these phenomena. This holistic overview helps knit the interplay of these separate phenomena into a phenomenon itself, aiding interpretation of the contribution of each of the participants in this study and to help better understand the intricacies of mothering self-harming adolescent daughters.

LITERATURE REVIEW

Literature search

A search of the literature up to and including July 2019 was conducted using electronic resources. Databases within a range of disciplines that may potentially undertake research on adolescent self-harm, parenting and motherhood were searched for relevant articles. These databases included: BioMed Central, PsycBOOKS, PubMed, SAGE Journals Online, SAGE Research Methods, ScienceDirect and Scopus. Initially the terms self-harm

AND parents' experiences of self-harm were entered into the databases as part of the scoping search. Further search terms were selected from the keywords that were stated most frequently by articles generated during the initial scoping search. Results were considered if they related to the research aim; a reflection on motherhood, parental experiences of a child's psychological disturbance, more specifically self-harm, examination of self-harming (including terms Non-suicidal self-injury (NSSI), self-mutilation, deliberate self-harm (DSH) and self-injury, as well as cultural perceptions and experiences of self-harming or mothering/maternity. Results were excluded if they were too specific in their aim, such as those regarding parents or children with specific co-morbidities (such as physical or mental disability or other psychosocial factors, such as domestic or sexual abuse or substance misuse in parents). The final list of search terms and other databases searched is shown in Appendix A.

Adolescence

"Adolescence is the period of experiencing and resolving the turbulence which is set into action by the biological process of puberty" (Hyatt Williams, 2015 p.12). Adolescence brings about changes in status within the home, as well as within the environment, with the adaptations required varying culturally and according to individual resilience in the face of challenges. Hyatt Williams discusses how psychological and behavioural disturbances in adolescents may be similar to adults but with a greater instability, with rapid shifts from a seemingly mature intellectual understanding to panic and rage.
Significantly, there is the reduction in the connection with parents, as there is a need to establish connections to other people to meet one's needs, as well as the greater development of personal identity. All this uncertainty can leave a young person prone to rapid mood swings and feelings of short-lived depression. Some adolescents may not be able to assimilate these mood swings and may deteriorate further in that direction (Allchin, 2015). Allchin (2015 p.91) goes on to describe that the handling of the depression is differentiated by the level of positive primary care and if not adequate there

‘may be efforts to generate a kind of excitement whose purpose must be to keep at bay the feelings of loss and rage, thus leading to serious self-injury’.

Also at this time parents are simultaneously negotiating alternative or novel ways of relating to the developing adults. This affords the child greater autonomy but in turn alters the intensity of parents’ monitoring and protection of their child. It must be noted that a parents preferred level of autonomy for their adolescent is likely dependent on cultural and socioeconomic contexts (Kerig, Schulz & Hauser, 2012). In addition to this, others heavily influence young people outside of the family, others whom parents are not always able to protect them from (Kerig et al., 2012). This can result in a complex balance between parents facilitating healthy autonomy for their adolescent whilst maintaining a firm care giving relationship. Kerig et al. highlight that an understanding of the links between adolescent autonomy processes and parenting across multiple family contexts is required to assist parents in managing the difficulties presented within this developmental phenomenon.

Parents’ responses to adolescent psychological disturbance

As highlighted, parenting an adolescent child brings about new challenges for parent and child, the interplay of unstable moods, emotions, needs and desires. Parents may feel bewildered with their attempts to manage these, often drawing only from an awareness of their own adolescence and information available within contemporary society. Moreover, they may not know how to feel or act when their child is beginning to demonstrate unusual behaviours quite atypical to their expectations; behaviours linked to psychological disturbances. Research has stated that parents’ perceptions of their child’s problems affect how they may respond to them (Ferrey et al., 2016; McDonald, O’Brien & Jackson, 2007; Moses, 2011; Oldershaw et al., 2008). Parents’ perceptions of distressing behaviours, such as self-harming, may be that it is simply ‘bad behaviour’, ‘a phase’ or the ‘current trend’ and result in less empathy or tolerance from parents (Ferrey et al., 2016; Oldershaw et al., 2008). Receiving a clinical diagnosis for their child’s problems, however, may make parents more likely to empathise and to have hope that the clinical interventions will resolve

the problems (Ferrey et al., 2016). However, Moses (2011) found that parental reactions of sadness, disappointment and pessimism (anticipating undesirable outcomes for the future) were associated with their child's problems being conceptualised by the parents as being psychiatric in nature. Conversely, parents may also experience greater empathy and hope if they perceive their child's difficulties to be a normal part of adolescent development (Ferrey et al., 2016).

This is notwithstanding higher levels of stress, anxiety and depression reported in parents of children with psychological or behavioural difficulties, such as self-harming Tschan, Schmid & In-Albon (2015). Therefore, with the aforementioned research in mind, gaining a greater understanding of parents' perceptions of, and responses to, their child's difficulties and any considerations about their child's future need to be considered in this study.

Self-harm

The literature discussion so far highlights the complex challenges parents must navigate in the process of recognising and responding to adolescents' psychological distress. This distress may manifest in a variety of ways, with different behaviours symptomatic of different disorders, however, adolescents are increasingly dealing with regulating their emotions is by self-harming (Chapman, Gratz & Brown, 2006). Moreover, young people with psychological disturbance in general are more vulnerable to involvement in risky activities that jeopardise their health and wellbeing compared to young people in the larger adolescent population (YoungMinds, 2011). Self-harm is considered among the most critical of these risky activities (YoungMinds, 2011). Much of the research discussed within the YoungMinds report concluded that it is critical that professionals better understand families' experiences in order to help families cope optimally with the realities associated with the variable challenges of children's poor mental health or mental distress, and specifically with the less understood phenomena of self-harm.

The National Institute for Clinical Excellence (NICE; 2004, p.4) defines the term 'self-harm' as "any act of self-poisoning or self-injury carried out by an individual irrespective of motivation". This most commonly involves self-poisoning (generally with medication), or self-injury by cutting, scratching or burning. Self-harm is a pervasive problem with recent statistics indicating that the issue is on the increase (Fisher, 2015; RCPsych; 2010), with the most recent empirical figures stating that hospital admissions rose in 2014 by 45 per cent in young males and by over 50 per cent in young females. Females are believed to be more likely than males to self-harm. The British Journal of School Nursing (BJSN; 2013) reported there were 13,400 hospital admissions in 2013 for female adolescents' self-harm, and just over 4,000 adolescent males. However, these statistics are hard to define as males may harm in ways that do not always come to the attention of professional services, such as wall punching (SelfharmUK, 2017). Rates of self-harm are higher in the United Kingdom than anywhere else in Europe, and a startling statistic indicates that approximately one in every twelve young people engages in the behaviour (Moran et al., 2012).

History and Culture of Self-harm

Although by definition within clinical services self-harm is not limited to wounding one's body-tissue, this is one of the most common associations with the term, as well as being the most significant self-harming method within the current study. In nineteenth century literature the rhetoric of 'self-mutilation' within Victorian literature helped to define self-harm as a new category of psychiatric symptomology. Self-mutilation is a term to describe self-harm by self-injury, but is less used within contemporary literature and more commonly found within historical or cultural/religious contexts. Self-mutilation is defined by Favazza as "The deliberate destruction or alteration of one's body tissue without conscious suicidal intent" (Favazza, 1996, p.xviii). It was perceived as a problem of religious extremes or sexual guilt and considered an inherently selfish act more so, as the zeitgeist of this period was that individuals must help themselves and others, and not involve themselves in selfish preoccupation with acts that bordered insanity (Chaney, 2011). This set the template for

shame surrounding self-harm and unhelpful discourses which often remain today, as demonstrated by the poor help-seeking discussed within this literature review.

Self-harm must also be considered within cultural contexts alternative to Western societies; however, Western societies are from which most self-harm literature originates, consequently resulting in self-harm showing itself in similar ways across countries (Gholamrezaei, Stefano & Heath, 2015). However, “Just as cultural variation clearly dictates the language children eventually speak, cultural variation exerts significant and differential influences over mental, emotional, and social development of children” (Bornstein, 2013, p.258). Gholamrezaei et al. explain that race, culture and ethnicities interact with psychosocial functioning and thus, to understand patterns of self-harm it must be studied within alternative cultures. To demonstrate, cultural conflict was considered a risk factor for those living amongst Western values but originating from a collectivist culture (Hahm, Gonyea, Chiao, & Koritsanszky, 2014; Gholamrezaei et al., 2015; Tummala-Narra, 2004). Alternatively, high rates of self-harm observed among Native Americans and Aboriginals were also being considered as possibly related to these cultures historical use of self-mutilation rituals, and therefore were not shrouded with shame and selfishness as appeared to stem from Victorian England.

Gulbas and Zayas (2015) state the importance of establishing which cultural factors are salient in the world-view of those affected by the phenomenon, indicating that a culturally grounded view of the meanings attributed to the insiders’ narrative is required through qualitative exploration. As highlighted within previous research, Gulbas and Zayas, in their study of Latina adolescents, discuss cultural conflict emerging as a key theme in self-harming and suicidal intent. These adolescents are described as being between cultural worlds and cultural subjectivities, often in conflict with their parents’ ideologies of their cultural past and the on-going societal developments. This often results in feelings of isolation for the adolescents and a sense of a lack of respect and despair experienced by the parents.

Other studies within the topic of different cultures and parental responses to their child's difficulties highlighted a lack of concordance between minority ethnic/racial groups and their awareness of their child's emotional or behavioural difficulties or self-harming behaviours versus those of white majority groups, such as, European/American (Mojtabai & Olfson, 2008; Roberts, Alegria, Roberts, & Chen, 2005). Nonetheless, there is a dearth of literature relevant to the parents' experiences of these issues, more specifically, self-harming, in non-western cultures. Thus, the above authors conclude that future studies are needed to explore family and child cultural factors that may contribute to parental detection, or what may play a role with their children's difficulties. Stewart et al. (2018) emphasise that the difficulty in acknowledging and talking about self-harm in some cultures may contribute to the lack of ethnic diversity in participants for study.

Who self-harms?

The questions of who self-harms, why and what can be done about it are still being asked, with self-injury support organisations maintaining that there is still an absence of awareness and understanding around the issue, resulting in isolation from society for those that self-harm (Parker & Lindsay, 2004). It is understood to have a multi-factorial aetiology with a high number of risk factors and each of these are highly individual for each person (Buresova & Hochmanova, 2016). Risk factors may include environmental stressors within a peer context, including bullying (Jutengren, Kerr & Stattin, 2011) and academic difficulties, or a generally troubled family situation (Byrne & Mazanor, 2002). This question of "why" is one consistently asked, specifically by parents of self-harming children and adolescents (Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008). Broadly, "self-harm can be understood as more than a disorder confined to an individual and that issues relating to power, marginalization, injustice and resistance may be important" (McAllister, 2003, p.182).

Fortune, Sinclair & Hawton (2008), in a literature review on factors associated with self-harm, support the idea that factors associated with the family are often a significant cause, as well as parents of adolescents whom self-harm reporting more parental stress and less parental satisfaction than parents of those who do not self-harm (Tschan, Schmid, & In-Albon, 2015). Parents feel unprepared for the process of supporting a young person following self- harm, appreciating support to help them navigate this unfamiliar phenomenon (Stewart et al., 2018). Therefore, parents' positions, perspectives and needs are factors requiring understanding and managing by professionals offering support.

Help-seeking

Self-harm is not considered a mental health problem itself but is linked to mental distress and is often a result of a long-term struggle with intolerable distress or a difficult to bear situation (Royal College of Psychiatrists; RCPsych, 2010).

A study by Stanford, Jones and Loxton (2017), on impulsivity and self-harm, found that a sample considered the second largest of the self-harm profiles (the largest being those with pathological conditions) were considered to be psychologically normal. Stanford et al. suggest this indicates this group may be unlikely to present to health care professionals (HCP's) and is therefore unlikely to be able to access adequate professional support. In addition to this, most young people who self-harm (between a third and one half of adolescents) do not choose to seek any form of help for this behaviour (Rowe et al. 2014), with most adolescents turning to friends, family and teachers, as opposed to HCP'S (Buresova & Hochmanova 2016). A study on a population of American College Students found that 40 per cent had told no one about their self-harm, with only just over three per cent having discussed their behaviours with a General Practitioner (Whitlock, Eckenrode & Silverman, 2006). This suggests a need for support for parents and communities in general, to establish a greater awareness and understanding around self-harm. The literature examined so far

is beginning to demonstrate the pervasive nature of self-harm and difficulties parents may face in identifying and supporting their children that self-harm.

Problems with help-seeking

As highlighted, help-seeking by the adolescents themselves, as well as from their parents, is highlighted as a complex factor within the phenomenon of self-harm. Yet literature states that prevention strategies and early intervention help to prevent escalation of self-harm behaviours (Bem, Connor, Palmer, Channa & Birchwood, 2017). In a review of international community epidemiological studies examining help-seeking for suicidal thoughts or self-harm in young people up to the age of 26, Michelmore and Hindley (2012) found that many variables had an effect on help-seeking. Variables such as, gender, geographical location, service provision and promotion, age, ethnicity, sociodemographic factors, mental illness, substance misuse, psychological variables, family factors, suicidal ideation and negative life events. The qualitative studies within Michelmore and Hindley's review identified fears of treatment, hospitalisation, and the consequent infringement to confidentiality were substantial barriers to help-seeking. As parents and, more often, peers appear to be a valuable resource in facilitating professional support for those with self-harm behaviours it is suggested that barriers to help-seeking by these groups should be explored. However, parents have also been found to delay help-seeking as they may underestimate the significance of the problem or hope that it may resolve itself (Oldershaw et al., 2008). Also, as discussed previously within the context of cultural differences, and parents' poor concordance with their child's emotional or behavioural difficulties, Roberts et al. (2005) conclude that consideration must be given for whether the extent to which a lack of concordance on the indicators of poor mental health by minority parent-child dyads plays a role in help-seeking and retention into professional health care.

Parental responses to their child's self-harm

Extending discussions of parental perceptions, studies examining the effects of chronic self-harm behaviour and the parental role in help-seeking found that

parents often knew that their adolescent was self-harming. Nevertheless, communication difficulties or underestimating the occurrence led to them not taking action (Ehrlich, Richards, Lejuez & Cassidy, 2016; Oldershaw et al., 2008). Ehrlich et al. investigated the significance of parent-adolescent open communication and consequences of communication difficulties. This research highlighted that not only did poor communication lead to misperceptions of conflict between parents and their adolescent, but also minor depressive symptoms in adolescents may lead to them experiencing negative misperceptions in the level of conflict. Communication difficulties between parents and children were also found as a predictor of self-harm (Bureau et al., 2010). However, parents have claimed to regret this type of response, recognising that earlier interventions could have stopped the behaviour sooner (Oldershaw et al., 2008; Usher, Jackson & O'Brien, 2007).

In addition to basic communication difficulties, the qualitative study of Kelda et al. (2016) found that parents underestimated the frequency of their adolescent's self-harming behaviour, suggesting that their adolescents were not fully honest about the specifics; this research highlights the complexities of communication between parent-adolescent relationships. Two studies were found to be similar to the current study in their exploration the experiences of parents of self-harming adolescents, both with slight variances in their sample and methodology. Both converged with suggesting parents struggle to make sense of their child's behaviours, leading the parents to search desperately for a reason for the self-harming behaviours. Thus, leaving parents with feelings of guilt and shame, wondering if it was as a response to familial environmental factors. Additionally, the general responses by the parents were found to fluctuate, with their parenting strategies changing as they journeyed through the complex processes of the psychological disturbance and behaviours that accompany the self-harm (McDonald et al., 2007; Oldershaw et al., 2008). More recently, Stewart et al's. 2018 study found that participants responded with feelings of bewilderment, ruminating on their child's self-harming. They examined the past and present for explanations. They also looked for expert information and information from people who shared similar experience; including young people, who may help them to understand the reasons behind

the self-harming and help them learn the best responses. Over time they constructed new ways of seeing self-harm.

Ferrey et al. (2016) focused the lens more specifically on these suggested changes in parenting practices, however, all three studies concurred with finding parents' initial overt monitoring of their adolescent's behaviour due to the fear of significant self-harm. Ferrey et al. and McDonald et al. also found that the balance of power was altered, as parents feared creating further upset to their children, thus reducing control and discipline in the early stages of discovery of self-harm behaviours. Ferrey et al. also highlighted that the parental dyad may also be in conflict over how to manage the phenomenon. Nevertheless, within the three studies the most significant impact on the parents were psychological and emotional, due to their concerns over a reduction in their capacity to parent other siblings, or reduced capacity as a partner. Any unique features or deviations of each study's results appeared to be a result of the participant samples used in each. All three used participants of both genders, however the McDonald et al. study was inadvertently only able to recruit mothers (their children were of both genders, however). McDonald et al's. study was, incidentally, the only of the three studies to emphasise the depth of emotional and psychological impact on the participants, with mothers somewhat internalising their child's difficulties and bearing what the researchers describe as maternal guilt. This insight underscores the value in exploring unique features of the female-mothering role.

Research as recent as only 2006 claimed to be the first of its kind to explore parents' responses to self-harm using a phenomenological approach, as a way of identifying parents support needs and identified confusion, shame and loss of closeness through communication they once had with their child (Raphael, Clarke & Kumar, 2006). Since Raphael et al.'s research of 2006, there has been an increase in qualitative studies exploring different aspects of parents and their adolescents' self-harming. Nonetheless, the literature examined unanimously suggests that there is still much to be explored. More recent research advocates the important role parents may play in either perpetuating or resolving self-harm. Through the use of questionnaires parents reported

significant distress and crisis within the family system at times of self-harming, resulting in less supportive parenting (Baetens et al., 2015). Baetens and her colleagues postulate that lack of support is directly connected with the occurrence of self-harm behaviour, causing depressive moods in the adolescents. This idea is consistent with the previous literature regarding depressive symptoms and self-harm, as well as the risk of the cycle of depressive symptoms- perceptions of conflict- psychological distress.

Baetens et al. also highlight the shortage of insightful literature into the consequences of self-harm for those affected by the behaviour, such as the parents, carers and siblings; a theme concurrent throughout much of the literature. Despite there being a shortage of qualitative self-harm literature, there is adequate evidence supporting quality family attachments, and the relevance of family cohesion in the mitigation of self-harming. As well as these increasing the likelihood of accessing therapeutic and treatment programmes (Buresova & Hochmanova 2016; Kelada et al. 2016; Sheridan et al. 2010).

Limitations of current practice

The role of clinicians in supporting parents is vital, as whilst adolescents may be predisposed not to seek professional support for their problems, untreated disorders in this population are associated with serious outcomes and recurrent psychological problems across the life span (Fortune, et al., 2008). Self-harm literature that discusses parents' experiences consistently highlights the requirement for greater support from HCP's for the issues encountered by the adolescents. There is a constant and consistent call for parental education, to help parents to be proactive in recognising signs, encouraging the opening of lines of communication, and developing strategies to help support the child. The NICE guidelines recognise that it is essential that parents are educated in not just recognising signs of their adolescents' distress, but in challenging these through informed discussion and consistent support. These guidelines focus more on the perspective of those that self-harm, adding that the autonomy of the adolescent must also remain respected; therefore, parents are not

automatically informed about what may be going on with their child (NICE, 2004).

Consequently, the autonomy of the adolescent may cause distress for the parents, including feeling isolated from the content and progress of therapy. This anxiety over autonomy may also run parallel to the parent's hyper-vigilance and lack of trust of their child once self-harming has been disclosed. The expectations of the parent are notwithstanding the confusing emotional and psychological impact on the parents themselves, with a stream of objective and subjective doubts and beliefs (Moses, 2011) and notwithstanding the profound shock, guilt and fear experienced by parents (Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008), which may lead to parents own psychological difficulties. Feelings of shock, confusion, devastation and fear may have a profound effect on the parent's wellbeing in the wake of self-harm (Byrne et al., 2008). Literature asserts that parents may find it helpful to seek their own personal therapy, as they try to negotiate their own emotions with a perception of failing to protect their child (Choate, 2015).

Byrne et al. (2008) also discuss significant changes reported in the dynamics of the parent-child relationship, with a fear that any conflict may actually illicit acts of self-harm, creating an environment with fewer boundaries being set, also discussed within Ferrey et al. (2016) and McDonald et al. (2007). This imbalance of power may lead to additional difficulties between parent and child, as well as unequal treatment of siblings, significantly detrimental outcomes which support the need for greater education within family systems for self-harm behaviour management. An additional issue to the heath professionals' confidentiality around their child's self-harm is that the young people are not always honest about the true extent of their self-harming. The young people may experience shame and discomfort around conversations about their behaviours, as well as a potential fear that the consequent hyper-vigilance of their parents will limit their opportunity to self-harm (Kelada et al., 2016). This may affect the level of trust and autonomy afforded to the adolescent, resulting in further problems between parent and child.

Barriers to communication are an obvious issue; with evidence existing that communication between parent and child is a positive step to engaging with professional help (Moses, 2011). As well as self-reports that portray positive outcomes of love and support and a perceived closer relationship between parent and child after honest disclosures (Oldershaw et al., 2008), thus stressing the value of open and honest communication. Despite this, fear, anger, confusion and mismanagement of the issue, is a common theme among families. Therefore, greater understanding of the impact on the family, more specifically the parent that is most involved in the childcare, with the strongest emotional bond, and targeted support for their role as such, seems crucial in the long-term management of the phenomenon of self-harm.

As mentioned previously, research exists that supports a unique bond between mother and child, with McDonald et al.'s 2007 research happening to discover negative affect of the self within the female-mother participants in their particular study. This phenomenon should, therefore, be explored further from the perspective of mothers as women and the primary caregiver, as is the aim of the current study.

Mother and Mothering

The literature demonstrates that mothers are often the primary caregivers and, although fathers are progressively becoming more involved, gender stereotypes still persist (Jan & Janssens, 1998; Moon & Hoffman, 2008). Gender theory highlights the concept of socialisation into masculine or feminine roles and that gender is a dominant factor for parents and children (Russell & Saebel, 1997). There are numerous studies regarding parenting and families, including investigations into similarities or differences within the four separate dyads: Mother/Daughter, Father/Son, Mother/Son, Father/Daughter. Much of this literature is quantitative in nature, which although offers significant ideas as to the complexities of each dynamic, for the purpose of the current study the focus of interest is that of the Mother and Daughter, specifically the perspective of the mother and the qualitative narrative of her experience of self-harm within this dyad.

Mothering, although not exclusive to gender, for the purpose of this study is to be associated with the practice of women due to this being its most common association. Mothering refers to women's practices and experiences in bringing up the next generation; moreover, it substantially shapes a woman's gender identity and her relationships (Barlow & Chapin, 2010; Glenn, Chang & Forcey, 1994). The basic outline across many cultures is that the 'good mother' is one that promotes the wellbeing and development of her children; she is protective, patient and nurturing (Barlow & Chapin, 2010). When a woman becomes a mother she goes through a process of embodied change, with this offering a chance for consideration of issues such as the construction of self, and women's own assumptions of their responsibilities and needs, as well as essentialist ideas about the endowments of women (Miller, 2005). The essentialist interpretation flows, in part, from the circumstance of women's reproductive functioning, with the interpretation being that this gendered mothering is static in being natural and universal and her primary role. However, some feminists argue that the concepts of mothering should be regarded as socially and not biologically constructed meaning they are culturally formed, have varied meanings and are subject to change (Glenn et al., 1994).

The mother, and mothering, cannot be examined without consultation from these feminist writings. Feminist academic and analyst foremothers, such as Nancy Chodorow, have contributed hugely to psychology's understanding of women, and their felt place in historical and contemporary society (Bassin, Honey & Kaplan, 1996). These feminist foremothers stress that there are consequences to this assertion of the mother's role. These consequences may be defined by dread and devaluation of their sex (Bassin et al., 1996); shame (Smith & Estefan, 2014); and a longing for separateness (Stiffler, Sims & Noerager Stern 2007). Within the book 'Representations of Motherhood' Bassin et al., and their contributors', focus on the complex issue of how motherhood is represented; with the aim of seeing 'Mother' as a subject, a person, with her own feelings and needs.

As highlighted, most literature focuses the lens on the ideology of the 'good mother' and her duties as such, namely as the provider of emotional care and nurturance, versus the father's role as the provider of practical instruction and sustenance (Moon & Hoffman, 2008; Stolz, Barber & Olson, 2005). With reference to the roles traditionally assigned to each gender, one of the most complex and investigated issues concerns the mother's decision to work outside of the home. Conflict within mothers regarding their choice to work outside of the home, and the impact of this on their children, may be fuelled by popular media, thus contributing to mothers' feelings of guilt and inadequacy (Tummala-Narra, 2009).

Nevertheless, a study on Western mothers explores how women position themselves within cultural ideologies when they perceive that they have a choice in defining their maternal work status (Johnston and Swanson, 2004). These researchers found that mothers' claim that their personal work status decision benefits their children, with mothers describing this thus, at-home mothers are accessible, part-time mothers have quality communication with children, and full-time employed mothers empower their children, building their children's self-esteem. Mothers choose a work status based partly on their individual mothering ideology, and their mothering ideology emerges, in part, to fit their lived experience with a particular employment decision. This offers the suggestion that mothers feel a sense of autonomy with their decision whether or not to work outside of the home. Nevertheless, mothers' narratives may appear to be motivated by a desire to reduce any internal conflict between their needs and those of their child's, as portrayed in contemporary media, literature and research.

Nonetheless, Bassin et al. (1996) state that society complicates female independence with a longing for a 'selfless other' to take care of us and as we develop and grow we struggle to accept a mother's separateness and own life. It is said that society cannot escape from the fact that women mother, and all that is feminine - the personality and the self - is defined in connection and relation to others (Chodorow, 1995). This continues to be demonstrated in

contemporary literature, which persists in asserting that the mother provides a more nurturing, caring supportive role, attending to emotional needs. As discussed, nurturing has a strong link to sentiment and the bodies of woman and child, and appears excluded from the ideas of free will. However, within the works of Everingham (1994), and in her analysis on motherhood and broader debates on modernity, she explores the autonomy and agency of women carrying out nurturing activity. Everingham concludes that sometimes a mother's reasoning for action can be understood from the standpoint of the individual, as highlighted by Johnston and Swanson's, 2004 employment ideology; often their reasoning takes in the needs of the family as a whole.

Mothering ideology

Psychoanalysis and attachment theory, although helping to legitimise women's function in society, has resulted in the ideal as women being responsible for raising morally and emotionally stable citizens. Therefore, a woman's role of mother was considered to make up the core of female identity and appraisal in patriarchal societies (Gajardo & Oteíza, 2017; Laney, Hall, Anderson & Willingham, 2015). A contemporary reinforcement of this ideology of mothering came with Hays 1996 book 'The Cultural Contradictions of Motherhood'. Hays analysed the history of ideas about child rearing, conducted an analysis of contemporary literature on child-rearing- looking for common themes, and also spoke with mothers themselves to identify how mothering would look in the perfect world. The resulting concept was a culturally contemporary (and arguably Westernised and Middle-Class) model of socially appropriate mothering in the form of an ideology of 'Intensive Mothering' (Hays, 1996). Intensive mothering as a concept is a gendered model suggesting mothers spend an extensive amount of time, energy and money on raising their children. This concept has become controversial as the 'intensive mothering' ideology apportions mothers absolute responsibility for children's upbringing (Gajardo & Oteíza, 2017). In addition, there is growing research indicating that intensive mothering diminishes mothers' emotional wellbeing (Gunderson & Barrett, 2017). Gunderson and Barrett found that, consistent with other research (see also Rizzo, Schiffrin & Liss, 2013), mothers who spent more emotional time

supporting their children and less time on other pursuits were at risk from self-reported poor mental health, as well as these sacrifices eliciting their anger and annoyance, leading to consequent feelings of guilt. Rizzo et al. (2013) also highlight the paradox of the detriment to positive outcomes for children's futures if their mother's suffer with low wellbeing and poor mental health. So, what should mothering look like in contemporary society and what identity do women take-on as they become 'Mother'?

Mother as an identity

Exploring the debate of mothers' working outside of the home, as discussed previously, demonstrates a wealth of literature involving varied discourses and attitudes surrounding this on-going debate. Academics have vigorously explored the extent to which family and work roles interconnect with women's emotional, physical, and relational health, thus highlighting the enduring focus on cultural and societal expectations of mothers. There are disagreements about the level of autonomy or choice that women and mothers have regarding their life-choice decision-making. Despite previous feminist writers' suggestions, Hakim (2003) believed that women's choices are not necessarily led by cultural attitudes or social policies, but due to preference or built from components of their identities. Research on mother identity has demonstrated that the customary model of motherhood, one that considered motherhood to be at the heart of feminine identity has changed (Maher, 2005). Maher explains that women have found additional sources of identification, such as occupation and individual interests. Maher also found that, although the women in her studies were aware of cultural expectations and societal images of motherhood, they did not see their identity of mother as distinct to any other identities available to them. Mothering was an extension, something fluid and temporally adaptive, an addition to other roles within their lives. Maher's findings are that, although this is notwithstanding tensions mothers felt about choice-making, there was no distinct conflict of self within them.

Another study challenging the concept of mothering as a fixed identity is Valencia's 2014 ethnography involving 18 months of fieldwork within low-income families in the North of England. Valencia's study explored mothers as targets of state intervention and how these mothers deal with expertise and 'psy-knowledge' projected upon them. Valencia found a disparity between what policy-makers (Health Care, The Welfare State, Charities etc.) felt was required regarding good parenting and parenting skills and those felt necessary by the mothers themselves. She explains that the women in her study resisted this expert language, and through everyday practices created and reproduced their own practical knowledge according to their own social climate. Mothers negotiate tensions and anxieties of self by creating a more realistic dialogue of themselves as everyday experts. Therefore, they commit themselves in different ways to caring for their children based on their learned understanding of their individual and specific social needs, opposed to what the state, with its professional services and language, maintains is required. Mothering, as far as Valencia's study determines, is not fixed or determined by what professionals have decided it should be, but that mothers have discovered their autonomy and are fluid with their social negotiation and development of motherhood.

Nonetheless, there is likely a process of adaptation and change that is undertaken as one travels the journey from non-mother to mother. One grounded theory study claimed to provide unique contributions to the production of a model surrounding identity changes of women becoming mothers and the intrapsychic processes involved (Laney et al., 2015). The results suggest a complex process commences when women become mothers. A process which may involve a brief period of self-loss and identity transformation but results in 'expansion', as opposed to a linear change of their identity. This expansion simply includes another person within the boundaries of the self and of consciousness. Laney et al. also discovered that women varied in their freedom and fusion with their children, thus affecting the degree to which women used the mother-child relationship in reflexive ways. Laney et al. conclude that the process is, nonetheless, uniquely relational and identity transforming.

These writers' suggestions highlight the many complexities and individual differences within mothers, mothering, self and others expectations, as well as the importance of cultural and economic influences. Nonetheless, they all suggest a shift within mothers to reframe motherhood from a sole identity and purpose, to something pragmatic, fluid and flexible; contingent on the temporal or situational context, as opposed to essential. The mothers in the studies also demonstrate an awareness and pride, as they reflect on their ability to balance work, life and motherhood. Is the landscape finally shifting, as mothers' narratives change to a voice of choice and independence, or are mothers' narratives a deliberate attempt to push against expectations of them, a method employed to reduce any internal destabilisation of self, as they search for identities alternative to 'Mother'.

Cultural issues

As discussed previously regarding attitudes to emotional and behavioural difficulties within their children, cultures alternative to European and American may have alternative philosophies for their role as 'mother'. The formation of female-mother role identity is strongly linked with changing cultural identifications (Tummala-Narra, 2004) and this is more commonly demonstrated by research exploring immigrant mothers, and the complexities surrounding mothering cultural practices within a foreign environment. Complexities already demonstrated within this study with regards to the high rate of self-harming due to cultural conflict. However, cultural changes do not occur consistently across all social groups, as social, cultural and historical factors influence the way in which mothers construct their identities (Gajardo, & Oteíza, 2017). Gajardo and Oteíza investigated the ideological model of mother identity articulated in the discourse of four mothers from the lower socio-economic group of Santiago, Chile. They concluded that postmodern cultural transformations (such as those discussed above in the Western studies) do not seem to occur equally across socio-economic strata. Therefore, Gajardo and Oteíza found that traditional identity constructions of mother existed despite cultural transformations in the concept of mothering brought about by postmodernity and the implementation of gender equality programs. In this case it was found to be due to these

particular mothers' ideological constraints, such as poverty and vulnerability and, more-so, because they are often the only figure on whom those duties can fall. Therefore, changes in attitudes are dependent on historical, social and cultural factors.

This in part explains the concept of the problem of cultural conflict, as the offspring of these mothers develop within a postmodern society. Another issue discussed by Nancy Chodorow, in her works on the psychodynamics of the family, is the need for some immigrant mothers to hold on to the memories of their mother's values and traditions that were entrenched within their cultural origins. Therefore, demonstrating these within their own mothering practices, thus reconnecting with their idealised images of parenting and heritage (as cited in in Tummala-Narra, 2004, p.170). They may send children to classes on religion or language and although this can be stabilising for a mother to reconnect with her heritage and past, this may create problems of conflict within the home. The mother's desire to reconnect with the country of origin may hinder the mother and child's ability to engage with a new cultural context. The level of success with this relies heavily on the mother's ability to function effectively within two different cultures. Levi (2014) studied immigrant Sudanese mothers in Australia, thus discovering evidence of these mothers having the strength and willingness to find new ways of parenting to adapt to new situations and contexts. Levi concluded that some women struggle with these adaptations and some mothers' flourish, but highlights that why this disparity exists requires further study. It seems a mother's ability to adapt to new contexts, such as, cultural, social, economic or other, and whether with regards to societal expectations, cultural expectations or their own embedded ideologies, is crucial to their capacity to provide adequate support and understanding for their children. This alone highlights the concept of the responsibility that often befalls women as mothers.

Despite numerous studies on the culture, practice and definitions of mothering, there is still a shortage of literature exploring the experiences of, and giving voice to, mothers (Shearer, Crouter & McHale, 2005). Thus, Bassin et al. (1996)

explore how previous discourses have excluded the woman's voice. The current study aims to explore the narrative of the mother's experience and her ideology in her own personal narrative, and help to disentangle the subjective from the general and choice from the expectation, at a time when what is traditionally defined as a mother's aim - nurturing, patience and protection - is unremittingly tested.

Mothers and daughters

These ideas of mothering are also reinforced by the attitudes of mothers themselves and the influence of this on their daughters. This is played out within child-rearing styles and mothers' own attitudes to gender roles with their daughters, with the main proportions of household chores are still being undertaken by the mother (Jan & Janssens, 1998; Kulik, 2004). Additionally, the mother continues to be the one to reduce employment after the child is born (Jan & Janssens, 1998). There are indications that the level of mothers' education correlates with more liberal gender-role attitudes thus influencing daughters. This is a positive finding as it holds potential for mediating anxieties mothers experience managing the work-childcare balance. Daughters may develop a more balanced view in the future, as they become employees and mothers, mitigating the emotional battle mothers feel trying to be successful professionally alongside fulfilling their own, and others, expectations as a mother. To add to this, pressures within contemporary society have evolved, with mothers now facing the increasing demands of successful careers - yet still be available as Mother (Moon & Hoffman, 2008).

To continue this theme, the mother/daughter dyad has been described throughout much of recent literature as representing a distinct relationship (Russell & Saebel, 1997). This is in part explained as due to characteristics such as expressiveness, emotional support and connectedness. Moon and Hoffman in their 2008 study on gender-based expectancies in parenting, found that not only were mothers more involved in the emotional aspects of parenting, but that they evidenced these behaviours more with their daughters than with their sons. They continue by asserting that, consistent with other literature,

fathers demonstrate less involvement with their daughters than with their sons. Russell and Saebel (1997) also support the idea of fathers' reduced involvement with daughters compared with that of mothers. Galbo's 1984 research into adolescents' perceptions of significant others indicated that fathers were viewed as of little importance in comparison with other adults significant in the adolescents' lives. In contrast, Lollis (2002) highlights that all parent/child dyads are distinct, with no two relationships being the same, as interactions, thoughts and experiences will all differ.

It has been discussed that historically the role of mothering may be rife with complexities of stereotyping, internalised expectations and a yearning for one's own needs to be met. Still, in the present day mothers are frequently described as having the greater involvement in caregiving roles; with the mother/daughter bond generally considered one of the strongest. Mother/daughter dyads have been found to have greater concordance with discussing sensitive issues, such as self-harming behaviours, than other parent/child dyads (Mojtabai & Olfson, 2008). Nevertheless, adolescence is said to be the most difficult time for this dyad (Karp & Tanarugsachock, 2000) with changes such as, adolescent females evolving from being receivers of care from parents to becoming self-sufficient and potential caregivers to others, i.e. peers and romantic partners (Allen 2008).

During the time of the child becoming an adolescent, mothers may also be dealing with their own developmental issues. This may be a time of separation and self-identification for both mother and daughter (La Sorsa & Fodor, 1990). Mother and daughter are confronting developmental challenges simultaneously, which can either enhance or diminish each other's attempts toward autonomy and growth (Clarke & Clarke, 1999). For many women the transition from mothering the dependent child to mothering the emerging adult is a difficult one. Nevertheless, although this can be a painful time for mothers it may also be a time of gain, offering a sense of freedom and relief from the heavy burden of parental responsibilities (Stiffler et al., 2007). Additionally, as part of the separation process daughters may impose restrictions on their intimacy and

limit what they tell their mothers, resulting in mothers finding this a vulnerable period of midlife, evaluating themselves whilst suffering loss and rejection with the process of a daughter pulling away. One mother has explained this loss by asking “What happened to the little girl who followed me everywhere and wanted to be by my side?” (La Sorsa & Fodor, 1990, p.601). This loss may be exacerbated by the fear that there is nothing to replace this role of ‘Mother’. La Sorsa and Fodor (1990) found that the most common pattern between mothers and daughters was the dance between intimate involvement and attempts at separation. This may involve complex feelings of idealisation, competition, envy, guilt, resentment and rebellion.

Mothers explain that they live with blame and shame as they feel their duty as mother, is perceived by society as responsible for their child’s behaviours. They have voiced that they feel shunned with an assumption that they play a role in the causation of their child’s problem (Smith & Estefan, 2014; Usher et al., 2007). This feeling of shame may have the detrimental afect of avoidance of seeking support from significant others or HCP’s resulting in a lack of adequate support for both parent and child.

As the mother/adolescent daughter relationship could already be complex it seems of value to explore how women experience the role of mothering a daughter whom she knows to be self-harming; a practice blanketed in assumptions, confusion and fear. A practice that has come at a time when mothering customs are expected to be altering to accommodate a developing adult, customs anticipated to be reducing in intensity even. What may it feel like to experience the mothering role from an unanticipated position?

Limitations of previous research

Within the literature discussed, variables are defined that may influence individual mothering practice such as mothers’ individual perceptions of their role, including perceptions of their relationships with their daughters. In addition to this, as a result of these dyadic relationships being constructed through interactions over time, 15 plus years in the case of the present study, parents

and children engage in present-time interactions influenced by their past history of interactions and the prospects of future interactions (Lollis, 2002), each with their own individual differences. Differences exist, such as the mother's own developmental template, environmental and cultural experiences and perceptions of gender.

Limitations to previous studies which call for further exploration are that many are theoretical or quantitative, thus, supporting the current study's aim for a qualitative exploration into the depth and richness of individual experience and subjectivity. This philosophy contrasts with quantitative approaches that deduce and test hypotheses (Janssens et al., 2015; Galbo, 1984) or theoretical assumptions on parenting with no direct evidence-base.

RESEARCH RATIONALE, AIMS AND QUESTIONS

Research rationale

The literature reviewed suggests that while the empirical base for parental experiences of their child's self-harming is growing, indicating a need for studies in this area, there is still a paucity of literature specifically exploring the internal processes of the parents, significantly those of the primary caregiver. Moreover, the research to date has ignored the distinct role of the primary caregiver, the mother (as indicated within the present study), and the nuances within this unique role. This is despite the fact that for decades' literature has focused on the emotional and practical complexities of mothering and the impact of being a mother in contemporary society, this is notwithstanding the addition of intricacies such as psychological difficulties and self-harming behaviours of their child. The review has discussed a handful of studies that have examined the experiences of parents of self-harming adolescents, however, there have been limitations to these studies:

- Oldershaw et al., (2008), although used IPA to explore parental 'perspectives', in the noun form, versus 'experience', in the verb form, the research appears to lack a certain depth and specificity. The study captured many of the nuances of the parents' journey through their child's self-harm but appeared to not examine the depth of impact to the parents' personal-self. This seemed to be an outcome of interviewing mixed gender carers of mixed gender adolescents with the focus on being a parent as opposed to man, woman or individual in their own right.

- McDonald et al. (2007) highlighted this limitation as, by chance, recruited only mothers as participants. Although this appeared to have the consequence of a depth of emotional impact within the analysis, with the suggestion offered for services to consider the emotional impact on parents, the specific role as primary caregiver was not considered for its significance within this phenomenon.

- Ferrey et al. (2016) focused on changes in parenting strategies after the discovery of self-harm, and this is a significant occurrence within all the literature and key to the impact of self-harm and parents experience of. However, there was a large mixed participant sample, the implication of such is the loss of depth and richness of content. Their study did highlight a discord in attitudes between the mothers and father dyads, indicating a deeper exploration of the experience for one specific dyad and any impact of such dissonance.

- There were other studies of importance to the current study where convergence and divergence may potentially be demonstrated. However, only Oldershaw (2008) used an IPA methodology, with many others being quantitative in nature. All (apart from McDonald et al.) had mixed gender participants with non-specifically gendered adolescents. As a

result, there seems a reduction in the depth of exploration into the particular experience for the parent's unique role and individualism.

- Eight studies of importance into variations of the parental experience of self-harming adolescents all stated their conclusions as contributing to the need for greater education and training for parents and/or and health care providers. None specifically identified the impact of personal experience for the parent distinguished as the primary caregiver and the psychological impact on them as a woman – or man if applicable. Nor the impact on them within their individual role as part of the nuclear and wider family, or socially; features pertinent for exploration within individual therapy, which may be of particular relevance to Counselling Psychology. As well as this being a consideration for other HCP's understanding and treatment of individuals that may commonly present to them with extreme confusion and distress.

In contrast the current proposed study has several advantages:

- A unique and specific focus on the experience of mothering, as the primary caregiver (in this instance), and the social and emotional implications of this having the potential to bring a depth and richness to the analysis. The lens being focused specifically on daughters and any distinctions of the mother/daughter relationship bringing a particular detail not examined previously. Notwithstanding, the homogeneity of this sample sitting well within an IPA methodology, in itself the methodology of choice for examining a depth of experience.

- The researcher has extensive experience of working therapeutically with individuals and thus is able to sensitively provide maximum space for them to express their thoughts and feelings.
- The researcher is adept in reflexivity being aware of her position as researcher and as a psychological therapist to mothers of self-harming

adolescents, and adolescents who self-harm. As well as being a mother of adolescent daughters (although there are no indications the researcher's children have self-harmed according to the definitions offered within the current study).

Research aims

The literature discussion, thus far, has touched on the pathology of self-harm from the clinician's and the parents' perspective. Although, counselling psychology's philosophy is not led by the labelling or pathologising of individual's psychological difficulties, it is somewhat naïve to believe that health care professional practices are not influential to the parental experience of the phenomenon. Whilst a great proportion of those that self-harm never present to clinicians (Rowe et al., 2014) it is important to consider that as a health care professional (a Counselling Psychologist in Training and Counsellor within a Further and Higher Education establishment) those who self-harm that present themselves to the researcher as a psychological therapist, will obviously fall within the group that do present to HCP's. In addition to this, mothers may present to the HCP as distressed, confused and requiring her own support at any point throughout her journey with self-harm. Therefore, it is considered valuable to include how participants are affected within their concept of self, how their ideologies may be challenged and any processes involved alongside these.

Nevertheless, a parent's role within their child's development and problems with is undisputed, with the literature review thus far emphasising the significance of parents' thoughts, emotions and behaviours surrounding their child's self-harming; including cause, maintenance of, and help-seeking. Consequently, a particular research aim within the present study is to gain an understanding of how the phenomenon of self-harm affects the parent at a deeper, experiential level, but this not only includes the emotional impact on the parent but their experience, perceptions and subsequent behaviours within other relationships inside and outside of the home.

The general scope of research examined, has been the parental dyad (Mother and Father). However, this study aims to focus on the experience of mothers, more specifically, the experience of mothering a daughter that self-harms. This experience not only encompasses the clinical or socially described psychopathology of self-harm but how the phenomenon is experienced and affects, what may be described as, the primary giver of care - the nurturer - the mother (Galbo, 1984; Liat, 2004; Moon & Hoffman, 2008).

This focus is not merely motivated by the requirement for homogeneity within a methodology such as that used within the current study, but inspired by questions elicited by the discussions of previous research of this kind. Questions, such as the expectations of society and individual expectations of the mothers themselves when faced with such phenomena. Exploring the question of division between selflessness and freedom of choice, and whether a mother is able to define such when offered the opportunity to reflect on herself as a woman versus mother. Furthermore, with such emotive and episodic reflection, what may Applied Psychology Professionals learn from 'experts by experience' to help direct a phenomenon branded with shame and poor understanding into the realms of healthy acceptance and stable management by those most likely to be closely affected.

Research questions

1) What does 'Mothering' and being a mother mean to each participant?

2) What is each participant's narrative and experience around when they first discovered their daughter had self-harmed?

3) Who did they first discuss this with, including any others they felt able to share this with, and reasons for why or why not?

4) How have the participants' experienced others within family or social groups?

5) How has the self-harm affected their experience of being a mother?

6) How has the self-harming experience impacted on the participants as an individual, specifically as a woman?

METHODOLOGY

Design

Counselling Psychology's distinctive identity as a discipline emphasises alternative discourses about psychological wellbeing and distress as distinct from those of the medical model (Woolfe, Strawbridge, Douglas & Dryden 2009). Counselling Psychology works in recognition of the sufferers' own experiences and perceptions; thus research formulated within a counselling psychology context should be undertaken whilst maintaining inquisitive and open minds.

Ontology and Epistemology

When conducting research, the methodology of choice is informed by the ontological (the nature of being) position of the researcher and the researcher's epistemological (the nature of knowledge) position (Braun & Clarke, 2013). Critical realism is an ontological assumption in keeping with the researchers own position as a counselling psychologist in uncovering individuals' truths. Critical realism asserts that reality independently exists, and that an individual's experiences and perceptions of reality are subjective (Bunge, 1993; Wertz, 2005). Nevertheless, there are a number of different qualitative approaches which critical realism underpins.

Contextualism is an epistemological assumption, which does not assume a single reality, seeing knowledge as emerging from contexts, as well as reflecting the researcher's positions. Contextualism asserts that knowledge will be true in certain contexts- human beings are not passive perceivers of an objective reality but interpret their world by way of formulating their own personal stories in a form that makes sense to them (Brocki & Wearden, 2006). This idea seems congruent with the philosophy of counselling psychology, which is phenomenologically focused and concerned with understanding people's inner worlds and uncovering subjective truths (Woolfe et al., 2009). Wertz (2005, p.176) asserts that a phenomenological methodology is especially suited to Counselling Psychology as their work 'brings them close to the naturally occurring struggles and triumphs of persons. Counselling Psychologists require high fidelity knowledge of persons that maximally respects the experience and situational contexts of those they serve'.

With such a subjective ontology generating a more interpretivist approach it seems appropriate to use qualitative methods of enquiry to explore adequately the depth and complexity of human experience (Morrow, 2005). Qualitative research is focused on describing the aspects that make up experience (Polkinghorne, 2005), therefore, with the current research focus being directed at the lived experience of the participants, a qualitative methodology has been deemed the most suitable approach. This philosophy contrasts with nomothetic and quantitative approaches which deduce and test hypotheses

One such qualitative methodology respected for adequately exploring the depth and complexity of human experience is Interpretative Phenomenological Analysis (IPA). IPA is a qualitative approach that has been described as a way of "…moving beyond the divide between the quantitative social cognitive approaches and discursive approaches…" (Langridge & Hagger-Johnson, 2013, p. 446).

What is IPA?

IPA explores people's experiences and the meanings they attach to them; it is essentially the study of lived experience and personal perceptions (Braun & Clarke, 2013). IPA assumes an epistemological stance where it is possible to access an individual's cognitive inner world through cautious and explicit interpretative methodology (Biggerstaff & Thompson, 2008). Thus, use of such a methodology aims to communicate to readers a sense of quality and texture (Smith, 1996).

The theoretical underpinnings of IPA come from phenomenology, hermeneutics and idiography (Smith, Flowers & Larkin, 2009). The philosophy of phenomenology holds that psychological reality, and its subjective processes, can be authentically discovered. The phenomenological view of experience is complex. It may be uniquely situated within an individual but in relation to the world and relationships (Smith et al. 2009).

The qualitative research method of phenomenology was developed by philosopher Edmund Husserl, as a response to what he considered a general dehumanization of psychology (Wertz, 2005). Husserl's aim was to offer theory and research that reflected the unique characteristics of human behaviour. Husserl believed that life was not lived objectively in a positivist philosophy, nor did he believe it was lived subjectively. He would say that it is lived through a phenomenological philosophy, joining together the subjective and the objective. Heidegger, a student of Husserl, felt that phenomena show themselves in the world but that a phenomenon is not a *thing* residing in consciousness. He believed that it was brought into being in the day-to-day *contextualised* living in the world- the mind and the world together, interconnected. Heidegger was concerned with how a phenomenon appears to the observer (analyst), who facilitates and makes sense of this appearance (Vagle, 2018).

Hermeneutics, the theory of interpretation, was a separate body of thought to phenomenology, and Heidegger brought hermeneutics and phenomenology together through his philosophical writings (Smith et al., 2009; Vagle, 2018).

Whereas, Gadamer (another German philosopher) popularised philosophical hermeneutics, strongly influencing interpretative phenomenology as a research methodology (Vagle, 2018). This was in slight opposition to Husserl who was more concerned with non-prepositional, pre-cognitive knowledge (Wertz, 2005). Interpretation, a vital aspect of IPA, enhances a standard phenomenological approach by contextually grasping portions of a larger whole (Wertz, 2005). Heidegger's (and later developed by Gadamer) hermeneutic circle describes interpretation as an on-going act, and any interpretation should be made in the context to which that text was written (Vagle, 2018). This is also consistent with the position of a counselling psychologist, for example, within the context of an on-going, continually developing client formulation.

An additional influence on IPA is that of idiography (Smith et al. 2009). IPA uses small purposeful samples from which to obtain a depth of analysis of each individual's unique experiences, but which is also able to move to an examination of particular people and general claims (Smith et al. 2009).

Role of the researcher in the research process

Smith et al. (2009) emphasise that Heidegger's insights of phenomenology as a hermeneutic undertaking highlights what happens within interpretation of data. We may not necessarily be aware of our fore-structures until we have engaged in an interpretation of a phenomena which, in turn, aids us in understanding what our preconceptions were; a concept resonant with reflexivity in research. Reflexivity refers to the process of critically reflecting on the knowledge we produce, as well as our role in producing that knowledge (Braun & Clarke, 2013), hence the necessity of keeping a research journal to record thoughts, feelings and other reflections during the research process.

Rationale for chosen methodology

In planning this research various methodologies were considered in terms of their relevance to the research question.

The decision to apply qualitative rather than quantitative methods

The idea of general claims within qualitative research, as discussed previously, is prescribed in an alternative way to nomothetic enquiry, which is concerned with large group averages, rather than individual cases. Although popular in psychology, as the most dominant approach in the United Kingdom, United States and other countries of significance, a nomothetic approach may be criticised as oversimplifying the complexity of human nature, failing to recognise the individuality and autonomy of humans (Langridge & Hagger-Johnson, 2013).

To attend to its objectives, the design of this study is explorative, descriptive and contextual in nature. Being qualitative in form it offers the opportunity to uncover the nature of mothers' experiences of their daughters' self-harm, and examine how this affects how they feel about, and experience, their role as a parent. Therefore, the primary purpose of this exploration is to gain a richer understanding of their experiences and focus on the interpretation of meaning by use of an inductive strategy. The descriptions by the participants reflect the details in lived situations, rather than through hypotheses or opinions, explanations, generalisations or inferences. The concreteness of a qualitative approach, such as IPA, is a significant quality (Wertz, 2005).

The aim of the current research is concerned with individual complexities of human nature and experience, not concrete testable statements. How mothers have experienced mothering daughters whom choose to harm themselves as a result of their individual distress, cannot be easily quantified. Themes may be identified individually or in the context of the sample selected, but it is not the aim of this project to measure specifics accurately enough to make claims with a degree of certainty about the object of study.

Rationale for using IPA

IPA is often described as similar to, but going beyond, standard methodologies such as Thematic Analysis and Grounded Theory. For example, during the interpretative phase the intention is to keep revisiting the data, analysing how

the expressions already categorised reflect respondents' individual and unique experiences (Brocki & Wearden, 2006). IPA is said to be grounded in psychology, as opposed to these other methodologies holding stronger links to sociology; thus providing a systematic method that psychologists can use to carry out phenomenologically informed social research (Langridge & Hegger-Johnson, 2013). Langridge and Hegger-Johnson also maintain that, as a relatively modern approach, IPA has had to argue its usefulness to the degree that its utility need no longer be contested.

In contrast, other methodological approaches are often designed to explore potential *factors of influence*, such as with grounded theory, or specifically the *structure* of the participants' story, as with narrative analysis (Smith et al. 2009). For this study the concern is to gain rich experience of how a mother perceives, feels, and has lived her role of mothering a daughter who self-harms. The concerns are not for what has influenced her experience, or *how* she tells the story of her experience. IPA is said to be similar to Thematic Analysis (TA) but the distinct difference between the two is the focus on interpretation in analyses for IPA, whereas TA's results are broadly descriptive and may, in comparison, lack the depth required for this study (Smith et al., 2009). In addition, from the original concept of hermeneutics, along with a symbolic-interaction perspective, IPA suggests that the meanings an individual ascribes to events are of central concern but are only accessible through an interpretative process. It assumes an epistemological stance whereby, through careful and explicit interpretative methodology, it becomes possible to access an individual's cognitive inner world (Biggerstaff & Thompson, 2008).

As IPA is a qualitative research approach that is compatible with a realist epistemology, it sits in accordance with the researcher's personal and professional view. To add to this, IPA is informed by hermeneutics and with this the assumption that humans are sense-making. Therefore, their accounts given at interview will reflect their attempts at making sense of their experience (Rodham, Fox & Doran, 2015).

This study aims to give voice to mothers' experience of their adolescent daughters' self-harming, to listen and understand the cognitions and emotions of each individual participant, and therefore to help humanise a phenomenon little understood and all too often ignored. Therefore, it seems most appropriate for IPA to be the methodology of choice.

Data collection

Development of the Research Instrument

The research instrument evolved as a result from the literature review already conducted and the development of questions arisen from the researcher's experiences of working with mothers of daughters who self-harm, as well as the adolescent daughters that self-harm (see Appendix B). An interview schedule of semi-structured questions was designed with a view to glean information concerning a breadth and depth to the mothers' experiences of their daughters' self- harming behaviour.

The Research Instrument

Interviews were used solely for this project. The interview schedule comprised open-ended questions, with prompts that aid the researcher in encouraging the participants to elicit narratives regarding:

- What mothering means to them
- How it felt on discovering the self-harm
- How they have been able to share their thoughts and feelings and their experience of others
- The extent to which their experience of mothering been affected
- The impact on them as an individual (not as a mother)
- Anything else they wanted to share concerning this experience

The initial question was placed first as a way to focus the participant on the mothering aspect of the research, as it was felt there might be too much emphasis by the mothers on the self-harm aspect of the research. The aim was to home in on their parenting role as a woman, as well as placing them in that

role for the purpose of the interview and to get an understanding of how they see themselves as mother to their daughter and other children.

This was in contrast to the last-but-one question, which was designed to encourage participants to reflect on their role outside that of being the mother, and on their identity and how this may have been affected after the self-harm disclosures.

Method

Participants

Sampling considerations:

Despite the suggestion that mothers *and* fathers, are both an important factor regarding adolescent self-harming behaviours, a review of literature examining the role of parents of adolescents that self-harm brought to light the phenomena of mothers as the participants most sampled (Baetens et al., 2015; Barrocas, Hankin, Young & Abela, 2012; Ferrey et al., 2016; Fortune et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006), Many authors explain this as being due to mothers being the most willing respondents, a factor which must be considered for recruitment purposes in a study of this kind, but also a factor to be explored in more depth in the context of the role as mother. Research in other domains also highlights the greater willingness of women to volunteer for participation in studies of this nature and explains this as consistent with their generally greater involvement in caregiving roles of all sorts (Karp & Tanarugsachock, 2000). A distinct trend is also that many of their self-harming adolescents were also female. Notwithstanding the literature and statistics examined previously pertaining to this, there must be consideration for the limitations of this mothering and mother/daughter exploration, emphasising a future requirement of similar studies devoted to the male perspective.

Homogeneity

IPA is a partly idiographic approach concerned with understanding particular phenomena in particular contexts and therefore homogeneity of sample is preferred. Within a relatively uniform sample group the psychological variability can be better examined by analysing the pattern of convergence and divergence that may arise (Smith, 2009). For the purpose of the present study and appropriate to the desire for homogeneity of IPA, solely a sample of mothers of adolescent daughters was sought.

As discussed previously the mother daughter dyad is established as particularly complex during adolescence, with both mother and daughter going through life changes, including mothers' attempts to develop new ways of parenting an emerging adult (Stiffler et al., 2007). Furthermore, previous studies on self-harm have determined influences regarding gender, such as discovering an age by gender interaction, as well as gender influencing the behavioural methods used to self-harm (Barrocas et al., 2012). Likewise, those that self-harmed were found to have a poorer relationship with mothers than those that did not practise self-harm; in contrast, it was found that poor identification with fathers had an effect on only frequency of the behaviours (Di Pierro, Sarno, Perego, Gallucci & Madeddu, 2012). Finally, Padilla-Walker, Hardy & Christensen (2011) concluded their findings were consistent with previous research that suggested the differential role of mothers and fathers on adolescent outcomes.

Inclusion criteria:

There is much evidence for self-harm being a common phenomenon in adolescents in both clinical and community samples. Therefore, whether the daughter had accessed clinical support for her self-harming was neither a requirement nor a reason for exclusion. By chance, all the participants' daughters had accessed clinical services for support, but the above statement demonstrates the potential for generalisability (Swannell, Martin, Page, Hasking, & St John, 2014; Burešovà & Hochmanova, 2016). Accounts from caregiving experiences suggest that reactions to their children's diagnoses change over time as more information becomes available, as their children's functioning alters, and as they interact with different professionals. In addition,

previous research found a limitation of the true experience of parents if they were interviewed too soon after the process of discovering about their child's self-harming behaviour (Ferrey et al., 2016; Raphael et al., 2006).

The population available that meet the desired criteria for the study is therefore not considered to be vast. The criteria used were therefore simply birth mothers who had, or were currently, living with their adolescent daughter who was between the ages of 15-18 years when she was engaging in self-harming behaviours, and that the discovery by the mothers, of these behaviours was six months or more prior to interview, for reasons explained above. Behind the rationale of the selected age of adolescents sits the idea that the participants would have already experienced the transitions through puberty - a development stage that itself warrants individual exploration (Paikoff, Carlton-Ford & Brooks-Gunn, 1993). The upper age limit for this study was decided with the idea that at 18 years (or younger) adolescents have not commonly reached an age of significant independence and autonomy through leaving home to attend university or full-time employment. Moreover, it is of interest to explore the parent's experience of anticipatory thoughts, ideas and anxieties, with these having greater ubiquity whilst parents still have only a presumed sense of the responsibilities yet to befall their children. Previous research, and its conclusions, has been variable regarding the specificity of the age-range of adolescents.

Exclusion criteria:

There were no significant criteria outside of the inclusion criteria that would exclude a participant from the research, aside from not selecting a participant who had themselves, or their daughter, been a client of mine at any point.

Participant information

Smith et al. (2009) recommend anywhere between and four and ten participants for an IPA study for a Professional Doctorate, emphasising that less is more, due to the idiographic nature of IPA. The recommendation is that participant numbers should be decided on a study-by-study basis. It was felt that six

participants would be a manageable number to recruit and be small enough a number to be congruent to examining in greater depth. Yet it would also be enough to satisfy IPA's focus on convergence and divergence within a participant group's experience of a phenomenon (Hefferon & Gil-Rodriguez, 2011).

The purpose of this research was to provide an interpretation of each individual's account of her experience of mothering an adolescent daughter who self-harms, and to demonstrate this by discussing these interpretations alongside quotes embedded in the person's account. Due to the depth of individual interpretation, IPA has a preference for fewer participants examined at a greater depth whereas these other methodologies may suggest a broader, shallow and simply descriptive analysis of sometimes many individuals (Hefferon & Gil-Rodriguez, 2011).

A summary of participant information is detailed below in table one:

Table One

Participant number	Demographic Information	Daughter's Information
1	Aged 50; married to father of daughter; four other children; employed part-time	Currently self-harming; 15mth duration (history of ED, cutting; self-poisoning)
2	Aged 46 years; married to father of daughter; two other children; employed part-time	Not currently self-harming; 1yr duration (history of cutting)
3	Aged 50 years; married to father of daughter; one other child (twin); employed part-time	Not currently self-harming; 8yr duration (history of ED, cutting, self-poisoning)
4	Aged 53 years; unmarried - separated from father of daughter many years	Currently self-harming; 9yr duration (history of ED,

	previously; one other child; employed part-time	cutting, self-poisoning, risk-taking behaviours)
5	Aged 55 years; married to father of daughter; two other children; employed part-time	Not currently self-harming; 5yr duration (history of cutting, self-poisoning, risk-taking behaviours)
6	Aged 47 years; married to father of daughter; one other child; employed part-time	Currently self-harming 18mth duration (history of cutting, self-poisoning)

Procedure

Ethical considerations

Ethical Approval

In accordance with the four principles laid out in the British Psychological Society's (BPS; 2009) Code of Ethics and Conduct, informed consent was obtained before undertaking the interviews required for this research. Confidentiality and privacy were maintained, with all information regarding this outlined within the participants' information and consent forms. Participants had the right to withdraw up to the completion of the data collection.

No unnecessary risks towards the participants were taken and signposting to an appropriate agency was provided if the participants become distressed in any way, as it was acknowledged that the mothers were being requested to reflect on such an emotive experience. Supervision was available for the researcher provided by her Director of Studies (DoS) or Second Supervisor (SS) as required.

The ethical application to pursue the project and recruitment of participants was scrutinised and approved by The University of the West of England's Faculty Research Committee (see Appendix C for protocol summary). Subsequently, the ethical approval request was amended twice to counteract the difficulty in recruitment; these amendments were also approved (see Appendix D)

Consent process

Informed consent:

The skills learned as a counselling psychologist were helpful when informing the participant to anticipate their reaction considering the emotive nature of the topic, and with ensuring their ongoing consent by way of monitoring their coping; always keeping open the opportunity for them to withdraw if they felt this was necessary.

The full process and intention of the research was explained to the participants via email; then verbally on meeting and then via the written participant information and consent forms. This included the intention for the final write up, as suggested within the Professional Practice Guidelines of the BPS Division of Counselling Psychology (2005), to include a shortened version of the full thesis that would be submitted for journal publication. If appropriate, applications shall be made to present the research findings at conferences, such as the BPS Division of Counselling Psychology's (DCoP) Annual Conference, and similar.

The participants were asked to sign the information and consent forms (see Appendix E and F). The relevant policies of the University of the West of England were adhered to at all times.

Right to withdraw:

Participants were informed via the consent form they read through and signed of their right to withdraw at any point during the interview process and until write-up and submission. This was also clarified to them verbally before commencing the interviews.

Recruitment

The participants were recruited via purposive sampling, relying on volunteers recruited initially through advertising in emails around the employees of Bridgwater and Taunton College, a College of Further and Higher Education, within which the researcher works as Mental Health Team Leader and Counsellor of staff and students. It should also be noted that the participants would not have any links to any clients that the researcher was working with.

It was a requirement that participants were accessed directly, rather than through their daughters, and as it is predominantly younger people at Bridgwater & Taunton College there was not adequate access to the sample required, therefore, recruitment from these methods were deemed not sufficient. After further ethical considerations recruitment was also extended to local and national charities and support services via advertising (poster or online), forums or visits by the researcher and through a Facebook page not linked directly to the researcher's personal account.

Potential participants were requested to contact the researcher directly for further information via her university email address. On receipt of an enquiry the participants were emailed further information regarding the research and the information about the process involved in the interviews, as well as copies of the consent forms (see Appendix G). This offered them a more informed choice about taking part.

There were no criteria issues or ethical concerns surrounding any of the participants that emailed the researcher.

Interview Process

Interviews in IPA aim to enable the individuals to provide as much detail as possible, allowing the researcher to enter their life-world. They should incorporate questions about attitudes, beliefs and allow the participant to reflect on their experiences (Langridge & Hegger-Johnson, 2013). Each of the six

participants were interviewed one-to-one and face-to-face, with open-ended instructions to describe a situation or similar. Questions started with a broad, general question that allowed the participant to set the parameters of the topic, not the other way around. Participants should be guided not led (Hefferon & Gil-Rodriguez, 2011), for example in a question such as, 'what mothering means to them', the interviewer would offer space and time for the participants to proffer their personal reflections and not be led or guided to any particular response. Interviews then continued to take the format of semi-structured wide-ranging questions with a degree of flexibility allowing the participant to 'go back to the thing itself' (Smith et al., 2009, p.2), as the interview's aim is to explore the participants own reflection, thinking and feeling as they try to work out what it all means (Smith et al., 2009).

This strategy is useful when the phenomenon of interest is complex with subtle features that participants are not likely to offer spontaneously (Wertz, 2005). The research had significant complexities as the mothers were put in a position of reflecting on painful memories, being required to step outside of the 'chaos-like' lived experience of the events and to look back on what those events really meant for them; something none of the participants had been required to do in this way before.

It is common for the narrative descriptions provided by the participants to be somewhat restrained, as they may have concerns about the social desirability of the answer, a worthy consideration in a phenomenon such as being the mother of a daughter that self-harms. In this case, the interviewer must really establish a trusting and open relationship, reassuring the individual that the purpose is about recall, not accuracy or judgment (Morrow, 2005). As a practicing counsellor and counselling psychologist in training, the researcher has an awareness and understanding of the subject matter and participant sample's sensitivity to this.

The questions were tailored to examine aspects of how mothers make sense of the major life experience of mothering a daughter that self-harms. IPA

methodology is thus designed to elicit the rich idiographic data desired, as IPA's inductive procedures and its focus on meaning elicited how the mother makes sense of her role as mother to this child.

The interviews were recorded and transcribed verbatim.

Risk and Risk Management

After completion of a risk assessment, the project was considered low risk. The researcher remained mindful of the participants' resilience and wellbeing throughout the recruitment and interview process. There were no causes for concern apparent to the researcher.

Transcription

The interviews were transcribed verbatim in accordance to the university's policies and procedures and national data protection regulations.

Data Protection

The anonymised written transcripts and audio-devices were stored in line with the university's policy and procedure. Any identifying data was stored separately under lock and key and only accessible to the researcher. In terms of confidentiality and data protection, consent was gained to use verbatim extracts from the interviews in any write-up. The participants were reassured that all identifiable information would be removed to ensure anonymity. All data gathered by the project: electronic, written and audio-taped, was kept securely with reference to guidance from the Data Protection Act (1998). Data shared with the research supervisors was anonymised. The actions of the researcher regarding the participant's data also met the General Data Protection Regulation (GDPR) requirements introduced on May 25th, 2018.

Data Analysis

The transcripts were analysed for significant and recurring themes (Etherington, 2013). It is not generally considered appropriate to provide a rigid method for IPA (Smith, et al., 2009), however, Smith et al. outline suggested strategies,

which were drawn upon by the researcher (see below). Also, guidance to the analytical process is described in many papers (Rodham et al., 2015). Once in written form, data was openly read without the research focus in mind to allow comprehension of the participant's expression and meaning in a broad context (Wertz, 2005).

- A close line-by-line analysis of claims, concerns and understandings
- The identification of emergent themes
- The development of a dialogue between researcher, their data, their psychological knowledge and participants concerns in this context
- The development of a structure to illustrate the relationship between themes
- The formatting of the material to trace the process
- The use of collaboration to develop the coherence and plausibility
- The development of a full and evidence narrative to guide the reader
- Reflection on one's own processes and perceptions

The intention was to be honest and accurate in reporting results.

Considerations of Quality in Qualitative Research

Validity and reliability are strict components of respected quantitative research; thus, qualitative research continues to have to prove its worth in its absence of these criteria (Langridge & Hagger-Johnson, 2013; Smith et al. 2009). There are guidelines suggested by some researchers that offer criteria that can be applied regardless of the theoretical orientation of the qualitative study (Smith et al., 2009; see: Yardley, 2000).

Sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance (Yardley, 2000) are four key markers to quality in qualitative research. This project aimed to demonstrate these throughout:

1) *Sensitivity to Context:* As a practising counsellor and counselling psychologist in training the researcher has an awareness and understanding of the subject matter and participant sample's sensitivity to this. This role implies the training and experience in developing respectful,

collaborative and positive relationships with the participants (Morrow, 2005). This sensitivity to context carries through to the analysis, whereby, such professionals are able use the participant's language and observed features to glean meanings behind experiences and illustrate the nature of these. In addition, a comprehensive literature review is provided to provide context to the research, as well as extracts of the participants' experience are used throughout the writing, to give the participant voice (Smith et al., 2009).

2) *Commitment and Rigour:* Following a clear paradigm for the research by attending to the research question and careful sample selection demonstrates commitment and rigour. This is in addition to following the concepts of sensitivity to context, including a thorough and systematic analysis of the data.

3) *Transparency and Coherence:* The clarity of the research process and subsequent writing process, including drafting and re-drafting, have been adhered to within this project with close attention to the foundations of IPA; phenomenology and hermeneutics (Smith et al., 2009).

4) *Impact and Importance:* The aim, since conception to production, of the project has been to convey research of importance and interest to the readers. There has been much interest and support for this study, as health care professionals and non-professionals alike convey their lack of understanding, but desire for knowledge, about the phenomena of self-harm, and the effects on the parents of individuals that demonstrate such behaviours. There is a use (and need) for such work to help in formulating interventions and contribute to social change (Morrow, 2005).

REFLEXIVITY

The position of myself, the researcher, is that of a mother to female adolescents who to my knowledge, have no mental health issues, nor engage in self-harming behaviours. In addition to this I am also employed as a counsellor for an organisation within which I provide counselling to staff and students that may be mothers themselves, or are daughters that self-harm. Alongside this I am Counselling Psychologist in training, wherein self-reflexivity is encouraged, and when possible, bias reduced by use of a naïve stance, by way of this self-understanding (Yeh & Inman, 2007).

Prior to undertaking the research, I had never had never taken a keen interest in feminist literature, or had felt akin with the distinct role of a female as mother, despite belonging to this group. This was, in part, due to being a single mother for many years and never experiencing distinct separate roles of a father and mother, as these became intertwined within me as 'single-mother'. Socially and historically I did not identify comfortably within the female groups and conversations around mothering I encountered as myself and my children attended parent/child activities.

However, any preconceptions I had about not truly belonging to the 'female/mother' group were challenged on meeting and interviewing the participants of the study. During the time spent with the participants, and whilst attending to their lived experience, a commonality and empathy evoked emotion and a sense of kinship within me, that made me reflect on my own journey and experiences of mothering. This empathy was also compounded by the desire to fulfil a commitment to the participants in the delivery of the findings (Rager, 2005). I took these reflections to personal therapy, as I found them quite powerful and necessary to explore.

Self-care is necessary with research that may evoke strong emotions in the researcher (Rager, 2005). Therefore, throughout the entire research process I

reviewed my position within the research, as well utilising the provision of triangulation with alternative perspectives from my DoS and Second Supervisor, thus helping to reduce researcher bias. However, IPA acknowledges that the researcher will bring her/his own preconceptions and expectations to the research process and will consequently need to engage in both reflective practice and bracketing of these assumptions (Smith et al., 2009). I kept a regular research journal to document evolving thoughts and feelings around the research (Morrow, 2005), as well as the personal therapy to process any difficult feelings that arose.

Analysis

Table Two

Super-ordinate Themes	Sub-ordinate Themes	Example extracts
Super-ordinate Theme 1: *"I THINK YOU ALMOST FORGET ABOUT YOU, AND CAN'T BE BOTHERED, BECAUSE IT'S LIKE 'JESUS', BUT I'LL HAVE THAT ONE DAY OR THAT TIME TO GET OVER IT AND THEN I'LL GET UP AND GO OUT AGAIN AND CARRY ON":* IMPACT OF SELF-HARM ON THE MOTHER'S SELF	Mothering- my primary role	*"My ability to support her has meant she's still alive at the minute"*
	Destabilisation of self	*"As a mum my job is to make my kids stop hurting and to put them right and you can't with this"*
	Loss	*"The guilt of not being there for everybody else at that time, because I was holding myself together"*
Superordinate Theme 2: *"FOR ME IT'S BEEN TRYING TO LIVE WITH IT; 'CAUSE IT ISN'T GONNA GO ANYWHERE!":* SELF-HARM AS AN OMNIPRESENT PHENOMENON	Relentlessness	*"I hate the fact that it keeps going on and on; what am I doing wrong, what else can be done?"*
	Isolation	*"A lot of the despair of being a mother is the complete isolation you feel"*
	Creating fear	*"I was going into her room and nearly driving myself mad, as I was looking for what she was using"*

Data Analysis

The transcripts were analysed for significant and recurring themes (Etherington, 2013). It is not generally considered appropriate to provide a rigid method for IPA (Smith, et al., 2009) however, Smith et al. outline suggested strategies, which were drawn upon by the researcher (see below). Also, guidance to the analytical process is described in many papers (Rodham et al., 2015). Once in written form, data was openly read without the research focus in mind to allow comprehension of the participant's expression and meaning in a broad context (Wertz, 2005).

- A close line-by-line analysis of claims, concerns and understandings
- The identification of emergent themes
- The development of a dialogue between researcher, their data, their psychological knowledge and participants concerns in this context
- The development of a structure to illustrate the relationship between themes
- The formatting of the material to trace the process
- The use of collaboration to develop the coherence and plausibility
- The development of a full and evidence narrative to guide the reader
- Reflection on one's own processes and perceptions

As the data was read and re-read, and the researcher became increasingly immersed in, and familiar with, the transcripts, the initial summary of participants' accounts was analysed and interpreted. This warranted much time and a holistic approach involving placing oneself back to how each participant was experienced during their interview, the interplay and nuance of body language, semantics, tone, pauses, and so on. It was necessary to consider each individual's narrative in the context of her lived world. This proved a challenging process with such an emotive subject, and as a novice IPA researcher. When attempting to identify abstract concepts that made sense of patterns of meaning in the participants' account, there was a fear of challenging the congruence of some of the narratives, as well as a fear of being disparaging towards women that have placed trust in the interviewer's non-judgmental

stance. The participants' ability to reflect on their experience and articulate with such frank honesty also made the process of analysis less straightforward. Nevertheless, the analysis was produced openly and honestly, and true to the nature of the research question.

The intention was to be honest and accurate in reporting results.

The final categories emerged as themes developed from within the analysis of the participants' sense-making narratives. They reflect the participants' thoughts and the researcher's interpretations. Transcripts were compiled into files of emergent themes, which helped to look at internal consistency, relative broadness or specificity of each emergent theme. The process was started afresh with each interview and the themes then all drawn together in a consolidated list with new themes tested against earlier data, with some becoming sub-ordinate or super-ordinate to themes found previously (Biggerstaff & Thompson, 2008). Patterns were then identified between emerging themes, by predominantly a process of abstraction, and a sense of super-ordinate themes developed as the emerging themes were placed into groups (Smith et al., 2009).

Two superordinate themes with multiple sub-themes emerged from the data following IPA. Superordinate theme 1: Impact on the mother's self; with the mothers' perception of what mothering means to her, the destabilisation within the self, due to the self-harming of her daughter and any loss experienced due to the phenomenon, as sub-themes. Superordinate theme 2: self-harm as an omnipresent phenomenon; with the mothers' experience of it as relentless, the isolation experienced and the fear that is created by its presence, as sub-themes.

Super-ordinate Theme 1: ***"I think you almost forget about you, and can't be bothered, because it's like 'Jesus', but I'll have that one day or that time to get over it and then I'll get up and go out again and carry on"*****: Impact of self-harm on the mother's self**

To be able to explore the mothers' experience it is necessary to gain an understanding of what mothering and being a mother means to each participant, their ideologies, emotions and behaviours surrounding the phenomenon of motherhood. The general theme explored overviews the participants' instinct to be the primary caregiver and their drive to remain as such. This theme also explores the process of destabilisation; experienced when ideologies and practices are challenged. This destabilisation process includes experiencing loss in various forms - from the tangible loss of relationships, to loss and mourning for what once was.

Sub-ordinate-theme: *"My ability to support her has meant she's still alive at the minute": Mothering- my primary role*

The first sub-ordinate theme to be discussed relates to participants' comprehension of mothering; what mothering means to them, as asked in the first interview question. Much of what the participants describe surrounds their desire to support and care for their children, moreover, as the primary caregiver- hence the title of this theme. Within their narratives the participants' also discuss their experience of this primary caregiver role being challenged.

The extracts below highlight how some of the participants expressed that their ideology of mothering has been established through their experience of being parented themselves, furnishing them with ideals of what they wanted for their children and developing fixed attitudes about their intended mothering practice. Five of the participants used the term 'support' (mentioned in respect to a mothering role), indicating that they saw their role as very much 'giving assistance to' their children when needed, and assuming they had the capacity to do so. However, each one of the participants stated that, with reference to the self-harm behaviours, they did not feel 'equipped' with any skills or learned behaviour to support their daughter's complex needs and the challenges relating to their self-harm, despite the mothers' drive to support this.

Throughout the interview Jane demonstrated a controlled manner, mostly pragmatic in her descriptions of experience. Jane had parented four boys before her daughter was born and had described the gender difference as distinct. It would appear that her statement below, about emotion, ran parallel to her reflections on whether her lack of emotional expression was incongruent to her daughter's emotional expression, in contrast with her brothers'. This contrasting of character due to gender differences appears as part of the process of Jane looking for reasons for her daughter's self-harm; however, it also defers some level of responsibility for Jane not being equipped to mother her daughter as she may require. Carolyn speaks of her children having 'choice' but conversely discusses guiding them to not make certain mistakes, almost removing an element of the autonomy of choice. Is Carolyn conflicted about the level of control required over her children, so, as Jane, this may be part of her process in searching for answers as to why her daughter self-harms?

"I'm not one for showing my emotions. I've not been brought up that way. I think generally my family was not one for showing their emotions. I come across as quite hard sometimes, I'm not, but I think, probably, I don't cry easily…" (Jane: 18)

"I've tried to instill that in them a confidence, and also them having choice; pretty much what I never had in my childhood." (Carolyn: 1)

"I think it's being there for them, guiding them, not wanting them to make the same mistakes I've made." (Carolyn: 1)

Kelly expressed fear and anxiety about the mothering process (before and during having her children). Kelly's anxieties appeared to be focused around wanting to perform the role in a different way to her own mother, but fearing that she had no template of how to do this. Kelly was obviously aware of her mother's lack of maternal feeling, as her mother had stated as much. Were Kelly's anxieties exacerbated by a fear that she would mirror her mother by projecting negativity towards her children, even by transference of the

overwhelming responsibility she felt. Carolyn admits that she may have had an unrealistic 'rose-tinted' perception of being a mother before the event, resulting in the reality appearing starkly negative. Is this how she stabilises any distress within herself about wishing she had not had any children, alongside emphasising the extent of difficulty in mothering.

"My mum was never maternal; she always said she wasn't. When we were ill we got sent to my Nan's [laugh]. I was the youngest so, I didn't know what it was like to have a younger sibling, so, I wanted to be a mum, but I was scared what I'd let myself into, and the responsibility is huge when they first arrive; it's just massive." (Kelly: 2)

"I kinda had this image of this is how it would be and I think it had, has, affected my perception and my experience of parenting. I think it's been a lot harder than I thought it'd be. I think in the middle of it I thought if I had a time machine I don't think I'd have had any children, just because it's so hard and so relentless..." (Carolyn: 15)

In the following extracts two of the mothers have used the words 'awful' to describe what it was like for them as mothers not to feel able to adequately support their daughters during these times. With both Julie and Carolyn emphasising that they felt unable to help their daughters. Are these also reflections to stabilise a sense of guilt and justification for not managing the self-harm effectively at first? Linda describes that specific skills different to the perceived 'standard' mothering practice are required to manage the situation or behaviours. There appears to be anger behind her extract below, anger that she had to deal with the phenomenon alone and even anger that she had to deal with it at all. There could almost be an amount of justification for previously mishandling the situation, with the aim of reducing her guilt in her perception she has not mothered adequately as being due to having no formal training or internal template for these difficulties.

"I mean um, just not being able to help her, it was, um, it was awful actually [tears-up]." (Carolyn: 10)

“Again, when a child is on a road of despair and the mother doesn’t know how to help- is the next stage going to be… Oh god, it’s awful, it’s awful. I’ve seen some terrible things.” (Julie: 53)

“There's always books about how you manage the first few years of a child’s life and then nobody bothers after that ‘cause there's nothing, so, nowhere did I have any skills that prepared me for that I've had to deal with.” (Linda: 40)

Three of the participants went on to develop their understanding and skills around poor mental health and self-harm. This appeared to not only be effective in supporting their daughters, but it also appeared to serve in easing the participants’ distress at not feeling able to adequately perform the mothering role that they had always intended; a fully supportive role. Linda’s statement below sums-up her ability to negotiate any former guilt about not managing her daughter’s needs adequately.

“I know if I wasn't there she wouldn't be here today and there’s no question in my mind that my ability to support her has meant that she’s still alive at the minute.” (Linda: 51)

Sub-ordinate theme: “As a mum my job is to make my kids stop hurting and to put them right and you can’t with this”: Destabilisation of self

The following theme is concerned with the participants’ conflicting attitudes, beliefs, behaviours and values. There is the concept of destabilisation, as a process, within the mothers’ self, with dissonance between the participants’ beliefs about their role and the reality of what is now expected. Nevertheless, this destabilisation is a process; initially participants’ preconceived notions of their ideals, beliefs and behaviours are challenged and then subsequently adapted to result in a form of stability of self.

Within the extracts below the participants describe a conflict within themselves due to their pre-conceived perception of self-harm, thus challenging their expectations of what they felt they understood about self-harm and felt they knew about their daughters. Continuing the concept of challenging beliefs about others is the challenge to the beliefs about oneself. How dissonance occurs between the participants' ideal mothering practices and their actual behaviours, as a consequence of their daughters' distress. The extracts below demonstrate how the participants felt that adjustments to their usual parenting ideologies, or behaviour, were made either to ameliorate their daughter's distress or because they were simply unsure of how else to respond to the situation.

Jane alludes to the idea that she may have expected it with some of the young people she works with, implying she believes there are distinct differences between them and her daughter, that they fit into a category or group her daughter does not. This appears to have created a 'blind-spot' to her picking up on any signs of self-harm. Carolyn expresses what she felt were the differences between her daughter and 'typical' self-harmers. Carolyn also demonstrates the process of destabilisation, as she explains the distress of feeling she had failed in her role as mother, but then began to stabilise these feelings by negotiating with herself that the aetiology of self-harming is diverse; not singularly poor parenting.

"… if I'd seen a lot of the signs with [any of the young people Jane works with] I'd have definitely been questioning and picking up [pause], but, with Molly I just wasn't expecting it!" (Jane: 9)

"…I felt like an absolute failure as a parent… I felt that I'd done something wrong, in rearing her, the fact that she felt she had to self-harm because my viewpoint, very naively at the time, I thought that, well, children that self-harm or children that hurt themselves are the ones that are raised in an unsupportive family and that's absolutely not how she was." (Carolyn: 7)

Sarah highlights the dissonance between how she would cope with being unhappy herself and how her daughter uses cutting as a coping mechanism. Sarah repeats that she does not understand why her daughter feels she has to cut herself. Sarah feels destabilised as a mother, not only because she cannot empathise with her own child, but also feeling this is a barrier to being able to adequately support her.

"It's hard to understand because she's so unhappy and that's why she feels she has to do it, and she says it makes her feel better but I don't understand that. I don't, I can never imagine hurting myself physically if I've been unhappy." (Sarah: 26)

Jane demonstrates the process of destabilisation by way of behaviour-change. Jane had previously described feeling lost and confused with how to understand and manage Molly's self-harming and so is looking for ways to improve how Molly feels; one method is to buy her new things. However, Jane's unease with this behaviour, which is incongruent to her standard parenting philosophy, is apparent by her use of tentative language, such as, 'might', 'perhaps' and ''think'.

"… if we go shopping I might buy her something that perhaps I wouldn't have done, um. I think I'm trying to.. I think I'm just trying to make her happy." (Jane: 51)

The participants below discuss how they suppressed their mothering instincts to address particular issues with their daughters. Jane's metaphor of 'treading on eggshells' describes how, although she is attempting to do what she feels is best for her daughter, it comes at a price for her and the rest of the family. This conjures the image of stress and fear within the home, as they try to tentatively step around Molly, being careful of what they say and what they do. Julie's extract enhances this 'treading on eggshells' metaphor - that their usual practices of disciplining their child may be suppressed for fear of exacerbating her distress. Julie describes an almost parallel process whereby she is

empathic to her daughter's needs and therefore alters her usual parenting practices, but is also mindful of her daughter's empathy toward how Julie is feeling. Sarah's instinct to check on her daughter's physical health (cutting wounds) is suppressed, creating instability within her to care for and mother her child. This instability is compounded by Sarah's added fear that she herself may become a trigger for the cutting.

"Err, err. I'm very, sort of, wary about broaching anything really, in case I aggravate a situation. It's like treading on eggshells sometimes at home." (Jane: 66)
"They always pick up if a parent is under stress, so you become tense and you [pause] want to say certain things, and you want to tell a child off, but, you suddenly have to stop doing it in a way that you would have done it because, this is what happened, to a certain extent." (Julie: 28)

"I think because I don't want to draw attention to that as what I'm looking for I suppose [self-cutting wounds]. If she thinks I'm looking for it might it encourage her to do it again, it might give her the idea 'well I haven't done that for a couple of weeks'. I don't know, maybe that is me being silly but I don't want to implant that idea in her head. (Sarah: 45)

The following extract from Linda is an example of behaviour change that prompted psychological incongruence to her as a mother. Linda had frequently discussed her instinct to protect her daughter, doing all she could to remove dangerous implements from the home. However, Linda came to realise that removing Florence's coping methods was creating more conflict and distress. Linda tried an alternative behaviour of compromise, one that went against her mothering instincts. The impact of this act of Linda's was evident in the emotion behind Linda's words, however, the destabilisation leading to stability, of sorts, is apparent with Linda's relief with the outcome. Linda's language, describing the basket as 'pretty', a word in stark contrast to the ugliness of the phenomenon of cutting oneself almost parallels the conflict of Linda's feelings about this gesture.

"…I put a basket in her room filled with bandages, Vaseline and Steri-Strips and put it in a pretty basket with a note that said 'I love you and I don't want you to do this but, if you do, just look after yourself', and that was the day everything changed, that I had, on some level, I'd accepted what she was doing and she realised, on some level, I had accepted it; although I can never accept, um [tears-up]." (Linda: 22))

In Linda's narrative she conveys an internal conflict between keeping a child safe and learning to accept that hurting their self is what they feel they need to do at that time to keep them safe from greater harm. Despite this realisation manifesting years before interview Linda still struggled with this compromise. She refers to her role as mother as a job, this may be interpreted not as a chore but demonstrate her commitment to the role.

"I could never accept it, as it's a contradiction. As a mum my job is to make my kids stop hurting and to put them right [laugh] and you can't with this. So, you know, when your child deliberately hurts themselves it's a hard one to get your head around, as it goes against everything- and to allow and know they're doing it and to have to run a blind eye is probably one of the hardest things I've ever done, as it goes against every instinct I have." (Linda: 22)

In the following extracts Kelly and Sarah are both seen to ruminate over personal responsibility for their daughters' distress. Kelly not only felt responsibility with considering that maybe she had not parented well enough, but also for her daughter's distress potentially being caused by any action of hers. Sarah seems to take her duty and responsibility as mother to a level deeper than the supporting and nurturing described by the participants previously, whereby, she not only feels that she has failed by potentially letting her own sadness manifest for Charlotte to see, but also that she should take responsibility for managing decisions Charlotte's father has made that may have led to Sarah's unhappiness. Sarah may just be projecting what makes her unhappy onto her daughter.

"… yeah, yeah, well, [pause] I think [pause], I don't know if it affected, I know it brought into that, 'must be me, must be something I did', when I first found out. Well, if I'd been a better parent maybe it wouldn't have happened? (Kelly: 11)

"I think that probably, she has probably seen that mum's not all that happy here, as well, and that's maybe had.. and she's maybe taken that on; that I'm not really settled and I haven't settled well here and that possibly has had an influence on her as well." (Sarah: 32)

Interviewer: "Why have you said you're annoyed at yourself?"…
…"Um, annoyed at myself. I suppose I'm blaming myself [cries], if we didn't move here this wouldn't have happened. If I'd been stronger when James said he was moving and if I had stopped that happening and made him wait" (Sarah: 45)

Linda and Julie both discuss accessing professional counselling, as a way of communicating how their daughter's self-harm was affecting them emotionally. Both participants highlight that the timing must be right for one to be able to discuss and process the situation and surrounding feelings. This may indicate that they both felt similar to Carolyn, who described the concept of really talking with others as potentially opening up 'a can of worms' (21) whereby, if she had dug deeper and really explored what was happening for her emotionally, she may not have felt able to cope with the emotions counselling might have evoked. This highlights the processes participants went thorough, as they journeyed from shock and despair to a form of acknowledgement of the phenomenon and the awareness of the impact on themselves.

Linda has had years to reflect on her journey of living alongside self-harm, and she has broken it down into 'phases', maybe as a way of dealing with the trauma, and maybe something she has been enabled to do through counselling. Her reference to 'survival mode' not only creates an image of chaos and readiness within her, not knowing what danger would come next, but also reflects the daily life for her daughter; surviving each day.

"I accessed a few sessions of counselling, but that came later really. Probably after she'd been admitted to the inpatient unit. I didn't really, it was that acute phase, I was just in survival mode, I just took each day as it came, and for the best part of four months I would not know if she was dead or alive in the morning." (Linda: 31)

"… really there is no one to talk to, you don't really know what the problem is so, how can you say can you help me with this problem? You couldn't speak to your friends about it 'cause either they didn't know that these things were happening, it was never really in the news like it is now. And, if they did listen to you, they didn't know what to say or they didn't want it to mess up their lives, they didn't want this person, this mother, offloading." (Julie: 19)

Subordinate theme: "The guilt of not being there for everybody else at that time, because I was holding myself together": Loss

A sense of loss is contained within the interviews; loss of parts of self, losses that others' experience, or the loss of the child the mother felt she had prior to their self-harming; the child that, when born, was anticipated as having an idyllic development and future. Below, the extract from Linda seems to highlight this concept as a whole and conveys Linda's sense that the world she once lived in, and hers and her family's previous identities, no longer exist.

"It's huge, the impact is vast, and there are certain people who I'm no longer friends with, who were really good friends, who couldn't deal with it or said stupid things or, yeah, it changes everything. I'm not the same person I was, she's not; none of us are." (Linda: 49)

The participants below give examples of how their identity, self-esteem or individuality has been compromised in some sense due to their experience of their daughter's self-harming behaviours. Julie describes how her identity became lost when supporting her daughter and the distress that created for

Julie as an individual. Julie speaks quite pragmatically about herself, almost demonstrating dissociation, of sorts, similar to what she was feeling at the time. Whereas, Linda wants to detach from an enmeshment with her daughter for them to begin to live two separate lives, both as adults, and rebuild something individually from the foundations of what remains from their lives once separated. Like conjoined twins, once separated they would be learning to exist and cope with parts of the self that no longer exist. Yet for Linda, is the worry of what part of her is now missing from her daughter's life, which she depended on for so long?

"I think, then you almost forget about you, and can't be bothered, because it's like 'Jesus', but I'll have that one day or that time to get over it and then I'll get up and go out again and carry on." (Julie: 35)

"I want my life back, and there is a challenge, and that's something I'm trying to work with, with my counsellor. How do I continue to live my life whilst Florence lives her life, and I can't always be there for her?" (Linda: 62)

Sarah had spoken of her professional identity becoming lost to her desire to be a non-employed mother. However, once she became a working mother this identity returned. Sarah speaks of her professional identity as being 'secondary' in the context that her husband was able to continue his professional role, unaffected by their daughter's distress. Sarah mentions her 'needs' in the sense that these were lost. Sarah refers to herself as 'a role', is this a reflection on how she is perceived by her family, as there to perform a function, as opposed to an individual with her own personal identity?

"… and my role then became secondary, like me trying to find a job, it didn't seem a priority with him as things started bubbling up with Charlotte really, just a few months after moving in. So, of course, I was the one at home trying to help her, at one point there was so much going on I thought 'I don't have time to have a job', but I needed to get a job and I needed to meet people." (Sarah: 50)

Loss considers how self-harm impacts on relationships with those who are not family but are close to the participants. The participants below describe these losses occurring either because of frustration with others' attitudes or because, as shown previously, the participants in the study's lives became overwhelmed with caring for their daughters.

Linda demonstrates the frustration she felt with others not being able to understand the complexities of self-harm. There is a sense that Linda was unable to tolerate their attempts to understand and felt that she needed to withdraw from them to protect herself from this emotion. It feels as if Linda has projected her anger at the self-harm phenomenon onto friends. She could not discard or retreat from the self-harm in her life but she could withdraw from others whose responses evoked a negative reaction within Linda. It appears that there is not room for the phenomenon to be present in families, and something needs to be removed to make space for its existence.

"… and it is difficult as I've got lots of friends but, nobody, even less 8 years ago, 9 years ago now, people understood it less than they do now and I still find it extraordinary how people respond. But, people just didn't get it, and I was so consumed with what I was dealing with on a daily basis. I lost touch with many of friends who tried to understand and would make comments like 'my daughter is a picky eater' and it's like, anorexia is not about being a picky eater - and they didn't get it". (Linda: 32)

A particular feeling of loss of the daughter that was has been explicitly highlighted by only three participants' extracts. However, there was a sense of sadness within the body of the interviews as the participants reflected on the loss of innocence and wonder of their child. The loss of the daughter that was, is also with reference to any differences in the relationship or feelings between mother and daughter since the self-harm disclosures. Jane highlights how she feels that their relationship is similar to how it was pre-disclosure of self-harm. Nonetheless, with Jane's cautiousness around trust, and previously mentioned behaviour change, it is likely that there is a difference in openness and ease

between them; still ‘very good’, as stated by Jane, but different. Jane’s confidence about the strength of the relationship could be challenged, as she stutters with the beginning of the statement, and highlights that this is her perception of the relationship only.

Linda is quite aware that there are aspects of Florence that are kept hidden from her. This is most likely the case in any mother daughter relationship; however, the difference in this instance is that both are open about this defense between them. Linda talks of ‘dancing’ with this. This metaphor suitably conjures up the image of what is going on between them quite adequately.

“So, I’m, I’m, I’m, I’m, our relationship is, as far as I’m concerned, it’s still very good, but I’m probably more cautious now than I was, so, definitely not quite as trusting as I was.” (Jane: 53)

“So, the things she doesn’t tell me is not because we aren’t close, but because she doesn’t want to hurt me or worry me; so that’s something we dance with.” (Linda: 9)

Jane continues this theme, that the self-harm has significant impact on the child that was, and how distressing this is for a mother to accept. There seems some interplay of the word ‘damage’, referring to physical (with cutting) and psychological damage. Continuing with Jane’s ‘damaged’ theme, are the physical scars left by self-harm through cutting. Linda speaks about these and the impact these will have on Florence always. The words ‘forever’ and ‘never’ almost mirror Linda’s feelings of anxiety over ever being free from the worry and practical supporting of Florence.

“When you give birth there’s this perfect little human being and now she’s quite damaged and I can’t make that better, I can’t make that perfect again. That’s, as a mother, that’s, quite painful I suppose… yep.” (Jane: 74)

"She is covered head to foot in scars, and some very bad. So, the minute she enters into any intimate relationship with somebody she has to tell them her past because, you can't not see it… It's with her now forever and she can never be free of it and that is devastating for her." (Linda: 47)

All six participants showed concern for the impact their daughter's self-harming was having on their other children. This impact came in the form of loss to the siblings in some way, as expressed in the extracts below, where Linda and Jane use the words 'fixated on' and 'revolving around' to describe their minds at the peak time of their daughters' self-harming. Use of the words guilt and neglect are very powerful, negative phrases, leaving Linda with a sense of sadness and regret, and Jane with fear and worry. Jane does not echo Linda's attempt to reconcile her guilt with 'there's nothing else I could have done', instead, choosing the perspective that the siblings are 'old enough to understand' indicating she also feels that this is the way it must be at this time, as the balance of support for her offspring is weighted heavily toward Molly.

"So, it's hard 'cause then I worry I'm not treating the boys any different but I do worry then; then, I wonder, I mean they're old enough to understand but then you wonder if they're being a little bit…neglected? Or left out in some ways because life is revolving around Molly and what's going on with Molly." (Jane: 69)

"I feel huge guilt that for five years of his life my head was totally fixated on Florence. So, from the ages of 12 to 16, really important years for him, I just wasn't available emotionally to him and I only saw that later on, and I still carry guilt around that, even though there's nothing else I could have done." (Linda: 42)

In the cases of Julie and Carolyn, the siblings had verbally expressed how they felt. In Lauren's sister's case her frustrations towards the level of attention afforded to Lauren was demonstrated as an extreme, one-off, act of self-harm herself, perceived by Julie as having the motive of eliciting care from Julie and

her husband. Julie demonstrates that she perceives self-harm as having an impact on, and creating equal losses to, siblings as much as the child that self-harms, even using the word ‘massive’ to describe both incidents. In Carolyn’s extract, her other two children appeared frustrated by what they experienced as disruptive behaviour from their sister. Carolyn empathises with her other children, as she does not disagree that things are easier when the ‘dramas’ her daughter brings are not present. Does Carolyn’s absence of disagreement indicate her ideal too is that her daughter would leave home for university? Sarah’s concern for the impact on the siblings is apparent from her need to explain to Rachael about her sister’s need for extra support. Sarah may first appear a little frustrated by the sibling’s response to the increased care for the self-harming daughter, but her use of the word ‘jealousy’ may simply indicate Rachael’s fear of abandonment by threat of another party, as opposed to the more negative ‘envy’ or to ‘begrudge’.

“Well they go through hell as much as the other child, and that actually happened. Um, one morning I went in and Lauren had put herself in A&E, massive self-harming incident, and then that night the other one came into my bedroom at 12 at night and said ‘I’ve done something really stupid, I’m really sorry’… she had just taken a massive overdose.” (Julie: 24)

“… she was due to go to university in September, but she’s decided that she can’t cope with university and she wants to do an apprenticeship, which means she’ll stay at home. Now, her brother isn’t happy about that, as he wants her to leave, as does her sister, because things are easier when she’s not around; not so many dramas.” (Carolyn: 34)

“Charlotte, I think, definitely has needed more attention. I think Rachael, when she comes home, has a bit of a jealousy thing, but I say Rachael, you’re off with your friends, Charlotte hasn’t got many friends [pause].” (Sarah: 53)

Kelly, with this final extract on the super-ordinate theme of ‘impact on the mother’s self’ really encapsulates the sense of loss on the entire family, as well as the affect on self. Her narrative conjures the image of Kelly, alone, battling

with the ‘menace’ that is self-harm, a menace that has been summoned by her daughter. Fighting to stop it destroying both her and her daughter, but failing in doing so, whilst aspects of it attack the other family members who were left to fight these themselves.

“And the guilt of not being there for everybody else at that time, because I was holding myself together and feeling like I let the others down and not knowing how to help them through it. So, they dealt with it in their own way and she [Lyla] feels really bad about that now, as we’ve talked about it, and she feels bad that it affected them.” (Kelly: 11)

Super-ordinate Theme 2: “For me it’s been trying to live with it; ‘cause it isn’t gonna go anywhere!”: Self-harm as an omnipresent phenomenon

The second super-ordinate theme concerns what the participants think and feel about self–harm as a phenomenon. The previous super-ordinate theme: ‘Impact on the mother’s self’, explored how the experience of mothering a self-harming daughter affects the participant’s sense of self, their perception of themselves as mother, woman, partner and friend. This second super-ordinate theme explores the all-pervading impact the phenomenon of self-harm has on the participants’, their daughters’ and their families’ worlds; their everyday existence, thoughts and behaviours.

Sub-ordinate theme: “I hate the fact that it keeps going on and on; what am I doing wrong, what else can be done?”: Relentlessness

This sub-ordinate theme explores how persistent and uncompromising the phenomenon of self-harm can be for all participants, emotionally and on a practical level. The participants convey this in the extracts included by explaining how it has become a way of life for their family, what is required of them as mothers to cope with this intrusion and how the resilience required can be challenged by its overpowering presence.

The three participants' extracts below give a sense of how the phenomenon of self-harm has infiltrated their lives. Two of the participants convey a sense of acceptance. Julie is quite blasé with how she describes quite distressing events as 'a routine kinda thing'. Julie's listing of the different locations she had to collect her daughter from due to self-harming or distress is an exemplar of how the phenomenon infiltrated many areas of their lives. Linda's extract conveys her as matter-of-fact about living with self-harm. Linda's previous extracts have demonstrated her negotiating her family's lives around self-harm. Nevertheless, her brief laugh in this latest extract highlights how, despite her pragmatic tone, Linda feels despair of the situation and her defense of laughter helped ease her discomfort. In another extract from Linda she speaks of 'learning to live' with the self-harm and risk. The emotion of the journey Linda and her family have been through can really be felt, as she highlights that all the family live with it and carry it like an object weighing down on them.

"That was like a routine kinda thing at this point whether it was in a medical room, in an ambulance, or waiting outside [Headmaster's] office to go home (Julie: 13)

"… for me it's been trying to find another way to live with it, 'cause it isn't gonna go anywhere [laugh], yeah." (Linda: 39)

"…To live with a child however old yeah; she's still my child, and the fact she wants to be dead, it's really hard and as to say it's taken many different forms; so [sigh] yeah, it's hard it's hard, [pause] hard for everyone to carry it. And you either turn your back and pretend it doesn't exist or you're in it together, and I don't know any other way." (Linda: 50)

Sarah, although relatively early into her journey of living with self-harm, appears to already feel that it's a part of her life, as it intrudes on her life even when she isn't present with her daughter. There is a sense of desperation as Sarah expresses the emotion of hate. Is it hate of self-harm or hate for the way her

daughter is able to infiltrate Sarah's private space with text messages. Sarah's confusion over whether she is coping is possibly tied-in with her confusion over self-harm. She cannot make sense of it, so how could she make sense of how she thinks or feels about it.

"… but when you get these texts, like I did last week, it's like, how many more is there going to be? Am I coping with it? I hate the fact it keeps going on and on; what am I doing wrong, what else can be done?" (Sarah: 43)

The participants, in their role as mother, felt that their duty was to stay strong for their daughters, and the other family members, despite what they were feeling themselves- overwhelmed. The concept of how overwhelming it can become, as self-harm relentlessly engulfs the home. The participants' extracts give the sense of how emotionally or practically overpowering are the circumstances surrounding their daughters' self-harming. Julie, as Linda had done, describes self-harm entering lives as a journey the whole family goes on. Her metaphor continues as if there is no map for this journey, but Julie implies she is the one in control of navigating, as it is her that is at risk of harming herself if she does not manage the route capably. Would Julie have considered this as a coping mechanism before her daughter became victim to it? Linda describes a form of separation of self, detaching from the emotional mother. Linda also speaks of deteriorating into the same difficulties as her daughter; however, Linda's metaphor is like her navigating a ship to safety. It is like it has blown off course and the route is not as planned, but Linda's job now is to steer it through the storms and not sink along the way.

"So, it's a massive journey you all go through. It's not scripted for anybody, for children, for parents, but you just have to deal with it and hope you are grounded and don't reach for a bottle of pills yourself." (Julie: 25)

"So, if you respond as a mum, of course your instinct is to be devastated, and panicking, and annoyed and frustrated, and bewildered and making it stop. You know, all of those things 'cause I don't know how, well I can't be different as a

mum, those feelings never go away but I want it to be different but it isn't, so yeah. I have to engage with a different part of me or pull on different skills; otherwise I go down with her and that's not going to help." (Linda: 38)

Kelly's extract is less explicit about the self-harm specifically and more about feeling she had to stay strong. Kelly's cards, as a metaphor for life, imply that the cards are dealt relentlessly and she, as mother, is expected to keep playing whatever hand is dealt to her, with no one else able to see the intensity of what she is trying to manage.

"I just think, as a mum, it's just like the cards are put on the table, you play them, carry on, and the next lot come; they have broken hearts. Yeah, it's just what life's like and I don't think you ever stop… So, I think there've been lots of different stresses in the family that have demanded something of me, whoever that was; does that make sense?" (Kelly: 23)

When Carolyn describes her want for the world to stop spinning this conveys how overwhelming things were for her at that time, as this impossible analogy was the only way she felt would be an escape from the difficulties of parenting her daughter at the height of the phenomenon. Her description of things as 'really hard' Carolyn may be referring to coping with her daughter's self-harm, but it may be a reference to the internal distress Carolyn feels with questioning even becoming a parent.

"I mean, it's better now but, when I was in the middle of it, I thought 'what the hell have I done being a parent?' I'd had enough! Kind of like, I want the planet to stop spinning because I wanna get off - you know? It's really hard, really hard." (Carolyn: 16)

Julie's feelings of being overwhelmed are highlighted by her metaphor of a grey cloud, a metaphor similar to narratives of depression. However, in this instance, mothering a self-harming daughter, there is no one to listen or understand as there may be for those with depression. Whereas Linda, again, alludes to the family as a whole dealing with it together but as mother Linda feels her duty is

to disguise how confused and frightened she may be with trying to cope with what she describes as the most terrifying time of her life.

"When a child is like that you, it, it completely kind of, er, it's like a grey cloud comes over your whole world and you really don't know when you can function normally. But you, you know, you're just like living day-to-day helping the child dealing with the situation, but you really don't have anyone to talk to." (Julie: 20)

"None of us had a clue we were just like, oh, so yeah, it was, [sigh, long pause] yeah, the most bewildering and terrifying time of my life, um, absolutely." (Linda: 35)

Sub-ordinate theme: *"A lot of the despair of being a mother is the complete isolation you feel": Isolation*

The participants' expressed a sense of isolation created by the phenomenon of self-harm. This manifested in being isolated from others that may be able to help with the burden of worry and fear, as well as how some daughters had become isolated from the lives they once had.

Throughout the interviews the participants convey a sense of solitude, as they reflected on their experience- despite five participants currently living with the fathers of their daughters. The participants also all touched on aspects of the daughters' father's role, either as father or husband. There were varying accounts to the degree of involvement by the father, with three fathers not being physically present often; through separation or working away from home. All, but Julie, alluded to the father not being hugely involved in the care and management of the daughter's self-harm, reporting that they were not fundamental as a form support to the participants, with two participants indicating that the father/stepfather's behaviours were instrumental in the aetiology of the daughter's distress. The participants' concept of their role as mother was as the primary caregiver, and throughout the interviews there was a strong sense that these mothers drove most decision-making and management of their daughters. In addition to this there was a sense of acceptance of the

secondary role played by the fathers. Nonetheless, and continuing the theme of isolation, this is notwithstanding the interviewer interpreting some narratives as including a desire for greater support for themselves from their husbands.

The following extract from Jane can be interpreted as indicating that she is quite separate from her husband in managing Molly's needs. He is always present within their lives, but not at the forefront of the complex emotional or behavioural requirements of parenting. Jane describes him as present but a 'step back', has Jane stepped forward ahead of her husband or has he chosen to take a step back? Carolyn's husband appears to be unable to offer immediate or adequate support for her, with her descriptions of her role in managing her daughter's behaviours being similar to an employee reporting to a senior colleague about her performance at work. These narratives were spoken as if the participants were satisfied by this arrangement, that it is congruent with their felt place as primary caregiver.

"She has a good relationship with her dad but, he's, um, a step further back than I am, if you see what I mean. I do more of the close parenting myself, if you see what I mean, but he's always there." (Jane: 5)

"… and my husband has always worked away most of the time. So, every day, the majority of the time, I'd be dealing with it alone and I'd tell him how I dealt with it." (Carolyn: 15)

When Kelly was asked who she first spoke to about Lyla's self-harming, she said that her daughter had asked her not to disclose to anyone else; to keep it a secret. Kelly was unsure if she had even disclosed to her husband, Lyla's father, at that stage. This indicates a distinct relationship between mother and daughter, as far as Kelly believes, thus implying a difference between a mother's and a father's role, as opposed to them acting as a parental unit.

"… I mean I guess I spoke to my husband but I can't remember? I can't remember a severe reaction, which I would have expected [laugh]." (Kelly: 6)

Distinct from the previous examples, Linda suggests that it was circumstances with her partner that may have contributed to Florence's difficulties. Linda seemed very much isolated; trapped between two people she loved, leaving her with neither of them to support her difficulties with the other. She seemed not only alone with this, but conveyed a sense of hopelessness in overcoming this battle.

"It was miserable and really like a war zone, as far as I was concerned it was. So, I had Kevin (step-father to Florence) to speak to but he didn't really get it and he was part of the problem... So, I was physically holding them apart at times, which was devastating, as I couldn't ever win." (Linda: 31)

For mother and daughter alike, the journey through self-harm has already been shown as complex and challenging. There is a theme of it affecting their relationship with each other. The participants gave examples of their daughters' initial secrecy around the behaviours, thus creating a form of isolation between them. Some of the mother and daughter dyads experienced the challenges together over a longer period of time than others, with these participants describing this as eventually having a positive impact on their relationship with each other. Thus, it feels necessary to demonstrate examples of movement from the initial covert behaviours and intention to isolate their behaviours from their mothers, to recovery after years of managing this together. There are varied processes going on for Jane regarding feeling isolated from her daughter. Jane felt detached from her daughter's world by being excluded from it with lies and deceit, as well as a sense of isolation from their close bond in that Molly falsely believed Jane would form a negative appraisal of Molly. Jane also feels she may have overestimated this bond, by not seeing the signs of the self-harming, which she had described elsewhere as there being 'lots of' (33).

"Because I wasn't aware anything was going on, particularly. She did lie to me huge amounts; she's a very accomplished liar. I didn't see the signs." (Jane: 9)

"My main upset was that she didn't feel she could tell me; that was quite a big part of it. She didn't want to upset me; she didn't want me to be disappointed in her." (Jane: 14)

The journey of self-harm that Julie and Lauren have been through has made their relationship stronger. Through Julie's descriptions of this journey it could be assumed that the listening, understanding, negotiating and supporting that has happened between them has instilled a feeling of trust and security between them. This is echoed in the extract from Linda, when she was also asked what affect the experience has had on the mother-daughter relationship.

"So yeah, we've got a very good relationship, and I think it's stronger." (Julie: 43) between her and her daughter.

"Um, extremely close and I think it's probably self-harm that brought us closer in some bizarre way, but we are extremely close…" (Linda: 9)

The participants describe how the impact of their experience of their daughters' self-harm resulted in them withdrawing from social opportunities that they used to enjoy. In the extracts presented, Julie and Sarah both offer different reasons for why they began to exclude themselves from social activities, with Julie describing feeling symptoms of depression as a way of explaining why she withdrew from occasions with friends, which she would usually enjoy. Sarah, in contrast, describes the reasons as logistical, although these are driven by the emotional. Sarah uses the statements 'again', and 'it's another thing'. Conveying a sense of frustration with the impact her daughter's self-harm has on Sarah's life. Sarah was forced to cease doing something she once enjoyed not only leaving her isolated but also removing the opportunity to discuss her feelings. Whereas, Linda's reference to isolation was focused more on feeling safe and inclusive among others in general, especially with sharing experience, something that had been almost forcibly removed from Sarah. Linda really emphasises what a terrible phenomenon self-harm is and the negative judgments that she must have received from others, she is exasperated with the

idea any parent could contain that alone. Thus, indicating that she was unable to, and why she now seeks personal therapy for the impact it has had on her.

"… having time for you with the other ladies, but, it actually um, I, I must have got depressed as I withdrew from being able to integrate. That was a very, very tough time." (Julie: 35)

"… but again, it was another thing [Sarah stopped doing socially], it's a Tuesday night, I enjoyed going with [a friend] to the pub afterwards for glass of wine because then we'd have a chat but now I don't do that because if Rachael's not there I can't leave Charlotte." (Sarah: 50)

"We've got to get away from this whole blame thing. It's um, yeah, it's so unhelpful and if mums can't find space to talk to other mums then you become really isolated like I did. Then you're dealing with what is fundamentally a hideous situation on your own, and how on earth does anybody hold that on your own?" (Linda: 69)

The following extracts emphasise the feeling of loss and despair the participants felt with not having adequate support from specialist services. There was a sense that they felt isolated in their capacity to access this for themselves or their daughters. Julie has experienced a long and traumatic journey through her daughter's self-harming. There have been many complexities, yet the lack of support for her stands out as a crucial element within the whole experience, as throughout the interview Julie consistently draws her narrative back to that. This also felt like a retrospective cry for help to the interviewer, in that Julie's journey may not have been in vain if some good could come of Julie's participation in the current study.

"The one thing I always look back on, that I really wish I had more, was help for me. I don't think that parents get enough help... I don't think there's enough help or an intervention for the parents." (Julie: 47)

Jane implies that her, and her family, have support needs that could be met by suitable services and then justifies why she has not tried to access this. There appears to be incongruence with what Jane is saying, as throughout the interview there is a sense of Jane not having much confidence in herself, questioning her own thoughts and actions. Jane implies that she would maybe benefit from support, but then wonders if this would be deemed necessary- in that parents should be able to manage their daughters. It then feels as if Jane has not enquired due to not wanting to trouble others, as if she feels she is not worthy of their support.

"I do feel that there's a definite lack of support for family, I suppose of, I, I guess people don't feel that you need the support, I don't know. I do feel there's a niche in the market out there somewhere where there could be parental support around, maybe, I don't know. Maybe there is something, I haven't asked for it I suppose so, maybe there is?" (Jane: 44)

Sub-ordinate theme: "I was going into her room and nearly driving myself mad, as I was looking for what she was using": Creating fear

Within the transcripts was a strong theme of fear created by the threat of self-harm. Fear that produces anxiety about what could come next, fear of the act of cutting, of the risk to life and for the future. A sense of this anxiety emanates from the participants' accounts of the over-arching and lingering worry they experienced from day to day, not knowing what would happen next or if things would improve. The impact on the participants of the study is demonstrated in the extracts below, giving a powerful account of the worry for their daughters' safety, which is constantly present within the mothers. Although some of the participants' daughters had also demonstrated different forms of self-harming behaviour, such as eating disorders and social risk-taking behaviours, the participants' stated the act of cutting as one of the most distressing and confusing of the behaviours.

Not all the participants went into detail of how they behaviourally responded to their daughter's access to implements used for cutting; although, it was touched on by all. The participants' extracts shown are examples of how the fear of their daughters having access to sharp implements became the main focus when first learning about cutting behaviours.

Jane made the below statement near the end of the interview. It appeared to sum-up the whole experience of mothering a daughter with the self-harming behaviours that she had described throughout the interview. Worry, about her daughter's risk, future, her other family members and herself, emphasising the pressures and sense of responsibility for a mother. Linda's anxiety was present over many years, creating such distress and fear for her daughter's safety that she developed Post-traumatic stress disorder (PTSD). Linda has allowed her narrative to really explore what the experience, and impact of this, was like for her as an individual, aside from the difficulty of her family as a whole; which was her typical focus.

"But yeah, yeah, I suppose it's, you know, I do worry that, I don't know, it's just worry, worry about everything really." (Jane: 70)

"Yeah, absolutely and I know I've been having counselling for two and a half years… But, I also realised I suffered PTSD from when she was ill as a teenager, not knowing what I was going to find, not knowing what the day was going to bring, for months." (Linda: 52)

Although Kelly's daughter has been in recovery for some years, Kelly speaks of still feeling anxiety around the possibility of self-harm in the present day. The interviewer then checks that the anxiety was due to the self-harm, as Kelly had discussed anxiety and insecurities of mothering in general. Kelly mentions that she feels it may be for her own peace of mind, implying that there may still be affects from the fear and trauma hanging over her from how she felt when Lyla was self-harming. Sarah describes her anxiety as being constant. She appears quite distressed in describing how she cannot escape the worry and how this

impacts on her behaviour with Charlotte. However, it is understandable why Sarah is consumed by worry, as she cannot understand what is going on for her daughter, so how is she able to know what to put in place to manage this?

"I think there's still that anxiety that lingers." (Kelly: 11)

Interviewer: "That wasn't there before?"

"I guess that this is more to do with me but I like checking… not because she's more special, but she needs that regular contact, whereas the others can go two weeks without speaking; whereas I don't think she can." (Kelly: 12)

"So, something is going on in her head that makes her think she has to do that. So then I start to think 'I have to prepare and I have to make things in place, so she won't feel like that. It's a constant, always in my head. I don't get away from it and I'm always worrying about it..." (Sarah: 44)

Linda was describing how relentless the need to cut was for Florence; how it overshadowed both their worlds and became like a tormenting pursuit of Linda chasing her tail. There appears to be a parallel process of both mother and daughter frantically seeking cutting implements, yet for very different reasons. Julie echoes the thoughts of Linda - that the fear of her daughter cutting infiltrates thoughts, as well as changes in Julie's behaviour and routines consequently changing her thoughts and emotions; a perpetuating cycle. Sarah's fears are similar, as she mentions locking up anything harmful, and subsequently speaks of her fears of cutting even through the night, when all should be calm with everyone restful. It gives a sense of the relentless shroud of fear for the mothers. Sarah's metaphor of 'holding breath' conjures the idea that she feels at risk of drowning in this. Throughout the interview Sarah seems lost and confused with no idea of how her and Charlotte could maybe 'come afloat'.

"I was going into her room and nearly driving myself mad, as I was looking for what she was using, and the only thing that happened was she replaced it with another thing, another thing, and another thing. Um, and in the end we had no pictures in our house, as she would smash every single picture and take the glass out and she'd smash glasses in our house." (Linda: 20)

"And then when you realise she's self-harming: 'I've got to move; I've got to be careful that there aren't things that she can [pause] hurt herself with'. So your thoughts, your daily routines are affected by other thoughts that creep in that change some of your daily protocols, if you like. Um. So, that's the kind of um, um, physical chores that may become slightly different possibly and you become edgy as a person, as emotionally you are tense…" (Julie: 27)

"I locked up all the knives and scissors. I have them on my stand, but I've moved them to different places; tablets are all locked up." (Sarah: 22)

"We've just got to hold our breath and get through it and we put these things in place for her and I always worry about her. If I hear her go down the stairs at night, I say 'what are you doing?'" (Sarah: 44)

As may be expected, the participants' strongest concern about their daughters self-harming behaviours, specifically self-poisoning and cutting, is the risk of them taking their own life. There are contrasting narratives given below regarding the level of risk each daughter has been exposed to, nevertheless, they all have similarities in that they convey feelings of fear and desperation at the thought of losing a child. Jane appears quite rational about the cutting throughout the interview, and here she explains it as a way to possibly prevent more serious harm. Jane even looks at suicide quite pragmatically, rather than emotionally, as 'final' as opposed to any emotional description. Whereas, Julie is able to express the emotion surrounding what it is like for her as a mother experiencing her child wanting to take her own life. 'Hell' and 'heartbreak' are two strong and negative nouns, both giving a sense of why Julie would describe her world like living under a grey cloud at points during her journey. Linda's

emotion is also very apparent, and she appears to feel the need to arm herself with as much knowledge as she can to feel more able to cope and more in control and to fight the control self-harm has over her and her daughter. She mirrors Julie's statement about there being no words to describe her feelings, this touches on the destabilising concept; that it is in conflict with all a mother is expecting to feel and cope with in her role.

"It but it doesn't worry quite as much [the cutting], in as much as I feel it's a way for her to. And again, the eating, are ways of her perhaps controlling things in some way. Um, but I do worry more about the, the overdosing. It's the finality of it all; and I guess that's natural." (Jane: 79)

"When it gets acute, people don't understand what you're going through. It's like, as a mum, it's so hard to find words to explain to someone who hasn't been through it what it feels like to be living it, because its hell, and to know your child wants to die, and its heart-breaking." (Julie: 33)

"She said 'Mum, if you love me you'd let me die', and I was like 'I can't do that. I will fight with every ounce I've got to not let that happen'... I know I couldn't even come close to find words to how that feels and there's no support. I looked online to try and find what I could find in terms of arming myself with the knowledge." (Linda: 34)

The phenomenon of self-harm appears to create concern for the future of some of the participants' daughters. These concerns range from Jane's worries that Molly's suicide ideation will return when CAMHS cease supporting her, to Sarah's worries about Charlotte's potential academic failure. Jane emphasises the weight of her concerns, demonstrating that Jane is not only living with current fears; she is also bearing the additional weight of worries about the future.

"I do worry about how things are going to go, the way things are going to go when she's out of the CAMHS bracket…I worry that things could take a bit of a

turn for the worse again; it's always in the back of my mind, constantly in the back of my mind." (Jane: 20)

Sarah's narrative shows concern for the immediate future but in regards to how this may impact on the long-term goals for Charlotte. Her reference to 'everything that has happened' touches on her own feelings of guilt and blame for the family relocating, as described within the interview previously.

"… and what I'm really concerned about is how this is affecting her GCSE's. I don't want this and everything that's happened to ruin what she wants in life." (Sarah: 38)

Kelly discusses that self-harm has had a lasting impact on her thoughts and behaviour as Lyla's mother. Despite Lyla having been in recovery for many years, Kelly feels she still has the concern that it could become part of Lyla's life again and she appears to want to be proactive in preventing this.

"Um, and I think there's something about um, being more, looking for signs more you know? You become that vigilant, than I would've done before, maybe changes in mood and the anxiety that comes with that; are we gonna go back to that?" (Kelly: 11)

Julie's attitude toward the future is different to the previous participants mentioned here. From the, almost conflicting, nature of Julie's narrative there is the sense that she is saying that it is possible to become habituated to the horror, however, the horror increases. Is this another parallel process between mother and daughter? As the daughter becomes desensitised to her methods and extent of self-harming, thus increasing both, her mother becomes desensitised to the extent of the behaviour, despite its escalation.
"… but the more things happen the more you get used to it, the shock value is not the same. The scare gets worse as it's a longer time you go through this and you, kind of, think what's next, but I always adopted the view of not being pessimistic, of being optimistic." (Julie: 36)

In summary, the above analysis includes an abundance of narrative samples that demonstrate an overarching theme of self-harm as an omnipresent force, with the power to affect thoughts, feelings and behaviours and relentless in doing so. The participants' accounts exhibit a sense of exhaustion due to worry, pain due to sadness and guilt due to a mother's determination to remain strong, stable and capable in supporting the development of her children and other family members.

DISCUSSION

The aim of this study was to gain an in-depth understanding of the experience of mothering a self-harming adolescent daughter. This was carried out through analysing semi-structured interviews using IPA. Few studies have examined parents' experience in this context, and none were available to the researcher with the focus purely on the broader context of mothering. The main research question was:

'The experience of mothering a self-harming adolescent daughter'

The following areas were explored in relation to the present study:

1) What does mothering mean to the participants?
2) The participants' thoughts and feelings around their daughters' self-harming behaviours.
3) The participants' thoughts and feelings around support available to their daughter and for themselves.
4) The impact of the self-harming on the participants' relationships, mothering and individuality or self.

In the following section the key findings will be considered with reference to the factors outlined above, and discussed in relation to the existing theory and evidence base. The significance of the study, clinical implications of the results,

methodological issues, suggestions for future research and reflections on the study will then be explored.

Impact on the mothers' self

One significant theme that emerged from the data was concerned with the impact of the self-harm behaviours on the mothers' self. 'Self', in this instance, refers to the ideas of modern social psychology and the self-concept. Baumeister describes three major human experiences that form the basis of self - the experience of reflexive consciousness; the interpersonal being, and executive function.

In asking the participants to reflect on their experience they drew on their individual thoughts and feelings and how these were in relation to others. They told of their experience of mothering and what this role means to them; the destabilisation they experienced as a result of their original ideologies of mothering being challenged by their daughters' self-harming; the loss of self they experienced in the form of losses to identity and social connections; and the losses experienced by other family members.

Mothering

Supporting and nurturing were words used by most of the participants to describe their concept of mothering, with this idea being reflected in literature around mothering (Barlow & Chapin, 2010; Everingham, 1994). The participants within the present study felt their aim was to nurture, support, guide and encourage their children instinctively, as in the generally prescribed sense of the meaning of mothering.

This study has established that mothering is a construct shaped by individual experience and beliefs; with great adaptability as experiences and belief systems change over time and context. The participants within the study gave a sense of innocent naivety about what type of mothers they would become,

demonstrating an absence of consideration for the nature and behaviours of their future offspring, which could be regarded as a healthy perspective with which to begin the journey of motherhood. As had been stated by Carolyn: If she knew what was to come she may never have had any children.

The majority of the participants made reference to having been parented themselves. They had constructed ideals for mothering based on the impact of their childhood and the influence of their parents (Grusel & Danyliuk, 2014), as well as from information obtained through other means during their development, something demonstrated well in cultural studies (Gajardo, & Oteíza, 2017). Research has focused on parents' reactions to particular events through situation-specific schemas. Parents have beliefs about their parenting abilities, expectations of what their children are capable of, and reasons why their children may behave in a particular way - and this affects how they respond to situations involving their children. This reflects insights of many therapeutic modalities, including the psychoanalytic theory of Barlow and Chapin (2010 p.329) who claimed 'She is a product of her own lifetime of experiences and the sense she has made of them'. For example, Jane communicated that her absence of expressed emotion was 'a family trait', learned from her own childhood.

Most of the participants referred specifically to their own mothers, as opposed to their fathers. This is in accord with research such as that by Jan and Janssens (1998) and Kulik (2004) that highlights the influence mothers have on their daughters. Although half of the participants had offspring of both genders, the participants themselves were obviously all daughters and had been mothered by women. These findings support the idea of a distinct relationship between mothers and their daughters, as suggested in previous literature (Russell & Saebel, 1997), as well as fathers reduced involvement with their daughters, compared with the involvement of mothers (Galbo, 1984).

Within the present study, the fathers' absence of involvement with the issue of their daughter's self-harm may, in part, be due to research findings that

conclude that mother-daughter dyads have a greater concordance with discussions surrounding sensitive issues (Mojtabai & Olfson, 2008). This sense of absence of the fathers was not a specific focus within the interviews and therefore cannot be fully supported as a significant theme, except within certain narratives pertaining to the specific lack of understanding or involvement of the fathers, as is discussed in more detail regarding the isolation of mothers.

Capacity to help

Consistent within the majority of studies with a similar theme to this study, are the narratives regarding parents' poor capacity to adequately support their self-harming child and this being a key factor in their own distress (Byrne et al., 2008; Ferrey et al., 2016; Kelada et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006).

The participants' within the present study who had developed their knowledge and skills around managing their daughter's emotional and behavioural difficulties reported that this had proved extremely beneficial to their daughters' recovery. All participants described the poor availability of information or support for families and the trials of trying to educate themselves. Participants who were most recent to the self-harm disclosure appeared in a deeper state of flux around their ability to manage their own feelings and behaviours about the phenomenon and appeared quite desperate for answers and support - consistent with literature stating that parenting feelings and behaviours change over the duration of ongoing self-harming (Ferrey et al., 2016; Oldershaw et al., 2008; Raphael et al., 2006).

As the interviews developed it appeared clear that the participants' mothering ideals were challenged in a way that they had never anticipated. Any knowledge or beliefs about how they would support their child, whether based on their own experiences or social and environmental factors, where thrown into chaos as the phenomenon of self-harm was cast upon them. One participant expressed that nowhere, did she have any skills that prepared her for what she has had to deal with. This was a common theme among all the participants, as

well as being a major point of interest within all relevant literature discussed. Nonetheless, the impact of this on mothers has previously been overlooked for the potential emotional and cognitive destabilisation that may occur, as a mother's intentions for her primary role are challenged.

Destabilisation

Continuing with the theme of the impact on the mother's self, are the participants' conflicting attitudes, beliefs, values and behaviours. Cognitive dissonance theory as developed by Festinger in 1957 (see Harmon-Jones & Mills, 1999 p.3) postulated that if pairs of cognitions were related to one another, they would be either consonant or dissonant. They would be dissonant if the opposite of a particular cognition follows the other. This theory has been much developed in the decades since, but the premise remains that this dissonance results in psychological discomfort; thus motivating individuals to act to reduce this discomfort. Within the participants of the present study this appeared to result in a destabilisation of the mothers' self; all that they believed, felt and behaved became unstable. However, this developed as a process, as the participants then behaved in such a way that aided a form of stability within them.

Half of the participants admitted to having a pre-conceived notion about who may be at risk of self-harming citing a non-supportive home life or an absence of positive social influences, believing that their home did not conform to such descriptions. This supports previous research casting doubt about the supposed aetiology of self-harm behaviours (McDonald et al., 2007) and added to their shock on discovery of the self-harming, as well contributed to them not initially identifying the behaviour, a phenomena supported in research that asserts initial suspicions may be disregarded (Oldershaw et al., 2008; Usher et al., 2007). Upon reflection, however, parents within previous studies felt they should have realised what was taking place, consistent with the participants' thoughts within the present study.

Commonly featured within previous studies are the adjustments participants make to their usual parenting practices as a result of their daughters' self-harming. Within this study these changes ranged from lavishing their child with material things, to reducing their usual level of control and discipline and extending boundaries. Over time the participants found a level of compromise that felt more comfortable than the distress created by inner conflict and confusion.

This seemed to support previous findings that the response to the discovery of the phenomenon changed over time (Ferrey et al., 2016; Raphael et al., 2006). Within previous research, parental responses were that they initially acted cautiously and tentatively around the child, so as not to contribute to their distress. However, over time parents tended to reflect on the situation and consequently worked to develop their knowledge and strategies for managing the situation. Within the present study two participants stated they were more lenient with their daughters compared with their siblings, another made a significant decision, at the request of her daughter, to agree to not speak with anyone, friends or family, about her daughter's self-harm. These behaviours appeared to shift the balance in power of the parent-child relationship, a phenomenon found within previous research (Ferrey et al., 2016; Kelada et al., 2016; McDonald et al., 2007). Nevertheless, it seemed that over the course of time none of the participants appeared to fully shift back their former attitudes to parenting, contrary to suggestions in previous research. Some of this was due to the adjustment of living with the self-harm being recent and still adaptive, with any destabilisation still quite apparent, and some was due to new learning and understanding by the participants. This appears consistent with the concept of the mothers' destabilisation being a process, which stability develops through new learning and alternative ways of being brings. This is also congruent to research concluding evidence of many mothers having the strength and willingness to find new ways of parenting to adapt to new situations and contexts (Levi, 2014). Levi discusses that this may not be the case for all mothers, but within the current study there appears a strength and willingness for a process of adaptation.

One participant in particular discussed the internal conflict she felt with trying to accept her daughter's need to self-harm, reaching out to her with a gesture that let her daughter know she understood and would support her as necessary, serving to possibly reduce a sense of internal destabilisation, despite how conflicted the gesture initially made her feel. Another participant found compromise by including her daughter in some of her social activities alongside her adult friends, with this narrative came the sense that the consequent reduction of any internal conflict offset any need for her adult independence.

The discussion so far has addressed the impact of the daughters' self-harm behaviours on the participants' sense of self, what they felt they knew about themselves and their child, and how this affected their beliefs and practice of mothering. Continuing with this idea is the concept of the questioning self. How some of the mothers have since ruminated over and questioned their initial response to their suspicions about their daughters' self-harming has already been discussed. What sits alongside this idea are the mothers' ruminations over potential causes for their daughters' distress and whether they would have been able to reduce the harm had they intervened sooner.

A common theme within this was the inner conflict of guilt and reasoning. Half of the participants' expressed feeling guilt that they did not notice the sometimes *'obvious'* signs of self-harm, thus not beginning the harm-reduction and recovery process sooner. This rumination was subsequently stabilised with the assertion that their daughters had become quite accomplished in hiding distress and self-harm behaviours from their mothers.

Again, half of the participants in the present study expressed a sense of guilt and shame with their reflections that their mothering practices and behaviours may have contributed to their daughters' current distress. In McDonald et al.'s 2007 study, guilt and shame were highlighted as the most prevalent factors in their participants' experience of parenting a self-harming adolescent. The participants in McDonalds' study also felt guilty about their denial or minimising

the extent of the problem. Although indicated within their reflections, guilt and shame did not appear to be such a salient feature of this study as it was within McDonald's et als. This may be due to the majority of the current participants having experienced self-harm for a greater duration than the participants in the McDonald study (in which the majority had only experienced months of the phenomenon). This seems further supported by the reported volume of participants that became tearful, an occurrence featuring minimally within the present study, supporting an idea for the impact of salient emotions as a limitation to true experience when interviewing participants too close to the period of the initial disclosure (Ferrey et al., 2016; Raphael et al., 2006). There was also little mention of professional interventions within McDonald et al.'s study. Theirs was also the only study found to have recruited from a community sample, as opposed to a clinical sample. This prompts consideration for mothers or parents as being more likely to internalise blame on their selves if there is no distinct clinical reason for the self-harm on which to project the cause.

Regarding support from others, the two participants that discussed the opportunity to access counselling both felt that this would not have been beneficial in the early stages of the discovery of self-harming, due to the internal chaos and confusion experienced at that time. Thus, also supporting the discussion that attitudes and responses to their daughters' self-harm change over time (Ferrey et al., 2016; Raphael et al., 2008).

This reduction in options for support for the participants conjures a feeling of sacrifice - despite none of the participants explicitly describing a sense of sacrifice within any part of their narratives. This in itself articulates how the participants in the present study appear to have mothering (and all it may involve) entrenched as their primary role. This concept highlights the debate on 'Mother' as an identity. Hakim (2003) discussed that women no longer felt pressure to make choices due to the sociological ideals of motherhood; instead their choices and identity were due to preference or built from components of their identities. There is a sense that the preference of the mothers within the

current study is to ‘mother’ as their primary role. To continue the theme of self and identity are losses experienced around the participants’ needs within their relationships with others and the losses associated with any destabilisation experienced.

Loss

Loss within the participants’ narratives also appears under the theme of the impact on the mothers’ self, as the participants’ are personally affected by the impact of these losses on their identity, self-esteem or individuality. Two of the participants felt that they became so enmeshed in their daughters’ distress and behaviours that they forgot about themselves, or lost their identity. Both of these narratives convey a sense of losing the capacity for consideration of their own individual needs.

Another area important to their individuality was the participants’ social relationships. Half of the participants spoke of friendships they lost, making a conscious choice to withdraw from some friendships, as they found themselves becoming frustrated with the lack of understanding and naïve comments made by those to whom they were close. This is relatively consistent with the findings of McDonald et al. (2007) of a reduction in social networks. Whereas McDonald et al. describe this as being due to parents’ shame and guilt; the participants within the present study describe their decision as a protective mechanism or self-preservation.

Also consistent within previous literature are the statements made by some of the participants that their relationship with their daughters had strengthened as they went through the journey of their child’s psychological disturbance and self-harm together (Oldershaw et al. 2008). The disclosure of self-harm often performs the function of increasing affection, attention and time parents provide (Baetens et al., 2016; Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008), which may explain the improvement in relationships between parents and child. Three of the mothers spoke of the loss of the relationship they once had with their daughter, or the loss of the daughter that was. Linda and Jane

stated how they knew their daughters held information from them regarding their self-harm, thus reducing the level of communication they once had. They both explained their understanding of this as their daughters wanting to protect them and reduce the distress their mother's felt regarding the behaviours. Previous literature also explains how children may restrict parents' awareness, but predominantly due to a fear of them intervening and trying to control the self-harming (Kelada et al., 2016). The rationale behind some of these behaviours may also be explained as a common process adolescent daughters go through as part of the separation process between mother and child (La Sorsa & Fodor, 1990).

Continuing the theme of loss are the losses experienced by the siblings of the daughters mentioned within the study. The impact of the daughters' difficulties on the siblings was a key element mentioned by all the participants of the study. The question that was asked by the interviewer in reference to siblings was merely about how the mothers experienced their relationships with others, including siblings. However, the lengthy responses by the participants about the impact on the siblings highlighted the extent of this complex dynamic due to self-harm.

The impact on siblings within the home was salient, regardless of duration of self-harming behaviour. Some participants, where the self-harming had been taking place over many years, were able to discuss the significance of this in the context of the sibling's development, their relationship with their self-harming sister and the wider context, such as any behavioural issues themselves; an element not highlighted within the previous research. There were no positive factors noted for a sibling growing-up in a household where self-harm is present.

McDonald et al. (2007) described a sense of inadequacy and powerlessness surrounding what is described as parents' diminished roles with other family members, including other children and partners. McDonald et al. had a sample consisting purely of mothers, which may explain why such a strong sense of

loss existed around these diminished roles is paralleled between that and this study. Ferrey et al. (2016) also stated conflict existing within the mother, as she is aware of her increased focus and support on the self-harming daughter and consequent reduction in care for the remaining sibling/s. The impact of self-harm on the siblings is clear within the present mothers' narratives, as well as the narratives within other research. However, the participants, depending on how they are able to negotiate this within their conscience, experienced differing levels of concern for the siblings. With most performing a rational weighing-up of cost/benefit, as they reflect on the level of need and risk of their self-harming daughter versus the level of need of their 'well' child. Some of the mothers appeared very defensive and protective toward their self-harming child and sometimes frustrated by the siblings' attempts to elicit care and create an additional burden to these mothers, whose lives were already overwhelmed with complex thoughts and emotions. These behaviours appeared characteristic of the need to stabilise any emotional dissonance experienced. Nonetheless, it is clear that the mothers within the current study became stressed and overwhelmed and feeling overly responsible for the reactions of the rest of the family.

The discussion thus far has brought attention to the theme of the impact on a mother's self when she has a daughter who self-harms. The participants within the current study conveyed a strong sense of their position as primary caregiver and had embedded beliefs about what this entails. Nonetheless, their individuality as a woman with her own needs are challenged; even if those are predominantly her achievements as a mother, nurturing her child to flourish independently. This consequently creates a dissonance and distress that demands a level of understanding and support not readily available through their voyage of mothering a self-harming adolescent daughter.

Self-harm as an omnipresent phenomenon

The basis of this major theme is the sense that the phenomenon of self-harm is all pervading, with power and control over an entire family. This power and

control appears relentless, isolating and fear generating. The participants in this study described the significance of their role as mother during the period of self-harming and the salience of the negative impact on their own wellbeing, emotions and functioning. The literature on mothering supports the intensity of holding this position within the home; as a consequence, mothers may feel the main impact of the influence of self-harm over the family.

Relentless

The relentlessness concept refers to what Linda described well as the family having to 'find a way to live with it, as it is not going away'. It takes on a form of being a significant and constant feature, influencing the entire functioning of a family. This includes not only the emotional and psychological impact but also practicalities, such as health care appointments and hospital visits, and behavioural changes - whether that is protection from harm or changes in parenting strategies.

Due to its persistence in infiltrating their lives, there is a clear sense of exasperation, anger and hatred directed toward the phenomenon of self-harm, as opposed to those that self-harm. The concept of hating self-harm, as if it is a solitary, menacing entity did not come through as a specific feature of previous research, as it has appeared within this study. Nevertheless, some participants in this study had come to accept it as being a part of their lives, as if it has become a significant feature of the family structure. This however, appeared more to do with a need to maintain their own health and wellbeing and keep the family functioning as 'normally' as possible rather than willing acceptance. One participant stated 'we are all in this together', highlighting the position of self-harm as part of the family construct.

This concept also demonstrates how problematic it may be to disregard the experience of the siblings or not to share events that are occurring within the home with those also involved in the care of the siblings. One participant, however, kept her daughter's behaviours a secret from everyone within the home and therefore we may consider the impact on other family members when

the primary caregiver is so emotionally, psychologically and behaviourally distracted by managing this alone. All previous relevant literature asserts the powerful influence of the phenomenon on parents, not only indicating difficulties that may be encountered in trying to face this relentless menace but also supporting the requirement for greater parental understanding and management of the issue, and for individual support for themselves.

This idea of the participants' determination to find ways of managing such a relentless phenomenon, regardless of any impact on themselves, indicates strength and passion within these mothers. Two of the mothers specifically referred to the requirement for them to stay strong, due to the fear of taking their daughters down with them if they 'fall'. Another participant referred to the role of mother as having to deal with whatever cards are laid out to support her family. As these narratives played-out there was an immense sense that these mothers were not prompted to speak like this due to societal or interviewer expectations, but that their determination to fight to protect their children came from instinct and love. This was something that cannot be indicated within any relevant quantitative data available and is only vaguely apparent within other qualitative studies. As mentioned previously, there is an emotive depth and richness within this study, possibly due to the focus on the participants placing themselves securely within their role of mother and all that that means to them.

Maternal emotions, as well as the practicalities of dealing with issues, were very powerful and quite overwhelming for most of the participants. Narratives ranged from exhaustion from regular hospital visits, to the metaphor of a 'grey cloud covering your whole world'. One participant's metaphor of wanting the world to stop spinning so that she could get off captured how she wished to escape the engulfing capabilities of self-harm. The weight of it all was almost tangible in the room with most of the participants, as their exasperation was articulated. Desperation was present within previous research, for example the desperate request for greater knowledge or desperation for answers as to why (see McDonald et al., 2007; Raphael et al., 2006), but this sense of besiege by self-harm did not seem to appear so much. Much of the previous research sourced

participants from health services, thus by the very nature of their interest in undertaking research already had an element of understanding of parental need, and there is also little information on the duration of participants' experiences of living with self-harm. Therefore, as much as each encounter could be described as overwhelming (considering the bewildering nature of the experience), there may come a point where a care-giver feels so engulfed by the phenomenon and all that it comprises, that serious consideration must be given to the care-givers psychological and physical health (Kelada et al., 2016).

Isolation

In all but one case, the participants' husbands were all fathers of the daughters, and as significant people within a home, had a role to play in supporting their wives and daughters. Previous research had demonstrated conflict between parental dyads due to disagreements concerning the daughter's self-harm (Ferrey et al., 2016). This was only supported in one case in this study, with the mother left as mediator for both husband and daughter, with no one to turn to within her immediate family for support.

There seemed a common thread touched-on by most of the participants in the present study, that there were limitations to the level of support provided by their husbands. However, this message did not seem to be conveyed with any sense of disappointment or resentment. This may be due to internalised beliefs that as the primary caregiver the children are their ultimate responsibility (McBride et al., 2005; Tummala-Narra, 2004). Moreover, there was a sense that the participants felt comfortable with the level of control and autonomy afforded them by the fathers' apparent 'stepping-back' from the child rearing. The concept of maternal gatekeeping, described as a complex construct that accounts for a variety of ways of limiting and facilitating father involvement, could be explored further here (Puhlman & Pasley, 2013). McBride et al. (2005) suggest that mothers play a central role in influencing how fathers approach parenting, in-part due to maternal beliefs about the role of the father; supported by some participants' pragmatic and casual comments referencing marginal expectations of their husbands. However, without the fathers present for

interview it is only the mothers' perception and experience that may be considered in the current study (Charles et al. 2016). The fathers may have felt deeply involved in caring for their child, with the parental dyads diverging on their perception of this (Charles et al. 2016; McBride et al., 2005). Puhlman and Pasley (2013) go on to suggest that how these behaviours may change over time and context requires further exploration, something worth considering as the level of paternal involvement pre-self-harm disclosure, when in a more typical child development context, may have been quite different.

Irrespective of what the mothers' expectations or conscious awareness of their needs regarding the role of their husbands, their ostensible lack of participation appeared to leave the mothers somewhat isolated from a potential source of support and comfort; there was a sense that they were largely alone in managing their feelings and thoughts.

The isolation between mothers and daughters was mostly demonstrated by the secrecy and dishonesty practised by the daughters to keep their behaviours a secret or to understate the level or their behaviours or distress; best practised by withdrawing from a parent's awareness. Raphael et al. (2006) described a reduction in closeness due to this. There is also a sense of isolation as a result of the mother's reflections after believing she knew everything about her daughter and then having the shock and realisation that there was much she never really knew or understood about her daughter.

A common theme was the social isolation experienced by the participants, partly due to the fear of judgment and of poor understanding by others. Two of the participants explicitly spoke of the isolation from the outside world that can be experienced, with both attributing much of it to changes in their mood and the attitudes of others. The negative attitude of others (or fear of) may cause isolation from the health care professions, as was discovered in research into poor help-seeking (Fortune et al., 2008; Kelada et al., 2016). This may be directly due to the HCP's responses to the daughters' self-harming or possibly due to the mothers' perception of this, as a result of their low mood.

Although one participant felt she overcame her social isolation issues by bringing her daughter into her adult social circle, there could be concern that this might risk her child seeking to maintain this behaviour to elicit this support and activity (Ferrey et al. 2016), as well as the mother not being afforded respite from the situation, which is important for her own wellbeing (Oldershaw et al., 2008). It could also be considered that the reduction of the participants' social connections may be a contributing factor in strengthening the bond between the mother and daughter dyads, with an increase of time and attention on their child rather than activities outside of the home.

Another outcome of the reduction in social connections is the lack of support for themselves. Although the participants maintain that they feel support would be most beneficial from HCP's, they also allude to benefits gleaned from speaking with other parents experiencing similar circumstances; a theme strongly supported in other studies (Ferrey et al., 2016; Oldershaw et al., 2008). As half of the participants in this study had experienced living with their daughters' self-harming over many years and the other half were relatively recent to it in comparison, this provided the study with contrasting views on their attitudes to help and support-seeking. Those experiencing the phenomenon most recently were at a stage where their focus appeared to be getting the right level of support for their daughters, with variations in their experience being from very distressing to pure desperation. However, these three participants still spoke of uncertainty over what, if any, support was available for them as mothers. The participants' desperation was experienced by the interviewer, as it was felt the mothers not only valued the opportunity to release their personal narrative in its entirety, but there was also a sense they were looking to the interviewer, who works as a psychological therapist, for reassurance and hints of guidance - a role the interviewer was not able to perform in that circumstance.

The remaining three participants spoke retrospectively of the time they were at the stage currently experienced by the other participants, wishing that they had support and guidance for themselves as early on as possible. They felt strongly that this would have mitigated against the self-harm and other difficulties

worsening, and would have reduced the negative impact on their own wellbeing. This supports all previous discussions iterating the requirement for greater support within the arena of parental support for adolescent psychological distress and self-harm.

Creating fear

In addition to the isolation created by the self-harm phenomenon is its ability to generate a constant sense of fear. The fear amongst the participants in the study mostly manifested itself as anxiety and worry for their daughters' wellbeing, safety, and future.

Jane highlighted this fear with her repetition of the word 'worry', resulting in her exclaiming 'I just worry about everything'; indicating that there appeared to be no respite from her anxious thoughts. This constant worry was supported by the narratives of some of the other participants, with their desperation to remove medications and sharp implements or covertly checking for fresh wounds, a practice outlined in much of the previous research (Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008). For some of the current participants the worry was exacerbated as they stated they withheld discussing their concerns with their daughters, thus compounding their worries with assumptions and drawing their own conclusions. These difficulties expressed by the participants reflect communication problems shown to exist between parents and their children that self-harm (Tulloch, Blizzard & Pinkus 1997).

Some of the current participants sought information about their daughters' current state from their daughters' health care coordinators, but were often not offered any content due to confidentiality - a practice highlighted as distressing for parents within other studies. This left the present study's mothers feeling anxious, fearful and confused, feeling they had nowhere else to turn. It appeared that the participants that had experienced the journey for a greater length of time no longer had fears about openly discussing with their daughter her feelings and difficulties; however, these three participants were also the most professionally or self-taught about self-harm. This indicates the

effectiveness of confidence and knowledge building for parents, notwithstanding that some parents may not have the motivation or capacity for self-education – highlighting the need for a more proactive approach to educating all parents of adolescents.

Despite the participants' differences in duration and stage they were at with their daughters' self-harm, there are still many demonstrations of convergence within the participants' narratives, with an ability to reflect retrospectively; possibly due to the emotive nature of the experience. These differences in duration of experience offer an insight into distinct processes and stages through the self-harm journey. The narratives of those that are most recent to the disclosure still have a fear that exerts a need for control of the situation, with a significant amount of rumination, guilt and confusion. This appears distinct from the participants that have lived with the self-harm phenomenon over a period of years, where they have developed a level of understanding, compromise and acceptance. Previous studies highlight the change over time when living with their child's self-harm (Ferrey et al., 2016; Oldershaw et al., 2008). However, this understanding and acceptance is despite the significant, enduring impact on these mothers, with the development that fears for their daughter's welfare will remain for many years to come, even following recovery from self-harm. One participant was able to reflect that she suffered from PTSD due to the trauma of events when they were at their peak during her daughter's adolescence, for which she now receives private personal therapy; also undertaken by two other participants once their daughters had begun to recover. This indicates the strength and drive within a mother during the peak of the self-harming, as it appears that it is only once they are not at odds with the chaos of protecting their child, they allow themselves to reflect and feel the true impact on themselves.

Suicide

Continuing with the theme of fear is what came through as the most salient fear for the participants- the fear that their child may take their own life. All but one of the daughters that were the subjects of this study had an emergency

hospitalisation due to extreme self-poisoning. There had also been incidents where some of the daughters were caught in a cycle of wanting to end their lives, finding themselves unable to escape these feelings. The emotional pain experienced by the mothers as they considered this, was palpable in the room, as they attempted to make sense of what they were describing to the interviewer. These raw reflections also suggested a lack of previous opportunity to discuss this most intimate and emotive concern.

Two of the participants experienced the possibility of suicide to the greatest degree, with a very real fear of this happening. They were extremely articulate in describing their experiences throughout their interviews. However, at this point Linda summed-up the intensity of the threat of suicide by proclaiming that 'there are no words to describe what that feels like as a mother'. What words or emotions could there be within a mother's framework that could possibly be drawn on to make sense of this? The potential impact of this ultimate fear demonstrates further the requirement for individual support for mothers as primary caregivers when dealing with such crises.

Future

It is clear that the phenomenon of self-harm is pervasive and relentless, generating fear and confusion. Its omnipresence seems most striking as the participants consider their daughters' futures. As with much of the participants' narratives, this consequent theme came to the fore of their minds with no specific prompt for any particular content. There were differing statements about this topic, but all with the same theme of anxiety over what the outcome will be for their child. There were fears around their daughter's coping once they were no longer receiving the level of support from the HCP's. Other fears were that their daughter's distress would result in academic failure, thus further contributing to their current difficulties and, as mentioned previously, the fear of a need to remain vigilant over their daughters, however far into recovery they may seem. However, one participant described her perspective as optimistic, that although the fear worsens over time, thus potentially risking a reduction in the level of hope, she refused to lose her optimism of positive futures for herself

and her daughter. Previous studies state that hope plays a significant role in the outcome of the parent-child relationship, with parent-child connectedness being considered an important predictor of hope (Padilla-Walker et al., 2011). Bland and Darlington (2002) also found hope, as experienced by parents, to be a crucial component of parents' acceptance of their child's condition.

Finally, Linda echoes some of these ideas as she describes her fears for her daughter's future, with reference to her distinctive physical scars and how these will be forever visible. Whatever the future holds for her the self-harm by cutting will always remain physically present, with no chance of her child ever being free from that. In addition to this Linda considers her own future and the concern she has over letting her, now adult, daughter go and for Linda having to find the courage to proceed with her life free from the confines of this pervasive phenomenon. For Linda this would mean relinquishing responsibility over to her daughter, and as a mother this goes against every sense of what the role means to the participants within this study. Although this is expected of parents as their children emerge into adulthood, the instinct to nurture and protect is still very prevalent, as their child remains at risk. Their primary role is to mother and this entails supporting, nurturing, guiding and, what is apparent from their narratives, providing a container for their children's distress – no matter what their age and whatever the cost to their own self.

IMPLICATIONS FOR COUNSELLING PSYCHOLOGY

Parents have beliefs about their parenting abilities, expectations of what their children are capable of, and their own representations of why their children may behave in a particular way; with this affecting how they respond to situations involving their children. This draws on psychoanalytic theory explained thus, 'she is a product of her own lifetime of experiences and the sense she has made of them' (Barlow & Chapin, 2010 p.329). The dissonance between expectations and reality may create inner conflict and thus psychological

disturbance within the parents themselves. In addition to this, often, mothers are stretched to fulfil many functions, however, they feel guilt and failure for not meeting the 'intensive mothering' ideal. Psychological therapy professionals must to be aware of the impact of the social construction of motherhood on their clients and themselves, despite the context of their need to access therapy (Medina & Magnuson, 2009).

This is notwithstanding, that during the time of the child becoming an adolescent, mothers may also be dealing with their own developmental issues. This may be a time of separation and self-identification for both mother and daughter (La Sorsa & Fodor, 1990). Mother and daughter are confronting developmental challenges simultaneously, which can either enhance or diminish each other's attempts toward autonomy and growth (Clarke & Clarke, 1999). For many women the transition from mothering the dependent child to mothering the emerging adult is already a difficult one.

The Counselling Psychologist is well positioned to understand and work well in providing support for families and, more specifically mothers- as primary caregivers- affected by a child's self-harming. The aim of counselling psychology is to reduce psychological distress and to promote the wellbeing of individuals by focusing on their subjective experience as it unfolds in their interaction with the physical, social, cultural and spiritual dimensions in living. Counselling psychology also places relational practice at its centre, with the therapeutic relationship considered to be paramount to the understanding and alleviation of psychological difficulties (Jones Nielsen, & Nicholas, 2016). This must be respected as a valuable requirement in addition to the psychoeducation and management strategies suggested by previous research within the domain of families coping with self-harming.

Nevertheless, the language of social contexts, interpersonal relationships and subjective experience, as holistic considerations in problems with living is fast being replaced within health care settings by mental health 'disorders' and 'diagnoses' (Cromby, Harper & Reavy, 2013). These may be described as

‘descriptive diagnoses’, concerned only with which ‘disorder’ a patient/client may have, as opposed to ‘functional diagnoses’ where the conditions under which the patient/client may think, feel and behave in particular way are explored and formulated. Counselling Psychology’s distinctive identity as a discipline empahsises alternative discourse about psychological wellbeing and distress from those of the medical model (Woolfe et al., 2009). Moreover, counselling psychologists have enjoyed interdisciplinary team working, alongside other allied mental health professionals, within a variety of settings. They have a unique ability to position themselves among other specialties that support the scientist–practitioner model (Jones Nielsen & Nicholas, 2016). Nonetheless, counselling psychology has the capacity to distinguish itself from other applied psychologies by its distinct use of a phenomenological and hermeneutic inquiry. This presents the opportunity to enrich medical and psychopharmalogical literature, and nomothetic testing (BPS, DCoP, 2012, as cited in Jones Nielson & Nicholas, 2016, p.212).

The current NICE clinical guidelines for supporting those that care for others that self-harm recognise that it is essential that parents are educated in not just recognising signs of their adolescents’ distress, but in challenging these through informed discussion and consistent support (NICE, 2004). These guidelines offer information that outlines the privacy rights of the child that is self-harming and also acknowledge the difficulties, distress and potential support required for the parents/carer. It suggests that HCP’s should signpost those in need to local support groups or voluntary organisations. However, it does not go so far as to acknowledge that these organisations or support groups may not be available in certain areas. Nor does it (especially if there is no further support readily available) highlight the nuances of the potential impact for parents, more specifically the primary caregiver, such as, the feelings of loss of control and inadequacy, especially if the child does not want information shared with parents. It does not touch on the processes involved (for all the family members) post disclosure, if the journey through self-harm is enduring, a phenomena discussed by the mothers within this study; primary caregivers that

require a depth of understanding, guidance and assistance not proffered through leaflets or general advice.

As a professional, I belong to a self-harm reduction group, a County-led strategic group working alongside the National Health Service and Clinical Commissioning Group, aimed at self-harm management and reduction in young people. As a Counselling Psychologist, a researcher in this domain and a Psychological Therapist working with young people and parents I am well positioned to provide guidance and recommendations on the impact of self-harm on the families, and more specifically, the primary caregiver. Without research such as this, heath care and social care professionals could be ignorant to the profound and chronic impact on those that care for children who choose to inflict physical harm and injury to themselves, more specifically, their primary caregiver.

A further implication for counselling psychologists as researchers is that the applicability of IPA and other qualitative methods to engender insights into human situations, and the processes that create them, is congruent with Counselling psychology. A discipline concerned with the study of being, the nature of "how we know what we know" and the clinical application of this. Therefore, IPA appears compatible with the ethos and philosophy of counselling psychologists, as this approach is especially suited to those whose work brings them close to the naturally occurring difficulties and success of persons. "Counselling psychologists require high-fidelity knowledge of persons that maximally respects the experience and situational contexts of those they serve" (Wertz, 2005, p.177). As a result of this study, the literature reviewed alongside it, and self-harm reduction initiatives such as those in my county, mothers, the wider family and support network have a greater chance of success at managing this pervasive phenomenon. Crucial to successful management of those that self-harm, service providers such as HCP's and psychological therapists should be educated in the processes involved in being the primary caregiver of those that self-harm. Thus, being able to provide suitable,

psychologically informed, relational help, whatever part of the process through the self-harm journey they are travelling.

LIMITATIONS OF RESEARCH PROJECT

1. Due to the size and scale of the study there were obvious limitations to the ability to generalise the findings. However, the findings do contribute to the knowledge base of experiences faced by parents, more specifically mothers. Moreover, the small group of participants offered a depth and richness of data not enabled by other data collection methods.

2. Diversity was limited, as participants in this study were limited to White-British of low to medium socio-economic status. It may be beneficial to reproduce the study with participants experiencing poverty or from non-English speaking backgrounds. This reflects the difficulty of recruiting participants from minority ethnic backgrounds, more specifically in rural areas such as the West Country, U.K., as was this case in the present study.

3. By the nature of the participants being volunteers willing to have their experience examined, results may be subject to sampling bias. Also, the reliance on self-reports might result in biases in the data through social desirability. However, the researcher felt that the participants' reflections gave an honest account inclusive of their concerns about their own perceived parenting successes and failures.

4. For some mothers the discovery of self-harm had been less than a year, for others it had been for many years. Parents who had known for longer may have more time to come to terms with the revelation, with the mothers for whom it was most recent still being in shock. However, this appeared to bring a breadth of richness to the data highlighting the need for support at whatever stage of the self-harm experience you are at with your child.

5. The retrospective design limits the study, as the participants' recollections may not have been entirely accurate. Nevertheless, there was little hesitation or confusion in recall of their narrative, most likely due to the emotive nature of the phenomenon.

6. Although not intentionally, the daughters as the subjects of the study had all been provided with access to CAMHS and thus may have self-harmed more severely, also with this being co-morbid with other psychological disturbances. This could affect the parents' experiences, as they may have been more distressed than mothers of adolescents from a purely community sample. Additionally, whilst questions were framed to be specifically about their daughter's self-harm the responses of the mothers may have been influenced by other aspects of their adolescent's condition.

7. Although the researcher clarified the participants' meanings during the course of the interview, the finished themes were not checked with the participants.

SUGGESTIONS FOR FURTHER RESEARCH

The present study's aim was to focus the lens specifically on the experience of mothering self-harming adolescent daughters. There is still paucity in rich qualitative research relevant to parental experiences of self-harm, although there are some similar studies available they did not specifically focus on the primary caregiver role within this phenomenon, more specifically the mother and how this may affect this particular experience with her daughter. This study's ideas offered insight into the distinct features of this dyad but, in turn, drew attention to alternative perspectives of the phenomenon.

Limitations noted within some of the literature-examined stress that the focus on mothers (and/or daughters) is influenced by the sex of the individual; however, there may be subtle differences within their internalisation of gender (Moon & Hoffman, 2008; Russel & Saebel, 1997). To this end, comparisons may be made regarding perceptions of their relationships if also mothering a son (Shearer et al. 2005), with researchers arguing for an exploration of these other factors, however, more often quantitatively. This factor was highlighted with one of the participant's questioning if her responses to her daughter were due, in part, to her being more used to mothering sons. Although, this particular dynamic is beyond the realms of the current study, these limitations could be addressed within future research.

Within the present study attention was paid to the absence of any significant involvement of the fathers (of the daughters that were the subject of the mothers' experience). Although, it should be noted, however, that because the close focus of this study is on mothering and mothers, the participants may have been inclined to focus on their own experience rather than considering the role of their husbands within the narrative. Nevertheless, these findings may highlight the need for closer inspection of the phenomenon of self-harm from the father's perspective, as well as bringing attention to the ideas of maternal gatekeeping or similar constructs and any level of changes in this due to the self-harm.

In addition to this, as a psychological practitioner (more specifically a Counselling Psychologist) a particular concluding focus of the researcher was on the requirement for targeted psychoeducation and individual or family therapy, more specifically for a mother, as primary caregiver, and the complexities experienced due to this position. Future examinations of the experience of this, and the impact of such on the outcomes of managing a child's self-harming could further support this suggestion.

CONCLUSIONS

This research has contributed to developing an understanding of how parents' experience the phenomenon of their child's self-harming behaviours. Moreover, it builds on previous findings with its focus on the unique experience of a mother, as primary caregiver, when her role of nurturer, supporter and protector are significantly challenged.

The position of a mother is often presented in literature as a woman deprived of a level of autonomy and individuality, as it describes the societal, cultural and her own adopted expectations of this role. Some of the findings within the present study seem to support these ideas, including the impact on the mother's social networks, her capacity to mother other children and the impact of the emotional and cognitive anomie on her wellbeing. However, the mothers within this study convey a sense of inherent fortitude with mothering being their primary role, whatever the role commands, thus giving support to the ideas of an element of choice and the adaptability of mothering.

This study highlights a process of destabilisation of the mothers' self; the disregard of obvious clues or behaviours, due to stable beliefs about her daughter being challenged after the disclosure of self-harm. The accounts from mothers not only support previous research casting doubt about the supposed aetiology of self-harm, but also demonstrate the importance of their potential role in reducing a delay in help seeking. Over time mothers may find a level of compromise that feels more comfortable than the distress created by inner conflict and confusion, reinforcing the ideas that the response to the discovery of the phenomenon changes over time (Ferrey et al., 2016; Raphael et al., 2006). Nevertheless, it also indicates the relentless and often overwhelming voyage of stress and confusion encountered with mothering a self-harming child.

Previous studies similar to this one conclude that health care practitioners and principally parents require training and education in managing self-harm. Although the results of this study demonstrate a similar conclusion, they also highlight the requirement for a closer inspection of the individual psychoeducation and therapeutic needs of the mother as primary caregiver. The common and complex natural processes of separation between mother and child must be understood and respected by psychotherapeutic practitioners when working with this dyad, as well as an understanding of the mother's individual needs. It is clear that the mothers within the current study became stressed and overwhelmed, experiencing confusion and self-doubt. They often became hypervigilant, cut off from social networks and felt overly responsible for the reactions of the rest of the family.

Self-harming behaviours and psychological difficulties are not something most parents would anticipate affecting their children. This exploration into the mothers' narratives defines this notion well, but when a child has complex needs and behaviours, this places intense physical, emotional and psychological responsibility often on the person closest to them. In the case of this study, this is their primary caregiver – their mother. Despite this, there appears little regard for the enormity of the burden placed upon mothers, as they are often assumed as invincible and able to disregard their own suffering to give strength to those close to them. They assume this burden with little or no learning to support what they have to deal with: - the fear for their child's safety and the anxiety that they may be partly to blame. How can there be such disregard for the requirement for understanding, support and the education of mothers to perform this primary caregiver role to the best of their ability at a time of such complex challenges?

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JOURNAL ARTICLE

"I'm not the same person I was, she's not; none of us are": The experience of mothering a self-harming adolescent daughter

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Abstract

Objectives

Self-harm is a pervasive phenomenon, with an increasing number of adolescents using such behaviours in response to their distress. Much research has been undertaken to establish the aetiology and management of self-harm, as well as the impact on those that self-harm. However, little research has been completed with a focus on the impact of self-harm on the primary caregiver, most often the mother. As many adolescents who self-harm do not connect with clinical services, how the primary caregiver is affected, challenged and able to cope is vital to their own wellbeing as well as the recovery of the child.

Design

Semi-structured interviews were completed with six participants, all mothers of daughters who self-harmed between the ages of 15 and 18 years.

Methods

Participants' accounts were analysed using Interpretative Phenomenological Analysis (IPA), a qualitative methodology that explores the lived experience of a particular phenomenon using a small sample.

Results

Two main superordinate themes emerged from the data: 1) The impact of self-harm on the mothers' self (with a focus on their ideology of mothering, destabilisation and loss) and 2) The existence of self-harm as an omnipresent phenomenon (with a focus on self-harm as relentless, isolating and creating fear).

Conclusions

This study supports the primary position that mothers may have to support and manage their child's self-harm, thus indicating the vital requirement for greater practical and emotional support for the mothers themselves.

Literature review

There are many complexities of parenting (Janssens et al., 2015) and many parents today find themselves in unfamiliar territory as their adolescents introduce behaviours and ideas into the family system that are quite different to adolescents of their generation (Sheridan, Peterson, & Rosen, 2010). In addition to this, adolescents with mental health problems often place a significant burden on families, becoming a source of immense family distress (Kuhn & Laird, 2014; Oldershaw, Richards, Simic & Schmidt, 2008). Studies exploring how the parents of adolescents receiving treatment for mental health disorders make sense of, and respond to their children's problems, found that over one third of parents indicated that they found it difficult to comprehend and cope with the symptoms displayed by their adolescent (Ferrey et al., 2016; McDonald, O'Brien & Jackson, 2007; Moses, 2011); displaying what researchers termed, a kind of emotional anomie (Karp & Tanarugsachock, 2000); a form of instability resulting from a breakdown of expected norms.

Mothering

When we consider a parenting role, it may be postulated that mothers are generally considered the primary caregiver of offspring (Everingham, 1994; Galbo, 1984; Liat, 2004; Moon& Hoffman, 2008) and have greater responsibility for the more emotional 'caring' aspects of parenting (Everingham, 1994; Moon & Hoffman, 2008). This suggests value in a closer examination of the intricacies of this particular parenting role, not only at a time when the transition from childhood to adulthood is producing challenges enough (Janssens et al., 2015), but also when adolescents present with complex behaviours beyond the parents' understanding.

The present study examines the complex challenges mothers must navigate in the process of recognising and responding to adolescents' psychological and emotional distress. This distress may manifest itself in a variety of ways, with different behaviours symptomatic of different disorders, however, adolescents

are increasingly dealing with regulating their emotions by self-harming (Chapman, Gratz & Brown, 2006).

Self-harm

The National Institute for Clinical Excellence (NICE; 2004, p.4) defines the term 'self-harm' as 'any act of self-poisoning or self-injury carried out by an individual irrespective of motivation'. This most commonly involves self-poisoning (generally with medication), or self-injury by cutting, scratching or burning. Self-harm is a pervasive problem with recent statistics indicating that the issue is on the increase (Fisher, 2015; RCPsych; 2010). It is understood to have a multi-factorial aetiology with a high number of risk factors and each of these are highly individual for each person (Buresova & Hochmanova, 2016).

Mothers explain that they live with blame and shame as they feel that their duty, as mothers, is perceived by society as being responsible for their child's behaviours. They have voiced that they feel shunned with an assumption that they play a role in the causation of their child's problem. (Smith & Estefan, 2014; Usher, Jackson & O'Brien, 2007).

As the mother-adolescent daughter relationship could already be complex (Karp & Tanarugsachock, 2000) it seems of value to explore how women experience the role of mothering a daughter whom she knows to be self-harming; a practice blanketed in assumptions, confusion and fear; a practice which comes at a time when mothering customs are expected to be altering to accommodate a developing adult; customs anticipated to be reducing in intensity. What does it feel like to experience the mothering role from an unanticipated position?

Therefore, the present study's aims are to:

a) Give voice to a seldom-heard group within the phenomenon of adolescents' self-harm; the mothers
b) Introduce the focus specifically toward the mothering experience for a woman

c) Outline the serious and pervasive nature of adolescent psychological distress and its symptoms, specifically with regards to self-harm, and how a mother makes sense of this
d) Explore the impact of adolescents who self-harm on the wider family, as experienced by a mother
e) Highlight how networks and relationships outside of the family are experienced when an adolescent daughter is self-harming

Methodology

Counselling Psychology's distinctive identity as a discipline emphasises discourses about psychological wellbeing and distress that are alternative to those of the medical model (Woolfe, Strawbridge, Douglas & Dryden, 2009). Counselling Psychology works in recognition of the sufferers' own experiences and perceptions. Thus research formulated within a Counselling Psychology context should be undertaken maintaining inquisitive and open minds.

With this in mind it seems appropriate to use qualitative methods of enquiry to explore adequately the depth and complexity of human experience (Morrow, 2005). Qualitative research is focused on describing the aspects that make up experience (Polkinghorne, 2005), therefore, with the current research focus being directed at the lived experience of the participants, a qualitative methodology was deemed the most suitable approach. This philosophy contrasts with quantitative approaches that deduce and test hypotheses.

What is Interpretative Phenomenological Analysis (IPA)?

IPA explores peoples' experience and the meanings they attach to them; it is essentially the study of lived experience and personal perceptions (Clarke & Braun, 2013). Human beings are not passive perceivers of an objective reality but interpret their world by way of formulating their own personal stories in a form that makes sense to them (Brocki & Wearden, 2006). Thus, use of such a method aims to communicate to readers a sense of quality and texture (Smith,

1996), therefore, IPA was considered the methodology most suited to the current study.

Inclusion criteria

There is much evidence for self-harm being a common phenomenon in adolescents in both clinical and community samples. Therefore, it was neither a requirement nor reason for exclusion if the daughter had accessed clinical support for her self-harming. Accounts from caregiving experiences suggest that reactions to their children's diagnoses changes over time (Ferrey et al., 2016). In addition, previous research found a limitation of the true experience of parents if they were interviewed too soon after the process of discovering about their child's self-harming behaviour (Raphael, Clarke & Kumar, 2006).

Consequently, the sole criteria for inclusion in the sample was being a female mother who was, or is, living with their adolescent daughter when she was self-harming between the ages of 15-18 years. The discovery, by the mother, of these behaviours being six months or more prior to interview, for reasons explained above.

Due to the depth of individual interpretation, IPA has a preference for fewer participants examined at a greater depth, whereas other methodologies may suggest a broader, shallow and simply descriptive analysis of sometimes many individuals (Hefferon & Gil-Rodriguez, 2011). Therefore, it was concluded that six participants should be adequate for the current study.

Results

Direct quotations from the participants' interview transcripts are used to illustrate points of interest. It is recognised that these themes are only one possible account of mothering a daughter that self-harms. They do not cover all aspects of the participants' experience and were selected due to their relevance to the research questions. It is also acknowledged that they are a subjective interpretation and other researchers may have focused on different aspects.

Two super-ordinate themes with multiple sub-themes emerged from the data following IPA.

Super-ordinate Theme 1: The impact of self-harm on the mother's self

This theme examines what the concept of mothering means to the participants, and their ideologies, emotions and behaviours in terms of being mother. The theme also includes a process of destabilisation experienced by mothers when ideologies, beliefs and practices are challenged. It also discusses experiencing loss in various forms - from the tangible loss of relationships, to loss and mourning for what once was.

Sub-ordinate theme: Mothering – my primary role

The first subordinate-theme to be discussed relates to participants' comprehension of mothering; what mothering means to them. Participants' narratives describe what they had, or had not wanted for their children based on their own experiences. Five participants, thus, offered the term 'to support' demonstrating that this is perceived as a significant role of a mother. Within the narratives the participants also discuss their experience as the ideologies of their role as mother are challenged.

The extract below demonstrates how the participants suggest that their ideology of mothering has been established through their experience of being parented themselves. Therefore, furnishing them with ideals about what they wanted for their children and creating fixed attitudes about their intended mothering practice.

"I've tried to instill that in them a confidence, and also them having choice; pretty much what I never had in my childhood." (Carolyn)

As mentioned above, the participants' desire to support their children indicates that they see their role as very much 'giving assistance' when needed with an, initially, fixed belief that they have the capacity to do so. However, each one of

the participants' state that with reference to the self-harm behaviours they were not 'equipped' to support their daughter's complex needs and challenges. This declaration regarding a lack of skills appears to help stabilise a sense of guilt surrounding how the participants first managed the self-harming.

"Again, when a child is on a road of despair and the mother doesn't know how to help- is the next stage going to be.. Oh god, it's awful, it's awful. I've seen some terrible things." (Julie)

Sub-ordinate theme: Destabilisation of self

Within this theme the participants describe the conflict within themselves due to any pre-conceived perceptions of self-harm, beliefs about their daughters, themselves and their own needs.

What the participants' think they understand about self-harm and believe they know about their daughters is challenged. Almost as if those that self-harm belongs to a group or category of which their children would not belong, as the extract below demonstrates.

"… If I'd seen a lot of the signs with [the young people Jane works with] I'd have definitely been questioning and picking up [pause], but, with Molly I just wasn't expecting it!" (Jane)

Continuing this theme of destabilisation is how participants' altered their parenting practices, hence, being incongruent to their parenting ideologies, with the intention of ameliorating their child's distress, as seen in Jane's extract below.

"… If we go shopping I might buy her something that perhaps I wouldn't have done, um. I think I'm trying to; I think I'm just trying to make her happy." (Jane)

The discord the participants' feel when ruminating over theirs and their daughter's past behaviours was also included in this theme. The participants

reflect and question whether they are responsible for their child self-harming and whether they could have prevented this.

"… yeah, yeah, well, [pause] I think [pause], I don't know if it affected, I know it brought into that, 'must be me, must be something I did', when I first found out. Well, if I'd been a better parent maybe it wouldn't have happened? (Kelly)

The idea of sharing with others what is going on for their daughters and the impact of this on themselves creates a shift within the participant's self. Below, Linda conveys the impact of the phenomenon with regards to other relationships and that, as a consequence of self-harm, the world her and her family once knew no longer exists. Nevertheless, the development of this new form of existence may also serve to balance the destabilisation that the phenomenon first created.

"It's huge, the impact is vast, and there are certain people who I'm no longer friends with, who were really good friends, who couldn't deal with it or said stupid things or, yeah, it changes everything. I'm not the same person I was, she's not; none of us are." (Linda)

Sub-ordinate theme: Loss

The participants give examples of how their identity, self-esteem or individuality has been compromised in some sense, due to their experience of their daughter's self-harming behaviours. There is also a sense of sadness within the body of the interviews as the participants reflect on the loss of innocence and wonder of their child - hence the title of this sub-ordinate theme.

Below, the loss of self, a kind of dissociation and loss of the daughter that was, as she is now damaged emotionally and physically, is described.

"I think, then you almost forget about you, and can't be bothered, because it's like 'Jesus', but I'll have that one day or that time to get over it and then I'll get up and go out again and carry on." (Julie)

"When you give birth there's this perfect little human being and now she's quite damaged and I can't make that better, I can't make that perfect again. That's, as a mother, that's, quite painful I suppose… yep." (Jane)

All six participants show concern for the impact their daughter's self-harming is having on their other children. This impact comes in the form of loss to the siblings in some way, as demonstrated by the following extract where Linda uses the word 'fixated on' to describe how absorbed she was in her daughter's self-harm thus, in a sense neglecting her other child.

I feel huge guilt that for five years of his life my head was totally fixated on Florence. So, from the ages of 12 to 16, really important years for him, I just wasn't available emotionally to him and I only saw that later on, and I still carry guilt around that, even though there's nothing else I could have done." (Linda)

Super-ordinate theme 2: Self-harm as an omnipresent phenomenon

The previous super-ordinate theme - impact on the mother's self - explored how the experience of mothering a self-harming daughter affects the participants' sense of self, their perception of themselves as mother, woman, partner and friend. This second super-ordinate theme explores what impact the phenomenon of self-harm has on the participants', their daughter's and their family's lives, including their everyday thoughts, behaviours and existence.

Sub-ordinate theme: Relentlessness

This subordinate theme concerns what the participants' think and feel about self-harm as a phenomenon. It explores the all-pervading impact on the participants', their daughter's and their family's world.

For some of the participants there is a sense of acceptance that self-harm is now part of their lives, the extract below gives a sense of how the phenomenon

of self-harm has had to be accepted within the home, with the sense of despair being conveyed through the defense of laughter.

"… For me it's been trying to find another way to live with it, 'cause it isn't gonna go anywhere [laugh], yeah." (Linda)

The participants, in their role as mother, feel their duty is to stay strong for their daughters and the other family members, despite what they are feeling themselves. Three of the participants autonomously seek to develop knowledge, learning what they can about their daughters' mental health difficulties and self-harm. The extract below demonstrates this determination, due to fearing the consequences of not coping.

"… Well, I can't be different as a mum, those feelings never go away but I want it to be different but it isn't, so yeah, I have to engage with a different part of me or pull on different skills; otherwise I go down with her and that's not going to help." (Linda)

The sense of how emotionally and practically overpowering the circumstances are that surround their daughters' self-harming, forms part of the theme of omnipresence. The extract below demonstrates its overwhelming impact, almost like a metaphor for the pervasive nature of depression.

"… It's like a grey cloud comes over your whole world and you really don't know when you can function normally; but you, you know, you're just like living day to day helping the child dealing with the situation..." (Julie)

Sub-ordinate theme: Isolation

The participants' express a sense of isolation created by the phenomenon of self-harm. This manifests in being isolated from others, thus reducing the opportunity for a mother's individuality, and becoming isolated from potential support.

The participants alluded to the daughter's fathers not playing as significant a part in their child's lives, or in managing the self-harm. Although the participants offered a sense of acceptance with this, possibly due to their perceptions of the roles of the mother and the role of the father, this did appear to serve as isolating the mothers from someone who may have related emotions and understanding around the situation.

"She has a good relationship with her dad but, he's, um, a step further back than I am, if you see what I mean. I do more of the close parenting myself, if you see what I mean, but he's always there." (Jane: 5)

Many of the participants' describe how the impact of their experience of their daughter's self-harm results in them withdrawing from social opportunities they once enjoyed. Julie's explanation of depression due to difficulties of living with her daughter's self-harm not only highlights the impact it can have, but also serves to reduce further any time for her as a woman and an individual.

"In terms of characteristics, it did affect me. I play tennis, and my husband said you have to carry on playing tennis, having time for you with the other ladies, but, it actually um, I, I must have got depressed as I withdrew from being able to integrate. That was a very, very tough time." Julie)

Sub-ordinate theme: Creating fear

Within the transcripts there ran a theme of fear created by the threat of self-harm. Fear of the act of cutting, fear about what could come next, fear about the risk to life and for the future.

The fear surrounding the cutting is conveyed below, the extracts demonstrate the confusion that is also present, as one participant conveys that she has no understanding of what causes her daughter to self-harm, thus no idea how to support her; exacerbating her worry and fear. The other extract suggests a constant torment of chasing your own tail in a vain attempt to prevent the cutting.

"So, something is going on in her head that makes her think she has to do that. So then I start to think 'I have to prepare and I have to make things in place, so she won't feel like that. It's a constant, always in my head. I don't get away from it and I'm always worrying about it..." (Sarah: 44)

"I was going into her room and nearly driving myself mad, as I was looking for what she was using, and the only thing that happened was she replaced it…in the end we had no pictures in our house, as she would smash every single picture and take the glass out and she'd smash glasses in our house." (Linda)

As may be expected, the participants strongest concern about their daughter's self-harming is the risk of them taking their own lives. The emotion behind this fear is demonstrated in the extract below, as the participant expresses the innate fight within in her as a mother to protect her child no matter what.

"She said 'Mum, if you love me you'd let me die', and I was like 'I can't do that. I will fight with every ounce I've got to not let that happen'…I know I couldn't even come close to find words to how that feels and there's no support." (Linda)

The phenomenon of self-harm elicits concern for the future of some of the participants' daughters. Concerns for the future range from their wellbeing deteriorating post recovery to the impact their current distress will have on personal or professional success.

"So, we just have to get to GCSE's and what I'm really concerned about is how this is affecting her GCSE's. I don't want this and everything that's happened to ruin what she wants in life." (Sarah)

In summary, the above results demonstrate an overarching theme of self-harm as an omnipresent force, with the power to affect thoughts, feelings and behaviours and being relentless in doing so. The participants' accounts exhibit a sense of exhaustion due to worry, pain due to sadness and guilt due to a

mother's determination to remain strong, stable and capable in supporting the development of her children and other family members.

Discussion

The aim of current study was to gain an in-depth understanding of the experience of mothering a self-harming adolescent daughter. This was carried out through analysing semi-structured interviews using IPA. Few studies have examined parents' experience in this context, and none were available to the researcher with the lens focused purely on the broader context of mothering.

The current study has established that mothering is a construct shaped by individual experience and beliefs, yet one that has fluidity as experiences and belief systems change over time and context. The participants gave a sense of innocent naivety about what type of mothers they would become, demonstrating an absence of consideration for the nature and behaviours of their future offspring, which could be regarded as a healthy perspective with which to begin the journey of motherhood. As had been stated by Carolyn: If she knew what was to come she may never have had any children.

Nonetheless, the participants within this study demonstrated a natural desire to support and nurture their offspring, thus challenging the notions of the aetiology of self-harm being in part due to problems within the home (Byrne & Mazanor, 2002). This was confirmed by the shock experienced by the mothers on disclosure, as most questioned why their daughters would have become so distressed.

Self-harming behaviours and mental health difficulties are not something most parents would anticipate affecting their children. This exploration into the mothers' narratives defines this notion well. When a child has complex needs and behaviours this places intense physical, emotional and psychological responsibility often on the person closest to them. In the case of the present study, this is their primary caregiver – their mother. Despite this, there appears

little regard for the enormity of burden placed upon them, with mothers often assumed as invincible, able to disregard their own suffering to give strength to those close to them (Bassin, Honey & Kaplin, 1996). They assume this burden with no adequate or specific education offered to support what they have to deal with; the fear for their children's safety and the anxiety that they may be the one to blame. How can there be such disregard of the requirement for understanding, support and the education of mothers to perform this primary caregiver role to the best of their ability?

Impact of self-harm on the mothers' self

One significant theme that emerged from the data was concerned with the impact of the self-harm behaviours on the mothers' self. 'Self', in this instance, refers to the ideas of modern social psychology and the self-concept. Baumeister (1999) describes three major human experiences that form the basis of self; the experience of reflexive consciousness; the interpersonal being, and the executive function.

In asking the participants to reflect on their experience they drew on their individual thoughts and feelings and how these were in relation to others. They told of their experience of mothering and what this role means to them, the process of cognitive and emotional destabilisation experienced as their original ideologies of mothering were challenged as a result of their daughters' self-harming, and what thoughts and behaviours developed to reduce this. They also told of the loss of self they experienced in the form of losses to identity and their social connections and the losses experienced by other family members. The impact on the other members of the family, more specifically the siblings, is documented within previous literature (Ferrey et al., 2016; McDonald et al., 2007), with this study offering further perspectives on this; honest and rich perspectives, which draw attention to the inner conflict that may be experienced by a mother.

Self-harm as an omnipresent phenomenon

The basis of this major theme is the sense that the phenomenon of self-harm is all pervading, with power and control over an entire family. This control appears relentless, isolating and fear generating. The participants in the current study described the significance of their role as mother during the period of self-harming and the salience of the negative impact on their own wellbeing and functioning. The literature on mothering supports the intensity of holding this position within the home, and as a consequence mothers may feel the main impact of the influence of self-harm on the family.

All six participants within the current study believed that due to the complexities of self-harming and their lack of understanding around this, they felt helpless to adequately support and manage their daughter's needs. Previous research undertaken within the arena of children's psychological disturbance and self-harm illuminates this as a particular issue (Baetens et al., 2015; Choate, 2015; Ferrey et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006). This highlights the need for mothers, or the primary caregiver, to be recognised for the significance of their position in supporting their children and family when self-harm has penetrated a home.

Other studies assert that parents found educating themselves on the complexities and management of self-harm to be a valuable strategy (e.g. Ferrey et al., 2016). The conclusions drawn by most studies exploring parental support of children with mental health difficulties or self-harm behaviours are that seeking help and psycho-education is crucial.

Relevance to Counselling Psychology

Parents have beliefs about their parenting abilities, expectations of what their children are capable of, and their own representations of why their children may behave in a particular way; with this affecting how they respond to situations involving their children. This draws on psychoanalytic theory explained thus, 'she is a product of her own lifetime of experiences and the sense she has made of them' (Barlow & Chapin, 2010 p.329). The dissonance between

expectations and reality may create inner conflict and thus psychological disturbance within the parents themselves. Notwithstanding, that at the time of the child becoming an adolescent, mothers themselves may also be dealing with their own developmental issues. This may be a time of separation and self-identification for both mother and daughter (La Sorsa & Fodor, 1990). Mother and daughter are confronting developmental challenges simultaneously, which can either enhance or diminish each other's attempts toward autonomy and growth (Clarke & Clarke, 1999). For many women the transition from mothering the dependent child to mothering the emerging adult is already a difficult one.

The Counselling Psychologist is well positioned to understand and work well in providing support for families and, more specifically, mothers- as primary caregivers- affected by a child's self-harming. The aim of counselling psychology is to reduce psychological distress and to promote the wellbeing of individuals by focusing on their subjective experience as it unfolds in their interaction with the physical, social, cultural and spiritual dimensions in living. Counselling psychology also places relational practice at its centre, with the therapeutic relationship considered to be paramount to the understanding and alleviation of psychological difficulties (Jones Nielsen, & Nicholas, 2016). This must be respected as a valuable requirement in addition to the psychoeducation and management strategies suggested by previous research within the domain of families coping with self-harming.

Limitations and recommendations for future research

Due to the size and scale of the study there were obvious limitations to the ability to generalise the findings. However, the findings do contribute to the knowledge base of experiences faced by parents, more specifically mothers. Moreover, the small group of participants offered a depth and richness of data not enabled by other data collection methods.

Diversity was limited, as participants in this study were limited to White-British of low to medium socio-economic status. It may be beneficial to reproduce the study with participants experiencing poverty or from non-English speaking backgrounds. This reflects the difficulty of recruiting participants from minority ethnic backgrounds.

Additionally, results may be subject to sampling bias. Also, the reliance on self-reports might result in biases in the data through social desirability. However, the researcher felt that the participants' reflections gave an honest account inclusive of their concerns about their own perceived parenting successes and failures.

As the present study's findings offer a richness of experience from the mother as primary caregiver this may highlight the need for closer inspection of the phenomenon of self-harm from the father's perspective, as well as bringing attention to the ideas of maternal gatekeeping or similar constructs. Maternal gatekeeping is described as a complex construct that accounts for a variety of ways of limiting and facilitating father involvement with children (Puhlman & Pasley, 2013).
In addition to this, as a psychological practitioner (more specifically a Counselling Psychologist) a particular concluding focus of the researcher was on the requirement for targeted psychoeducation and individual or family therapy, more specifically for a mother, as primary caregiver, and the complexities experienced due to this position. Future examinations of the experience of this, and the impact of such, on the outcomes of managing a child's self-harming could further support this suggestion.

Conclusions

The current study not only supports previous research casting doubt about the supposed aetiology of self-harm, hence contributing to parents not identifying the behaviour; adding to the shock of discovery (McDonald et al., 2007). It also supports research asserting that parents may disregard any initial suspicions

where, on reflection they feel they should have realised what was taking place; leading to a delay in help seeking for both child and parents (Oldershaw et al., 2008; Usher et al., 2007).

Over time the participants found a level of compromise that felt more comfortable than the distress created by inner conflict and confusion. This seemed to support previous findings that the response to the discovery of the phenomenon changed over time (Ferrey et al., 2016; Raphael et al., 2006). The current research specifically highlights the intensity and significance of the primary caregiver role, in this instance the mother, and the complexities experienced within this role. The common and complex processes of separation between mother and child must also be understood and respected by psychotherapeutic practitioners when working with this dyad, as well as an understanding of mothers' individual needs. It is clear that the mothers within the current study became stressed and overwhelmed, and experienced confusion and self-doubt. They often became hypervigilant, cut off from social networks and felt overly responsible for the impact on the rest of the family. Consequently, it is suggested that health care professionals recognise the significance of this primary caregiver role within the context of adolescent self-harm. Alongside the suggestions offered in previous research, such as family and individual psychoeducation and systemic therapy, the concept of targeted education and therapeutic interventions for this caregiver should be considered.

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APPENDIX SECTION

Appendix A

Search terms used for systematic literature review

Search terms
Self-harm
Self-harm*
Self injur*
Self-injur*
Mutilat*
Self-cutt*
Self cut*
Non suicidal self-injur*
NSSI
Deliberate self-harm*
DSH
History and Culture of Self-harm
History of self-harm*
History of self-mutil*
Culture and self-harm*
Culture and self-mutil*
Parenting/ Mothering

Parent*
Famil*
Maternal
Paternal
Mother
Mother*
Father
Father*

Adolescent

Adol*
Teen*
Young pe*
Child

Databases searched

BioMed Central, Cambridge Journals Online, Credo Reference, DOAJ (Directory of Open Access Journals), Education Research Complete, Emerald, Journals@OVID, JSTOR, PsycBOOKS, PubMed, SAGE Journals Online, SAGE Research Methods, ScienceDirect, Scopus, SpringerLink, Taylor and Francis, Wiley Online

Appendix B

Research Instrument

Participant code/pseudonym	
Age	
Marital status	
Profession	
Daughter's age at time of self-harming	
Daughter's age now	

Topic Guide

Introductions and building rapport

- Check consent
- Agree a sign to stop the interview or have a break
- Start audio tape

Thank you very much for meeting with me today. I would like to ask you some questions about your experience of mothering a self-harming adolescent daughter. The responses to which will help support my research aimed at bringing greater awareness to what this experience is like from a mother's perspective.

Please let me know if you feel too distressed at any point or if you would like me to elaborate on or clarify any of the questions asked.

Your identity will remain anonymous, as a pseudonym will be assigned to you and any other person mention within your narrative.

I would just like you to give the answer that feels as open and honest as you can, giving me a sense of exactly what things were like for you at the time of your daughter's self-harming. Does all this sound okay, do you have any questions?

A) Experience of mothering

The first question is about mothering and what being a mother means to you.

- *How do you experience it?*
- *How do you define it as an individual?*
- *Being a mother to your daughter, what is that relationship like?*

B) Experience of Daughter's self-harm

Could you tell me about when you first discovered your daughter had self-harmed?

- *What did you think?*
- *How did you feel?*
- *How did you respond?*

C) Experience of others

Who did you first discuss this with?

- *How did you experience 'others' that you discussed this with, such as, friends, family or professionals?*

D) Experience of self as mother

Has this affected your experience of being a mother?

- *Your relationship with your daughter and your relationship with friends or other family members?*
- *How did you make sense of this?*
- *What have you done or not done since?*
- *What has happened since?*

E) Experience of self as a woman

Has this experience had an impact on you as a woman?

- *As an individual, rather than just your identity as a mother?*
- *Is this something you had ever thought of before?*

F) Other

Is there anything else with reference to mothering, being a mother and having a self-harming daughter, which you would like to share?

Appendix C

Research Protocol Summary

1) Identify six participants with a daughter who has self-harmed between 15 years and 18 years of age with the disclosure of such being six months ago or longer. They will contact the researcher via email for further information.
2) The researcher will ensure that potential participants receive the study information literature and participant consent form to assist with informed participation.
3) Follow up contact will be made with participants who agree to take part once all project information has been read.
4) Arrange a convenient time and venue in which to carry out the semi-structured interviews.
5) Conduct the semi-structured interviews and audiotape.
6) Go through the topic guide. Monitor participants for distress and act accordingly.
7) Transcribe the interview data being careful to store separately any identifying information in lockable storage.
8) Arrange to follow up any participants if necessary to clarify any data, which may be ambiguous or need further exploration.
9) Carefully read and re-read the transcripts noting points of interest. Subject the data to Interpretative Phenomenological Analysis and gradually build up into a table of themes that most strongly capture the participants' views. Research supervisors will also be consulted although only anonymised information will be shared.
10) Write up the project using anonymised direct quotations from participants to illustrate the results of the analysis.
11) Provide feedback on the results of the study to participants if requested. Make arrangements to disseminate the results of the study through presentations and publications.

Appendix F

Participant Consent Form

An Interpretative Phenomenological Analysis of the experience of mothering self-harming adolescent daughters

Participant Consent Form

Participant basic information:

Name: …….

Age: …….

Marital Status: ……..

Occupation: ……

Nationality: …….

Please tick box

☐ I confirm that I have read and understand the information sheet, for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐ I understand that my participation is voluntary and I am free to stop and withdraw from the interview process at any time, without giving any reason, and without any consequences for me.

☐ I understand that all the information given by me will be for use by the researcher unless I request this to be withdrawn from the study by contacting the researcher or Director of Studies on the contact details within the information sheet. I understand that I have until

the data collection is complete and data analysis commences (approximately 3 months from interview) to withdraw my information and data; the researcher will confirm the date to withdraw.

☐ I understand that any information I give will be treated as confidential and will anonymised with pseudonyms given and identifying information altered.

☐ I agree to the audio recording of the interview/s I take part in.

☐ I agree to anonymised direct quotes from the study (with any unique identifying features altered) to be used in publications and presentations arising from it.

☐ I agree to take part in the above study.

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Name of Participant	Signature	Date

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Name of Researcher	Signature	Date

Appendix H
Table of Analysis Process and Emerging Themes Interview one

Themes	Page/Line	Key words
Boundaries	**2.7**	I don't class myself as one of her friends.
	2.12	I've got a definite line.
Learned behaviour	**18.8**	I'm not one for showing my emotions; I have been brought up that way.
It's a supportive role	**4.6**	Supporting but not guiding, not pressuring.
Primary caregiver	**5.16**	
	6.15	I do more of the close parenting. If she was gonna come to one of us, it would be me.
Ideology	**58.8**	It was always my aim to be a mother and have a big family.
Sacrifices	**62.6**	I feel it's something I need to do as a mother, that's my main role in life.
Worry	**71.5**	That's what nature intended [to worry over your children], for me it is, and mothering is.
	77.17	When you take on the role of mother then you've got to take the rough with the smooth…
Different to other parenting	**5.15**	[Her dad] is a step further back…I do more of the close parenting…
Attitude about S-H	**9.14**	I would have seen the signs with a YP I work with… wasn't expecting it with Molly

I didn't notice the signs	**19.11**	Sometimes I can understand, when there's an obvious reason for it, but as for molly- as far as I can understand she's had a normal upbringing, she's had no sort of, she hasn't suffered any major loss in her life, she, there's been no obvious trigger.
	16.6	
	9.4	You never think it is going to be your child.
	9.7	
	11.19	She lied huge amounts.
		I never expected it.
Guilt/regret/question self	**3.14**	Bit obvious at the time.
		I've always listened but I've never been sort of, you need to this and you need to that. I wonder if I should have been a little bit more proactive in that way?
	24.3	
		I still can't really understand what's happened, what caused this to happen, and that does play on my mind…I was thinking what I've done?
Have I mothered incorrectly?	**67.6**	
		I don't know, I suppose as a mother you have to question whether it's something you've done?
I should have noticed	**3.17**	
	16.12	Should I have been more proactive (directive).
		… had I been looking more carefully, perhaps, I would have picked up on some of the symptoms- you know- the missing college; she told me so many lies. I think definitely I that I should have picked-up on it… I could see this happened and I could see, not why, but I could see what had happened
	24.8	

Overcompensate	**49.16**	and I could see, oh yeah, how did I miss that…
Careful what I say	**53.1**	I probably try to overcompensate, so she probably has more financially…than I can manage.
Aware I behave differently	**59.8**	I'm more careful about what I say… with topics I think might upset her.
Don't leave her alone for long	**60.14**	I don't think it will change me too much as, as an individual. I think, I think I would probably still [pause] I have changed, haven't I, with regards to Molly, but not with regards to the others.
Tread on eggshells	**66.12**	I remember thinking that I couldn't go (away) for any longer than that because I didn't want to leave Molly for any longer than that.
Isolated from sharing burden	**36.14**	Err; err, I'm very, sort of, wary about broaching anything really- in case I aggravate a situation. It's like treading on eggshells sometimes at home.
Need for support for self	**80.16**	I don't regret telling her [Jane's own mother] but sometimes I think it might have been a bit selfish telling her; she might have been better not knowing?
Loss for daughter	**74.14**	I could probably do with talking to somebody else who's going through…
She deceived me	**9.5**	
Can play-up to it	**51.6**	When you give birth there's this perfect little human being and now she's quite damaged and I can't make that better…
Loss of control	**74.8**	She's a very accomplished liar.

		She does, she does lay on the guilt-trip a bit occasionally…
Risk	**79.11**	I'm not in control of the situation, so, I suppose as a mother that is difficult, you know, I can't make things right, I can't make things
Suicide	**15.11**	better, as much as I'd like to, I can't make things…
Worry/relentless	**17.3**	I worry more about the, the overdosing. It's the finality of it all- and I guess that's natural.
Future	**20.12**	… I do that now (give her, her tablets at night), but if she wanted to take another overdose I'm sure she could get hold of something to do that.
	20.16	I question everything she tells me now, in my head, not to her but in my head. And if I don't hear form her then I'm constantly on edge, yeah.
		I do worry about how things are going to go, the way things are going to go when she's out of the CAMHS bracket. I worry that things could take a bit of a turn for the worse again, it's always in the back of my mind, constantly in the back of my mind.