

2017

# Experiences of Parents of Self-Harming Adolescent Children

Sheila Nicole Russell  
*Walden University*

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# Walden University

College of Counselor Education & Supervision

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Sheila Russell

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2017

Abstract

Experiences of Parents of Self-Harming Adolescent Children

by

Sheila N. Russell

MA, Wayland Baptist University, 2012

BA, Oklahoma State University, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

November 2017

## Abstract

Adolescent self-harm is a growing epidemic in the United States with thousands of adolescent children being treated in hospitals every year. Despite awareness that self-harm impacts the family unit, little attention has been given to the full impact that self-harm has on parents. Due to this lack of knowledge, counselor educators and supervisors are not equipped to train counselors to work with parents of self-harming adolescent children leaving counselors feeling unprepared to work with parents. The purpose of this phenomenological study was to explore the lived experiences of parents who have self-harming adolescent children. Family systems theory was used to explore the concept that self-harm impacts the entire family system. The key research question for this study was: What are the lived experiences of parents of self-harming adolescent children? Six participants were interviewed using a semi structured design. The interviews were transcribed, coded, and analyzed using Pietkiweicz and Smith's 3 stage analysis process. Six main themes emerged from the data: (a) reaction to behavior, (b) change in self, (c) change in parenting style, (d) impact on relationships, (e) change in perception of mental health issues, and (f) support systems. The results of the study confirmed that parents have strong emotional responses to the self-harm and consequently adjusted their parenting styles. The outcomes of this study have the potential to impact positive social change by informing changes in counseling curriculum, training programs, and the level of support and services counselors provide when working with parents of a self-harming adolescent child.

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## Dedication

This project is dedicated to the brave mothers who chose to share their stories with me so that someone else could potentially benefit from their experiences. This study would not be possible without their willingness to courageously share their personal struggles about having a child who self-harmed. I hope that this project does their life experiences justice.

I also dedicate this project to the greatest teacher I ever had, my mother, Sheila Dixon. She was the first to achieve a higher education in her family and in ours, all while struggling to care for her family of three young children. Watching her sacrifice to receive her degree was one of the greatest life lessons I have ever learned. She taught me the importance of following my dreams no matter how hard it gets. She instilled in me a thirst for knowledge by sharing with me what she was learning in her college courses. In the late-night hours, when she thought no one was watching, I was watching. It was in those hours that I learned that things worth having require hard work and determination. Mom, I hope that you see this doctoral degree as a direct reflection of you and your dedication to education.

## Acknowledgments

This project could not have been completed without the support of many individuals. First, no one understands the time, tears, and hard work put into this project like my husband, Doug. Your support and encouragement throughout this journey was unwavering. I could not have accomplished this without your selfless sacrifices and willingness to help me succeed. You were my steady rock throughout this process.

To my parents, Charly and Sheila Dixon, who instilled in me a love for learning as a young child. Thank you for always encouraging me and believing in me. To my family members, thank you for your unconditional love and support and for understanding when I had to miss many family gatherings throughout this process.

I am forever grateful to my chair and mentor, Dr. Laura Haddock, for her continued support, constructive criticism, and commitment to excellence throughout this endeavor. Thank you for keeping me grounded and focused. A special thank you to Dr. Matthew Buckley, my second committee member, who graciously agreed to join my team in the middle of my journey. Your steadfast guidance, expertise, and continual encouragement was beyond what I could have ever expected. I am so thankful for you and the mentorship you have provided. Thank you to Dr. Corinne Bridges, my university research reviewer, for her commitment to helping me successfully complete my doctoral journey. Finally, I would like to say thank you to Dr. Joy Whitman who began this project with me and helped shape it into what it is. You were often the soft voice in the storm that helped calm my nerves. Thank you for your leadership.

## Table of Contents

List of Tables .....	vi
Chapter 1: Introduction to the Study.....	1
Introduction.....	1
Background.....	2
Problem Statement.....	5
Purpose.....	6
Research Questions.....	6
Theoretical Framework.....	7
Nature of the Study.....	7
Qualitative.....	7
Possible Types and Sources of Data.....	8
Definitions.....	8
Self-Harm.....	8
Adolescent Children.....	9
Assumptions.....	9
Scope and Delimitations .....	10
Boundaries of the Study.....	11
Transferability.....	11
Limitations .....	12
Significance.....	13
Summary.....	14



Chapter 2: Literature Review .....	15
Introduction.....	15
Literature Search Strategy.....	17
Theoretical Foundation .....	19
Family Systems Theory .....	19
Phenomenology.....	25
Literature Related to Self-Harm.....	27
Justification for the Concepts.....	31
Synthesis of Related Studies.....	34
Conclusion .....	37
Chapter 3: Research Method.....	39
Introduction.....	39
Research Design and Rationale .....	40
Research Tradition .....	41
My Role as the Researcher .....	43
Possible Personal or Professional Relationships.....	44
Researcher Bias.....	45
Member checking.....	45
Other Possible Ethical Issues .....	46
Methodology.....	47
Participation Selection Logic .....	47
Instrumentation .....	50

Interviews.....	51
Debriefing Procedures .....	52
Data Analysis Plan.....	52
Issues of Trustworthiness.....	53
Credibility .....	54
Transferability.....	55
Dependability.....	56
Confirmability.....	56
Ethical Procedures .....	57
Summary.....	59
Chapter 4: Results .....	60
Introduction.....	60
Setting .....	61
Demographic.....	61
Data Collection .....	62
Data Analysis .....	64
Themes and Subthemes.....	65
Theme 1: Reaction to Behavior: Denial and Blame .....	66
Theme 2: Change in Self.....	69
Theme 3: Change in Parenting Style .....	73
Theme 4: Impact on Relationships .....	75
Theme 5: Change in Perception of Mental Health Issues.....	77

Theme 6: Support System.....	78
Discrepancies/Nonconforming Data.....	82
Research Question .....	83
Evidence of Trustworthiness.....	84
Credibility .....	84
Transferability.....	87
Dependability.....	87
Confirmability.....	87
Summary.....	88
Chapter 5: Discussion, Conclusions, and Recommendations.....	89
Introduction.....	89
Key Findings.....	90
Theme 1: Reaction to Behavior: Denial and Blame .....	90
Theme 2: Change in Self.....	93
Theme 3: Change in Parenting Style .....	95
Theme 4: Impact on Relationships .....	95
Theme 5: Change in Perception of Mental Health Issues.....	96
Theme 6: Support System.....	98
Interpretation of the Findings.....	101
Theme 1: Reaction to behavior: Denial and Blame .....	101
Theme 2: Change in Self.....	103
Theme 3: Change in Parenting Style .....	105

Theme 4: Impact on Relationships .....	106
Theme 5: Change in Perception of Mental Health Issues.....	107
Theme 6: Support Systems .....	108
Interpretation of the Findings in the Context of Family Systems Theory .....	112
Limitations of the Study.....	113
Recommendations for Future Research .....	114
Implications for Positive Social Change.....	116
Recommendations for Practice .....	118
Conclusion .....	119
Appendix A: Advertisement for Participation .....	130
Appendix B: Participation Eligibility Sheet .....	131
Appendix C: Interview Schedule .....	132
Appendix D: Observation Sheet .....	133
Appendix E: Local Resources.....	134
Appendix F: Debriefing Handout .....	135

List of Tables

Table 1. Demographic Information..... 62

## Chapter 1: Introduction to the Study

### **Introduction**

Self-harming behavior among adolescents is a common occurrence in the United States and the behavior is increasing (Hay & Meldrum, 2010; Tsai et al., 2011). In 2010, Hay and Meldrum (2010) reported that almost 18,000 adolescents were treated for self-harm in hospitals in the United States. In a systematic review of 128 studies, Ougrin, Tranah, Leigh, Taylor, and Asarnow (2012) found that 13.2% of adolescents reported engaging in self-harm at some point in their lifetime. In 2013, 45,711 adolescents were treated for self-poisoning, and 30,000 adolescents were treated for cutting (Centers for Disease Control and Prevention, 2014). Of those teenagers who engaged in self-harm, 70% of them later made at least one suicide attempt, and 55% had multiple suicide attempts (Peterson, Freedenthal, Sheldon, & Andersen, 2008). These statistics do not show the full impact self-harm has on the family unit. Parents and guardians of self-injurious adolescents are also affected and often do not seek help for themselves from mental health professionals (Lindgren, Astrom, & Graneheim, 2010; McDonald, O'Brien, & Jackson, 2007). Yet, despite awareness that self-harming behavior is a systemic problem affecting everyone in the family (Lindgren et al., 2010; McDonald et al., 2007), a thorough review of the professional literature showed little attention has been given to parents' experiences of having adolescent children who self-harm. Due to this lack of information, many counselor educators and supervisors are not prepared to train counselors to meet the needs of parents of self-harming adolescents. Counselors have reported feeling inadequately prepared to work with self-harming clients and their

families and showed a desire to learn how to appropriately treat this specific population (Fox, 2011). Due to this inadequate training, parents of self-harming adolescents reported feeling invisible to mental health professionals and uninvolved in their children's treatment (Lindgren et al., 2010). Therefore, the significance of this study's outcomes provided vital information that counselor educators and supervisors could use to inform curriculum and program changes to better prepare counselors who work with parents of self-harming adolescents. Counselors with insight into the experiences of parents of self-harming adolescents could implement treatment more intentionally and effectively. The research outcomes could also inform institutional policy changes. Another social change implication of this study could be the personal benefit that parents could receive from participating in the study by knowing that they are helping someone else going through a similar experience. The personal benefit may increase parents' feelings of self-worth, parental satisfaction, and sense of social support as well as possibly decreasing the sense of isolation these parents experience.

In the following chapter, I will summarize research literature related to self-harming behavior and then present my problem statement, the purpose of the study, and the research question. I will also discuss the theoretical framework for the study, the nature of the study and the limitations of the study. Information regarding major definitions and assumptions will also be presented.

### **Background**

A thorough examination of the professional literature of self-harming behaviors indicated a lack of information regarding parents' experiences of having an adolescent

child who self-harms. Most of the literature available focused on actual self-harming behaviors (Ougrin, Zundel, et al., 2012), causes for self-harming behaviors (McMahon et al., 2013; Tschan, Schmid, & In-Albon, 2015; Tsai et al., 2011), and treatment modalities for self-harming behaviors (Oldershaw et al., 2012; Ougrin & Tranah, et al., 2012).

However, the literature that was available supported the need for further research that explores parents' experiences of having adolescent children who self-harm. For example, McDonald et al. (2007) conducted a phenomenological qualitative study to understand the experiences of parents who had self-harming adolescents and found that parents are negatively impacted by their child's self-harming behaviors. Parents reported feeling guilt and shame surrounding their child's self-harm. They also blamed themselves as if they did or did not do something that caused the child to want to self-harm (McDonald et al., 2007). Parents also stated that they became so hypervigilant of their child's behaviors that other relationships suffered (McDonald et al., 2007).

Morgan et al. (2013) echoed the adverse effects of adolescent children's self-harming behaviors on parents. The researchers conducted surveys to develop a psychosocial profile for parents who sought help when they had a child who was self-harming or suicidal. The researchers found that when children experience greater difficulties, such as self-harm, parents' mental health and well-being are adversely affected (Morgan et al., 2013). Parents of self-harming adolescents had a lower level of perceived social support, parental satisfaction, and poor family communication (Morgan et al., 2013).



Despite awareness that self-harming behavior is a systemic problem affecting everyone in the family (Lindgren et al., 2010; McDonald et al., 2007), many counselor educators and supervisors are not prepared to train counselors to meet the needs of parents of self-harming adolescents, which negatively impacts the therapeutic alliance and counselors' self-efficacy. For instance, Fox (2011) conducted a qualitative study that explored the experiences of counselors who work with self-harming adolescents and their families. The participants reported feeling anxious when working with clients who self-harmed because they were not prepared to work with the population (Fox, 2011). They also reported feeling as if therapy failed the client (Fox, 2011). Some of the frustrations and feelings of failure were rooted in not being adequately prepared or trained to work with clients who self-harm or their families (Fox, 2011).

Lindgren et al. (2010) explored parents' experiences of mental health professionals who worked with the participants' adult children in a qualitative study. The researchers' results echoed the frustrations found by Fox (2011) in that parents felt frustration towards the mental health professionals. Participants reported feeling invisible to mental health professionals because they were not invited to participate in the treatment planning or treatment of their children (Lindgren et al., 2010). Participants stated that they lost confidence in the mental health care professionals and the healthcare system (Lindgren et al., 2010). However, parents reported feeling supported and valued by counselors when they received support from the counselor (Lindgren et al., 2010).

Counselors should be aware of the needs of parents of self-harming adolescents. Feeling supported and valued by counselors increases the likelihood of involvement in

the child's treatment, which then decreases the probability of continued self-harm and reduces the burden on the family (Ewertzon, Lutzen, Svensson, & Andershed, 2010). However, the extant literature did not address the experiences of parents of self-harming adolescent children in the United States. Most of the literature included parents of adult children who self-harm (Lindgren et al., 2010), only one gender of adolescent children (Tschan et al., 2015), or was conducted outside of the United States (Byrne et al., 2008; McDonald et al., 2007; Oldershaw, Richards, Simic, & Schmidt, 2008; Raphael, Clarke, & Kumar, 2006; Tschan et al., 2015). None of literature examined sought to explore how counselors could support parents of self-harming adolescents. A possible cause of the lack of attention for parents and caregivers of self-harming adolescents was a lack of awareness of parents' experiences of having self-harming adolescents. Therefore, a study that explored the lived experiences of parents of self-harming adolescent children in the United States has the potential to inform training, curriculum, and institutional policy changes.

### **Problem Statement**

The statistics on adolescent self-harming behavior do not show the full impact on the family. Parents and guardians of self-injurious adolescents are also affected and often do not seek help for themselves from mental health professionals (Lindgren et al., 2010; McDonald et al., 2007; Oldershaw et al., 2008). Researchers did indicate that the issue of adolescent self-harm has impacted families and caregivers of self-harming adolescent children due to the trauma associated with self-harming adolescents not being addressed (Ewertzon et al., 2010; Lindgren et al., 2010; McDonald et al., 2007). Yet, despite

awareness that self-harming behavior is a systemic problem affecting everyone in the family (Lindgren et al., 2010; McDonald et al., 2007), a thorough review of the professional literature showed that researchers have given little attention to parents' experiences of having adolescent children who self-harm. Due to this lack of information, many counselor educators and supervisors are not prepared to train counselors to meet the needs of parents of self-harming adolescents.

### **Purpose**

The purpose of this phenomenological study was to bridge the gap in the professional counseling literature by exploring the experiences, characteristics, and needs of parents of self-harming adolescent children. Past studies focused on self-harming behavior and attitudes among adolescents (Fox, 2011; McMahan et al., 2013; Rissanen, Kylma, & Laukkanen, 2011; Tsai et al., 2011), but little attention was given to the experiences of parents of self-harming adolescents. Researchers did indicate the issue of adolescent self-harm had negatively impacted families and caregivers of self-harming adolescent children due to the trauma associated with self-harming adolescents not being addressed (Ewertzon et al., 2010; Lindgren et al., 2010; McDonald et al., 2007). A possible cause of the lack of attention for the parents and caregivers of self-harming adolescents was a lack of awareness of trauma in parents whose adolescent children are self-harming.

### **Research Questions**

The overarching central research question for the phenomenological study was:  
What are the lived experiences of parents of self-harming adolescents?

## **Theoretical Framework**

The theoretical foundation for this project was grounded in family systems theory, specifically Bowen's family systems theory (Berg-Cross & Worthy, 2013; Fleck & Bowen, 1961). Bowen's family systems theory states that individuals in a family are interrelated and interconnected (Berg-Cross & Worthy, 2013; Cottrell & Boston, 2002). Individuals' behaviors and interactions affect the entire system (Cottrell & Boston, 2002). Family members adjust or change behaviors to maintain the equilibrium of the system (Cottrell & Boston, 2002). However, the weight of the adjustment often negatively affects the people making the adjustments (Cottrell & Boston, 2002). Therefore, Bowen's family systems theory perpetuates the theory that adolescent children who engage in self-harming behaviors negatively impacts parents. Studies found in the literature search supported the idea that parents experience negative feelings and thoughts due to their children self-harming (Lindgren et al., 2010; McDonald et al., 2007; Morgan et al., 2013; Raphael et al., 2006). Therefore, the systemic theory informed the proposed study by supporting the idea that parents are affected by their adolescent children's self-harming behaviors. Accordingly, using this lens, the assumption was made that parents are impacted by self-harming adolescent children. A more detailed explanation of Bowen's family systems theory is provided in chapter two.

## **Nature of the Study**

### **Qualitative**

I used a qualitative approach to explore the lived experiences of parents who have adolescent children who self-harm. The method used was a hermeneutical

phenomenology. Hermeneutical phenomenology is used to explore the lived experiences of individuals and is followed by interpreting the meaning of the experience as lived by the individuals (Bellou, Vouzavali, Koutroubas, Dimoliatis, & Damigos, 2012). The design is a holistic approach that studies an individual within a situation rather than all the variables separate from the individual (Bellou et al., 2012). Accordingly, the overarching central question was designed to understand the lived experiences of parents, not the variables surrounding the experiences. Studies with a similar design in research questions validate the use of a hermeneutical phenomenology design (Bellou et al., 2012; McDonald et al., 2007; Vuori & Åstedt-Kurki, 2013). Participants for this study were parents of self-harming adolescents located in the southwestern part of the United States. Participation inclusion criteria were threefold. First, participants must have been at least 18 years of age or older. Secondly, they must have had adolescent children who self-harmed during the ages of 12 and 18 years of age. Lastly, they must have been English speakers because I am not bilingual and did not have an interpreter.

### **Possible Types and Sources of Data**

Participants who responded to the advertisements were asked a series of questions over the phone to ensure that they met the requirements to participate. Then, to collect data, I conducted face to face interviews with participants who meet the inclusion criteria.

### **Definitions**

#### **Self-Harm**

Self-harm was defined as deliberate bodily harm with the knowledge that the act will result in some degree of physical or psychological injury to oneself, not an attempt to

suicide, and usually does not require medical attention (Fox, 2011; McDonald et al., 2007; Morgan et al., 2013; Rissanen et al., 2011; Tsai et al., 2011). Self-harming behaviors could include, but were not limited to, cutting, poisoning, burning, scalding, scratching to the point it breaks skin, biting to the degree that it breaks skin, not allowing wounds to heal, and hair pulling (Fox, 2011). Self-harm with an attempt to suicide was delimited from the definition because self-harm with suicide ideation was defined in literature as being inherently different, with different presenting characteristics, than self-harm alone (Fox, 2011; McDonald et al., 2007; Morgan et al., 2013; Rissanen et al., 2011; Tsai et al., 2011).

### **Adolescent Children**

There was not a consistent agreement in the literature as to the exact ages that defined adolescence. The ages varied in the literature from 12 to 21 years of age (McDonald et al., 2007; Ougrin & Tranah, et al., 2012; Tsai et al., 2011). However, for the purpose of this project, adolescence was defined as individuals between the ages of 12 and 18 years of age in an attempt to stay within the boundaries of adolescence and not intrude on the boundary of adulthood.

### **Assumptions**

The inherent assumption was that participants would be honest and forthcoming about their experiences of having adolescent children who self-harm. Because there is no way to verify the data given, I assumed that parents provided accurate and honest information. I also assumed that parents would be interested in sharing information about

their experiences to improve the lives of other parents who also have self-harming adolescents.

### **Scope and Delimitations**

Due to a lack of awareness and understanding of parents' experiences who have self-harming adolescent children, counselor educators and supervisors are not able to adequately train counselors to work with this specific population. Therefore, the scope of the study was limited to parents of adolescent children who self-harm. The scope was narrowed to include only parents of adolescent children who self-harmed during the ages of 12 to 18 years of age. The adolescent ages were chosen for the study because research supported the idea that adolescence is the most frequent age of the onset of self-harming behaviors (Whitlock, Eckenrode, & Silverman, 2006). Whitlock et al. (2006) also found that adults who self-harm present different characteristics than adolescents who self-harm. For example, adults who self-harm are more likely to also have suicidal ideation or intention. Another reason this age group was chosen as the focus of the study was because research suggested that parents' experiences of having adult children who self-harm is inherently different than those parents who have adolescent children who self-harm. One primary difference is not being in control of the adult children's health care (Lindgren et al., 2010). Parents reported encouraging their adult children to seek help, but they could not force their child to receive the help (Lindgren et al., 2010). Parents also stated that they felt invisible to the mental health professionals because confidentiality laws do not allow for parents of adult clients to be involved in treatment

planning without consent from the client (Lindgren et al., 2010). These aspects of having adult children are not present with adolescent children.

### **Boundaries of the Study**

Inclusion criteria consisted of parents of adolescent children who self-harm. Parents must have been at least 18 years of age. The children must have self-harmed during the ages of 12 to 18 years of age. Participants must have also been English speakers. Another boundary of the study was that the participants were from the southwestern part of the United States because that is where I was located. The limited area allowed me to travel, when necessary, within a timely manner to meet with participants. Exclusion criteria included parents of adolescent children who had self-harming behaviors with suicidal intention. Literature supported the theory that self-harming without suicidal intention has important differences than self-harm with suicidal intention (Ougrin & Zundel et al., 2012). For example, Ougrin and Zundel et al. (2012) found that adolescents with suicidal self-harm had a later age of onset of self-harm, were more likely to have used self-poisoning, and were less likely to be successful with brief therapeutic interventions.

### **Transferability**

Transferability speaks to the ability to transfer results of a study to populations that were not included in the study. The level of transferability for the study is low since the sample of participants was small and they were recruited from a small geographical location. However, the results only reflect those of parents of self-harming adolescents in



the southwestern region of the United States who met the inclusion criteria set out in this study.

### **Limitations**

Every study has limitations either in design or methodological weaknesses. One of the limitations of the study was transferability. As previously discussed, the ability to transfer the results of this study to other populations not included in the sample is low. The geographical limitation prevented me from including many ethnically diverse groups in the sample. My inability to speak languages other than English also limited my ability to include cultures that could increase the transferability of the results. Therefore, researchers and counselors should take caution when transferring the results of this study to populations excluded from the sample.

Another possible limitation to the study was the credibility of participants' experiences. Since participants engaged in a face to face interview with the researchers, there may have been a tendency to answer questions in such a way that the participants appear socially desirable. Social desirability bias could skew the results of the study, thus limiting the credibility of the results.

Every researcher has biases that have the potential to influence the outcome of a study. Biases that arose were noted in a journal that I kept during the data collection and analysis stages. Member checking was also used at two separate points during the data collection and analysis processes to ensure that researcher biases did not influence the outcomes of the study and that the results reflected the actual experiences of the participants.

### **Significance**

Parents and guardians of adolescent children who participate in self-injurious behavior are affected and often do not seek help for themselves from mental health professionals (Lindgren et al., 2010; McDonald et al., 2007; Morgan et al., 2013; Raphael et al., 2006). For example, Lindgren et al. (2010) conducted a qualitative study and found that parents felt invisible by mental health professionals. The parents in this study wanted the counselors to ask them what they needed to feel supported but the professionals never asked. Lindgren et al. (2010) also did not describe reasons parents chose not to seek help themselves. In another qualitative study of parents with adolescents who self-harm, Morgan et al. (2013) found that participants had significant emotional challenges including a lack of social support and low levels of parenting satisfaction. Additionally, Fox (2011) also found that counselors felt inadequately prepared and ineffective when working with self-harming clients and their parents. Therefore, the significance of the study provided vital information that counselor educators and supervisors could use to inform curriculum and program changes to better prepare counselors who work with parents of self-harming adolescents. Counselors with insight into the experiences of parents of self-harming adolescents could implement treatment more intentionally and effectively. The research outcomes could also inform institutional policy changes. Another social change implication of the study could be the personal benefit that parents could receive from participating in the study and knowing that they are helping someone else going through a similar experience. The personal

benefit may increase parents' feelings of self-worth, parental satisfaction, and sense of social support.

### **Summary**

In this chapter, I presented the problem statement and purpose of the study. I also briefly discussed the background and theoretical framework. In chapter two I provide an in-depth literature review of the major concepts included in the scope of the study. Included in the literature review in chapter two is a more in-depth exploration of the theoretical framework and how it is applied to the current study.

## Chapter 2: Literature Review

### **Introduction**

Self-harming behaviors among adolescent children is a phenomenon in the United States that continues to grow and impact families nationwide. For instance, approximately one-third to one-half of adolescents in the United States has reported engaging in some type of non-suicidal self-harm (Peterson et al., 2008). In 2014, the Centers for Disease Control and Prevention reported 45,711 adolescents were treated for self-poisoning and 30,000 adolescents were treated for self-cutting in the United States. However, these statistics do not show the full impact of self-harm. From a Bowen's family systems perspective, family members of self-injurious adolescents are also affected yet often do not seek help for themselves from mental health professionals (Lindgren et al., 2010; McDonald et al., 2007). If parents were to seek help from counselors they may find that counselors are not equipped to properly treat adolescents who self-harm or their family members (Fox, 2011). Counselors reported feeling unprepared and inadequately trained to help these clients and their families (Fox, 2011). Some counselors even reported wanting to do more but did not know how (Fox, 2011). To add to the problem of being unprepared, few studies that examined the experiences of parents who have adolescent children who self-harm have been identified in the extant literature (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008). The current literature that I examined largely focused on adolescents' experiences when they self-harmed and the causes behind the self-harm. These statistics and the current literature examined do not demonstrate the full impact of self-harming behaviors. A

thorough review of professional literature showed little attention had been given to parents' experiences of having adolescent children who self-harm. Due to this lack of information, counselors and counselor educators feel that they are not adequately trained to work with these clients (Fox, 2011) and parents are not receiving adequate services.

The purpose of this hermeneutic phenomenological study was to explore the lived experiences, characteristics, and needs of parents who have adolescent children who self-harm. Past researchers have studied adolescents' self-harming behaviors and attitudes (McMahon et al., 2013; Rissanen et al., 2011; Tsai et al., 2011) and counselors and other healthcare professionals' attitudes about self-harm (Fox, 2011; Rissanen et al., 2011), but little attention has been given to the experiences of parents of self-harming adolescents. One potential cause for the lack of attention for parents of self-harming adolescents is a lack of knowledge regarding what parents experience when they have adolescent children who self-harm. This potential lack of awareness could change with a study that explored the experiences and needs of parents of self-harming adolescents in the United States. The outcomes of this study can provide counselor educators with vital information that could inform policy changes such as changes in curriculum and program requirements to better prepare counselors who might work with, and appropriately support, parents of self-harming adolescents. Counselors with insight into the experiences of parents of self-harming adolescents could implement treatment more intentionally and effectively so that parents feel supported. The research outcomes could also inform institutional policy changes at treatment facilities such as developing self-care plans for parents before adolescent patients are discharged.

In this chapter, I discuss the literature search strategy and the theoretical framework surrounding the study. I also present a comprehensive review of the literature that pertains to self-harm and parents' experiences of having children who self-harm. Some of the salient topics that I cover in this chapter include the expansiveness of adolescent self-harm, research regarding family systems theory, parents' experiences of having adolescent children who self-harm, and the lack of knowledge surrounding how counselors can best help parents of SHA.

### **Literature Search Strategy**

Primary sources were reviewed within the literature search. The literature was identified through many searches of academic databases from EBSCOhost such as PsychINFO, PsychARTICLES, and ERIC- Educational Resource Information Center. Dissertations were found using ProQuest Dissertations and Theses Global database. Online sources were also used through internet searches using Google search engine and Google Scholar search engine.

The keyword search began with the major theme of the study: *self-harm* or *self-injury* or *self-mutilation* and *parents*. These keywords produced thousands of results dating back to the 1800s. Therefore, limiters such as full-text only, peer-reviewed only, and articles within 10 years were used to narrow the search for more specific, current literature. Using the limiters, the results narrowed to 2,708 articles with most the literature about adolescent self-harm. The additional keywords with the same limiters also included were *adolescent self-harm*, *non-suicidal self-injury*, *children self-harm*, *teen self-harm*, *parents of self-injurious children*, *parents of self-injurious adolescents*,

*parents of self-injurious teens, parents' experiences of self-harm, parents' understanding of self-harm, family systems theory, systemic theory, Bowen family systems theory, hermeneutical phenomenology, and phenomenology.* The keywords were chosen because they were a major theme of the study or they were keywords used from relevant articles. For example, non-suicidal self-injury was added as a keyword after reviewing the literature and finding a distinction in the literature between suicidal self-injury and non-suicidal self-injury. Many of the relevant articles also used non-suicidal self-injury as a keyword distinguishing the articles from suicidal self-harm.

Several of the terms listed above were combined throughout the literature search to achieve saturation of the literature. For example, the literature uses the terms self-harm, self-injury, and self-mutilation interchangeably. Therefore, all the terms were used using Boolean Phrases to achieve saturation and to review the relevant literature surrounding self-harm. So, a combination could be *self-harm OR self-injury OR self-mutilation AND adolescents*. I found that the literature also used the terms teen, adolescent, and child interchangeably. Although this distinction is made in the current study, these terms were combined using Boolean Phrases to capture the entirety of the literature surrounding this age group.

The database searches yielded several results in specific areas. For example, a keyword search of *self-harm* with the above-mentioned limiters would yield thousands of articles but when combined with parents' experiences the results decreased to 166 articles. These results led to multiple searches using different combinations of keywords to perform the most exhaustive review of relevant literature possible. The combination of

search terms and Boolean Phrases helped reach a saturated level of literature reviewed determined by duplicate search results.

During the literature search, studies were found in which parents' experiences was the main topic (Arbuthnott & Lewis, 2015; Byrne et al., 2008; Donald et al., 2007; Raphael et al., 2006), or did not include parents of younger adolescents (Raphael et al., 2006). The search revealed no studies performed within the United States in which the self-harming adolescents were between the ages of 12 and 18 years of age. The searched also did not reveal any studies that related the parents' experiences to symptoms of vicarious trauma.

### **Theoretical Foundation**

The theoretical foundation of this study was grounded in family systems theory. This theory provided a lens through which to view and interpret participants' experiences. Family systems theory is discussed in further detail below.

#### **Family Systems Theory**

The theoretical foundation for this project was grounded in family systems theory, specifically Bowen's family systems theory (Berg-Cross & Worthy, 2013; Fleck & Bowen, 1961). Bowen developed his family systems theory based on the National Institute of Mental Health (NIMH) research project, which focused on enmeshed relationships between patients with schizophrenia and their mothers (Berg-Cross & Worthy, 2013; Haefner, 2014). Entire families lived in the ward with the patient. Bowen and his team observed the families and their interactions (Berg-Cross & Worthy, 2013; Haefner, 2014). He then ended the project and focused on developing the family systems



theory based on his observations at NIMH (Haefner, 2014). Bowen's family systems theory includes eight interlocking concepts that form family functioning. Those include differentiation of self, triangles, nuclear family emotional system, family projection process, emotional cut-off, multi-generational transmission process, sibling position, and societal regression (Berg-Cross & Worthy, 2013; Haefner, 2014).

**Rationale for using family systems theory.** Family systems theory focuses on understanding and interpreting family interactions and the system that is at work within a family. Individuals within a family are interrelated and interconnected (Cottrell & Boston, 2002). Per Bowen's family system theory, the family is an emotional unit and the theory promotes systems thinking to describe the interactions between family members within the unit (Berg-Cross & Worthy, 2013; Haefner, 2014; Kolbert, Crothers, & Field, 2013). Family members adjust or change behaviors to maintain the equilibrium of the system (Cottrell & Boston, 2002). Per Bowen's family systems theory, individuals are not seen as individual units, rather as members of a larger family unit that must maintain homeostasis (Cottrell & Boston, 2002; Haefner, 2014). The emotional dysfunction of an individual within the system disturbs the family system because the other members of the family must shift to maintain equilibrium (Cottrell & Boston, 2002, Haefner, 2014; MacKay, 2012). The adjustment that is made by the other members of the family is often stressful and causes emotional distress (Cottrell & Boston, 2002; MacKay, 2012), or what Bowen termed emotional functioning of the nuclear family emotional system (Haefner, 2014). Accordingly, a disturbance in emotional functioning could then lead to marital conflict, dysfunction in one spouse, impairment in children, or

emotional distancing (Haefner, 2014). Therefore, Bowen's family systems theory was chosen for the theoretical foundation for this research project because it perpetuates the theory that parents are impacted by their adolescent children participating in self-harming behaviors. Parents' experiences of having self-harming adolescents was viewed through the family systems theory lens to understand how the self-harming behaviors of the adolescent children impacts parents. I also used the theory as a lens when collecting, coding, and grouping data.

**Applications of family systems theory.** In recent literature, family systems theory has been effectively used in a multitude of settings with a wide range of participants including nursing, marriage and family therapy, family studies, psychology, and counseling (Kolbert et al., 2013; Miller, Anderson, & Keala, 2004). For example, Kolbert et al. (2013) integrated a family systems approach as a clinical counseling intervention with adolescent clients whose parents were unwilling or unable to participate in family counseling. Adolescent clients participated in one-person family therapy (OPFT) in which they explored family dynamics, explored feeling regarding the family, developed a more objective perspective, decreased harmful internalizing, identified family patterns that impacted the client's functioning, and developed problem solving skills (Kolbert et al., 2013). The approach involved having the adolescent clients change their behavior in ways that would require family members to modify their behaviors to adjust to the clients changed behaviors (Kolbert et al., 2013). Although the authors stated that adolescent clients must be in the formal operational stage to think objectively about

their family, the approach was effective and useful when working with adolescents in OPFT (Kolbert et al., 2013).

MacKay (2012) found that Bowen's theory was useful when working with adults who were abused as children. In times of crises, people forget their individual differences and needs and tend to pull together for the greater good of the system (MacKay, 2012). Individuals, then, sacrifice their individual needs and join the needs of the group to promote survival and equilibrium (MacKay, 2012). For example, parents of self-harming adolescents might sacrifice their individual needs to help the adolescent child through the trauma of self-harm. Some parents could potentially sacrifice jobs, relationships, and support for themselves to focus on helping the self-harming child (Arbuthnott & Lewis, 2015; Byrne et al., 2008; McDonald et al., 2007). This sacrificing of individual needs to maintain equilibrium can bring about stress and anxiety (MacKay, 2012). Accordingly, MacKay (2012) suggested that Bowen's family systems theory was useful in trauma work because the interventions promoted opportunities for emotional growth and viability within individuals and the theory explained generational issues of togetherness-separateness forces for the individuals.

Jankowski and Hooper (2012) examined the internal and external structure of the Differentiation of Self Inventory-Revised (DSI-R) with the intent to contribute to the ongoing validation of Bowen's theory of construct of differentiation. The researchers administered the DSI-R, the Parentification Questionnaire, and the Brief Symptom Inventory to a sample of 749 students. The researchers' data analysis supported the existence of two important central concepts to Bowen's theory of family systems: an

affect regulation within families and a dimension involving interpersonal negotiation of togetherness and separateness. Affect dysregulation seems to be present in many types of pathology (Jankowski & Hooper, 2012). The second central concept speaks to differentiation from the family. A significant lack of differentiation from the family is indeed related to anxiety, marital dissatisfaction, and distress (Jankowski & Hooper, 2012; Miller, et al., 2004; Priest, 2015). Therefore, one family member's behavior directly impacts the other members of the family system. Thus, this research supported the idea that self-harming behavior practiced by an adolescent child can also negatively impact other family members, specifically parents, by potentially causing anxiety and psychological distress.

**Criticisms of family systems theory.** Although Bowen's family systems theory is widely used, there are some distinct criticisms with Bowen's original work. For instance, Berg-Cross and Worthy (2013) pointed out that much of Bowen's theory is based solely on observation and not statistical data, preventing the theory being generalized to a population. The researchers also pointed out that the interventions used within Bowen's family systems theory failed to show clinical validation and were not widely conducted using diverse populations (Berg-Cross & Worthy, 2013). The impact of culture is missing from Bowen's work in both theory and results for the theory to be accepted as universal (Berg-Cross & Worthy, 2013; Miller et al., 2004). More current research that includes Bowen's family systems theory has been conducted using diverse populations in a way that might substantiate the idea that family systems theory is a universal theory within individualistic societies (Haefner, 2014; Kolbert et al., 2013;

Priest, 2015). Other research has supported some of the concepts within the theory (Berg-Cross & Worthy, 2013) while other concepts, such as sibling position and triangulation, have received little empirical support (Miller et al., 2004). Miller et al. (2004) stated that Bowen's specific theory of sibling position lacked empirical support but that the overall principle that a child's birth order impacts their personality development was supported in the literature.

**How family systems theory relates to this study.** Family systems theory supported the idea that the behavior of one family member effects the entire family system (Berg-Cross & Worthy, 2013; Cottrell & Boston, 2002; Haefner, 2014; Kolbert et al., 2013). According to family systems theory, the effect often causes emotional distress and relational problems (MacKay, 2012; Priest, 2015). Therefore, family systems theory supported the assumption that an adolescent child's self-harming behavior would cause distress to other family members, specifically parents of the self-harming adolescents. Understanding that parents might be affected by the self-harming behaviors is not enough. Therefore, this research project was designed to find out how they are impacted by exploring parents' experiences of having an adolescent child who self-harms. The current study outcomes also enhanced Bowen's family systems theory in that parents do experience some distress due to their adolescent child's self-harming behavior; supporting the theory that family members are negatively impacted by other members' behaviors.

## **Phenomenology**

Although a complete research design and plan will be presented in chapter three, some mention of phenomenology and how the phenomenological approach fits the research plan should be made. The design of the research project was a hermeneutical phenomenology approach. Edmund Husserl is considered the founder of phenomenology (Hein & Austin, 2001). Husserl sought to explore the experience of human meaning and argued that experience is constituted by consciousness (Hein & Austin, 2001). Thus, he argued that phenomenology is the science of consciousness (Hein & Austin, 2001). He claimed that experiences are made up of both concrete particulars and categories of meaning (Hein & Austin, 2001). Researchers who use phenomenology as an approach can do so using a valuable and practical means of studying human phenomena (Hein & Austin, 2001).

Heidegger added to Husserl's theory of phenomenology by arguing that researchers must not just explore the experiences of others, but also interpret the experiences (Finlay, 2009; Hein & Austin, 2001). Heidegger referred to this interpretation as the hermeneutics of existence (as cited in Hein & Austin, 2001). Hermeneutical phenomenology is used to explore the lived experiences of individuals and is followed by interpreting the meaning of the experience as lived by the individuals (Bellou et al., 2012). The design is a holistic approach that studies an individual within a situation rather than all the distinct variables that comprise an individual's personal context (Bellou et al., 2012). Therefore, researchers who use phenomenology can study subjective constructs that would otherwise not be studied in empirical-analytical studies

(Annells, 2006; Finlay, 2009). The approach also provides a depth of understanding about topics and constructs that researchers know little about (Annells, 2006). In this study, the central question was designed to understand the subjective, lived experiences of parents, not the variables surrounding the experiences.

Hermeneutics is more textual in form than other types of phenomenology (Annells, 2006; Finlay, 2009; Hein & Austin, 2001). Researchers who use a hermeneutic phenomenology approach are essentially treating human experiences as if they are semantic and textual structures (Hein & Austin, 2001). Researchers using hermeneutics strive to uncover rich accounts of human experiences versus accurately analyzing participants' descriptions of the lived phenomenon (Hein & Austin, 2001). The interpretation of the meaning and significance of lived experiences is key to this methodology (Hein & Austin, 2001).

Hermeneutic phenomenology has multiple assumptions that are worth mentioning. The first assumption is made in that researchers assume that participants have commonalities in their experiences of specific constructs; thus, making the experience a phenomenon (Annells, 2006; Bellou et al., 2012; Hein & Austin, 2001). For example, there is an inherent assumption in the proposed study that parents of self-harming adolescent children have common experiences. Without this underlying assumption, the experiences would not be a phenomenon. Secondly, the assumption is made in hermeneutic phenomenology that the lived experiences are similar only in the time and place that the experience occurred (van Manen, 1984). Therefore, the experiences of parents in a different time or place may not be like the experiences of the

parents involved in the proposed study. Thirdly, a complete understanding of a phenomenon is not considered possible because once one part of the phenomenon is understood other parts of the phenomenon are discovered (Hein & Austin, 2001).

The hermeneutic phenomenological approach does not have a step by step methodology that is required of researchers (Hein & Austin, 2001). However, most researchers follow a systematic structure when using hermeneutic phenomenology (van Manen, 1984). Researchers typically begin with a thorough investigation of an experience as it is lived, considering both parts of the text and the whole text, and coding and interpreting common patterns and themes (Bellou et al., 2012; Hein & Austin, 2001; Oldershaw et al., 2008; Raphael et al., 2006). Studies with a similar design in research questions validated the use of a hermeneutical phenomenology approach (Bellou et al., 2012; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006; Vuori & Åstedt-Kurki, 2013).

### **Literature Related to Self-Harm**

I identified an extensive amount of literature that focused on adolescent self-harming behaviors, including the reasons behind self-harm, effective interventions, and trends surrounding self-harm. However, most of the extant literature was focused on the actual self-harm or the adolescent child conducting the self-harm. The current literature on self-harm that I viewed did not demonstrate the full impact of adolescent self-harm on the family system. Most of the reviewed literature failed to mention family members' reactions or responses, specifically those of parents. Few articles focused on the experiences of parents; however, even the few articles available had limitations. For



example, some limitations included delimitations of participants with adolescent children (Lindgren et al., 2010), mothers as the only participants (McDonald et al., 2007), and participants who were recruited within a treatment facility (Byrne et al., 2008). These and other limitations are discussed in further depth below.

I reviewed studies similar in design and constructs that were found during the literature search using the terms *self-harm* and *parents*. For instance, Lindgren et al. (2010) conducted a qualitative, phenomenological study similar in design to the proposed study to explore the experiences of parents of self-harming adult children. The authors interviewed parents to understand what their experiences were. Lindgren et al. (2010) found that parents are indeed impacted by the self-harming behaviors of their adult children. The authors also found that parents felt more supported and valued when they received support from counselors. However, the researchers delimited the participants to include only parents of adult children who self-harmed who were seeking treatment from a treatment facility and did not examine the experiences of parents of adolescent children who self-harm.

McDonald et al. (2007) also conducted a hermeneutic phenomenological qualitative study similar in design to the proposed study. The study was designed to allow researchers to examine mothers' experiences who had self-harming adolescent children. The researchers used semi-structured interviews, similar to the current study, to explore, in-depth, mothers' experiences (McDonald et al., 2007). However, their study was different than my study in that the study was conducted in Australia, not in the United States, the study excluded male participants, and the study did not relate the

findings to vicarious trauma. Nevertheless, the study conducted by McDonald et al. (2007) was relevant to the current study in that the terminology, methodology, and methods were consistent with the scope of my study. For instance, McDonald et al. (2007) used the term *self-harm* instead of *self-injury*, and the authors conducted the data coding process using hermeneutic procedures. The authors reported that they read the transcribed interviews both in whole and in part to ensure that they did not miss something during the coding process (McDonald et al., 2007). The authors also journaled throughout the coding process to check for biases and assumptions about mothers, children, and self-harm (McDonald et al., 2007). These same methods were used in my study.

Other studies have used a qualitative approach to explore parents' experiences of having self-harming children (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006). Each study used the term *self-harm* versus some of the other terms used to describe self-harm in other studies (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006). The authors also used similar coding methods and journaling (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006). However, unlike the other authors' data collection method, Byrne et al. (2008) used a focus group to collect data. Although a focus group was an effective data collection method for Byrne et al. (2008), the common practice seemed to include individual semi-structured interviews when using a phenomenological qualitative approach (Lindgren et al., 2010; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006). The individual interviews were consistent across the literature with Byrne et al. (2008) being the exception.

The few articles that were found that focused on parents' experiences of having a child who self-harmed seemed to all have a similar overarching problem: there was not enough literature that explored parents' experiences. Apart from Byrne et al. (2008) and Tschan et al. (2015), the authors consistently approached the problem using a qualitative approach that explored and examined parents' experiences. Some explored only mothers' experiences (McDonald et al., 2007), some explored only parents' experiences who had adult children who self-harmed (Lindgren et al., 2010), while others explored parents' experiences while their children were receiving treatment or in a treatment facility (Oldershaw et al., 2008; Raphael, 2006; Tschan et al., 2015). There were a few strengths and weaknesses that stood out during the literature review. For example, one strength among the studies examined was that many of them used either triangulation or journaling to reduce researcher bias (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006). For example, Raphael et al. (2006) used three researchers from different fields to code the data and then compared the analyses of the three researchers to decrease researcher bias. The focus group approach used by Byrne et al. (2008), overall, was an effective approach. The strength of focus groups is that researchers can check with participants to see if there is an overall agreement with a statement made by one participant immediately (Byrne et al., 2008). The researchers can also check for outliers using the focus group approach (Byrne et al., 2008). Another inherent strength is that the researchers could bring to focus the subjective experiences of participants versus trying to objectively view them (Levitt, 2015).

Byrne et al. (2008) reported that one limitation to their study was that the focus group approach did not allow for the researchers to ask in-depth personal questions about the nature of their children's self-harming behaviors. They also stated that another weakness of their study design was that they did not do individual follow-up interviews, which could have increased the validity of their results (Byrne et al., 2008). Another limitation of phenomenological qualitative studies is an assumption that people's experiences are similar (Levitt, 2015). For example, Byrne et al. (2008) stated that the focus group included participants with similar experiences. However, all parents' experience may not be similar. It could be possible that self-harm could draw family members closer, begin quality conversations, and have family members address issues that might not have ever been addressed otherwise.

### **Justification for the Concepts**

Throughout the literature review, it became obvious that there was not an agreed upon term to describe self-harm. Some authors termed the behavior deliberate self-harm or DSH (Byrne et al., 2008; Raphael et al., 2006), self-injury (Arbuthnott & Lewis, 2015), self-mutilation (Rissanen et al., 2010), non-suicidal self-injury (Tschan et al., 2015), and self-harm (Lindgren et al., 2010; McDonald et al., 2007; McMahon et al., 2013; Oldershaw et al., 2008; Ougrin & Tranah, et al., 2012; Raphael et al., 2006; Tsai et al., 2011). Ougrin and Tranah, et al. argued that the term *self-injury* differentiated the type of self-harm from self-poisoning. There was also not a consistent, agreed upon, definition of self-harming behavior in the literature that I reviewed. For example, some authors described self-harm as being a nonfatal, deliberate act intended to cause self-

harm through injury which could include ingestion of a substance, illicit drug, or a non-ingestible substance (Byrne et al., 2008; Raphael et al., 2006). Other researchers included the intentional destruction of bodily tissue including cutting, burning, and picking at the skin (Arbuthnott & Lewis, 1015; Lindgren et al., 2010; McDonald et al., 2007; Tschan et al., 2015). One notable difference made within these definitions was the distinction between non-suicidal self-harm and suicidal self-harm (Tschan et al., 2015). Tschan et al. pointed out that non-suicidal self-harm is done intentionally to injure one's body but without suicidal intent. Accordingly, suicidal self-harm was delimited from the definition used here because self-harm with suicidal intention presents different characteristics than non-suicidal self-harm (Fox, 2011; McDonald et al., 2007; Morgan et al., 2013; Rissanen et al., 2011; Tsai et al., 2011). For instance, adolescents with suicidal self-harm have a later onset age, prefer high-lethality methods such as self-poisoning, and young women are more likely to participate in suicidal self-harm (Ougrin & Zundel, et al., 2012). There was a consistent theme in all the definitions reviewed as the injuries to one's body had to be deliberate or intentional (Fox, 2011; McDonald et al., 2007; Morgan et al., 2013; Rissanen et al., 2011; Tsai et al., 2011). The term self-harm was chosen due to its overwhelming presence in the literature and included both self-injurious behavior (cutting, scratching, etc.) and self-poisoning (Ougrin & Tranah, et al., 2012). Therefore, self-harm was defined as deliberate bodily harm with the knowledge that the act will result in some degree of physical or psychological injury to oneself, not an attempt to suicide, and usually does not require medical attention (Fox, 2011; McDonald et al., 2007; Morgan et al., 2013; Rissanen et al., 2011; Tsai et al., 2011). Self-harming

behaviors could include, but were not limited to, cutting, poisoning, burning, scalding, scratching to the point it breaks the skin, biting to the degree that it breaks the skin, not allowing wounds to heal, and hair pulling (Fox, 2011). Self-harm with an attempt to suicide was delimited from the definition because self-harm with suicide ideation was defined in literature as being inherently different, with different presenting characteristics, then self-harm alone (Fox, 2011; McDonald et al., 2007; Morgan et al., 2013; Rissanen et al., 2011; Tsai et al., 2011).

I chose to also explore parents' experiences of having adolescent children who self-harm versus other children in other developmental stages because the literature supported the idea that most self-harm is done during the adolescent years (Centers for Disease Control and Prevention, 2014; Hay & Meldrum, 2010; Ougrin & Tranah, et al., 2012; Tsai et al., 2011). In 2010, Hay and Meldrum reported that almost 18,000 adolescents were treated for self-harm in hospitals in the United States. In 2014, the most recent statistics available, over 104,000 adolescent children between the ages of 12 and 18 were treated for self-harm in the United States compared to only 99,000 adults between the ages of 19 and 29 (Centers for Disease Control and Prevention, 2014). These statistics are up from the 2013 statistics which showed 99,000 adolescent children had been treated for self-harm in a hospital setting (Centers for Disease Control and Prevention, 2014). Lindgren et al. (2010) specifically studied parents' experiences of having adult children who self-harmed, which illustrated some distinct differences in the child-parent relationship. One of the differences was that the adult children did not live in the home with the parents (Lindgren et al., 2010). Another distinct difference was that

of confidentiality. Since the children were adults, parents were not given an opportunity to be part of their adult children's treatment, which presented a different set of experiences for parents (Lindgren et al., 2010).

There was not a consistent agreement in the literature as to the exact ages that define adolescence. The ages vary in the literature from 12 to 21 years of age (McDonald et al., 2007; Ougrin & Tranah, et al., 2012; Tsai et al., 2011). However, for the purpose of this project, adolescence was defined as individuals between the ages of 12 and 18 years of age in an attempt to stay within the boundaries of adolescence and not intrude on the boundary of adulthood.

### **Synthesis of Related Studies**

When I searched the PsychInfo database using the search terms *adolescent self-harm*, 135 articles were found. Most of the researchers sought to determine why adolescents self-harm (Latina, Giannotta, & Rabaglietti, 2015; McMahon et al., 2013; Ougrin & Tranah, et al., 2012; Rasmussen, Hawton, Philpott-Morgan, & O'Connor, 2016; Stallard, Spears, Montgomery, Phillips, & Sayal, 2013; Tsai et al., 2011; Tulloch, Blizzard, & Pinkus, 1997; Wright, 2014), treatment and the perception of treatment for SHA (Doyle, Treacy, & Sheridan, 2015; Fox, 2011; Mitten, Preyde, Lewis, Vanderkooy, & Heintzman, 2016; Morgan et al., 2013; Nicolls & Pernice, 2009; Rowe et al., 2014), while very few focused on parents' experiences of having children who self-harm (Arbuthnott & Lewis, 2015; Byrne et al., 2008; Lindgren et al., 2010; McDonald et al., 2007; Morgan et al., 2013; Oldershaw et al., 2008; Raphael et al., 2006; Tschan et al., 2015). For this project, the reasons for the self-harming behaviors were not necessary nor

were the treatment modalities. Therefore, I will focus on synthesizing the research found on parents' experiences and perspectives of having children who self-harm.

Researchers have demonstrated that parents of self-harming children are negatively affected by the behavior (Byrne et al., 2008; Lindgren et al., 2010; McDonald et al., 2007; Morgan et al., 2013; Raphael et al., 2006). For example, Morgan et al. (2013) conducted a qualitative study and found that parents had significant emotional challenges including a lack of social support and low levels of parental satisfaction. Lindgren et al. (2010) echoed these results in a qualitative study that found that parents felt trapped in a healthcare system that they did not understand, invisible when trying to get support from the healthcare system, and felt valued when the healthcare system did invite them to be a part of treatment plans for their children. Accordingly, even the healthcare system where their children were receiving treatment for self-harm was not supportive towards parents (Lindgren et al., 2010). McDonald et al. (2007) found similar results in their qualitative study that examined mothers' experiences of having SHA. McDonald et al. (2007) found that the primary emotions expressed by mothers were both guilt and shame when they discovered that their adolescent children had self-harmed. The mothers felt that the self-harm was a result of something that they did or did not do for their children; having failed them in some way (McDonald et al., 2007). Mothers expressed that they felt embarrassed about their children's self-harming behavior and became hypervigilant to prevent any future self-harm (McDonald et al., 2007). McDonald et al. (2007) also found that the mothers had diminished or reduced other roles within the family or outside of the home. For example, the mothers reported that they felt



that they had unintentionally neglected the other children because they had become hypervigilant about their daughters' self-harm (McDonald et al., 2007). Other mothers reported leaving work early, missing more work days, and even leaving paid employment to be present for their SHA (McDonald et al., 2007).

Other researchers also found that parents of self-harming adolescent children lacked support (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006). The perceived lack of support was geared toward social, family, and healthcare support (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006). Some parents became angry at healthcare professionals for not providing enough support and not helping parents find support (Raphael et al., 2006). Fox (2011) supported this idea that healthcare professions might be perceived as unhelpful through a qualitative study that found that counselors felt inadequately trained to work with self-harming adolescents and their families. Some counselors reported wanting to do more for the clients and their families but did not know how (Fox, 2011). Parents desired help from counselors (Lindgren et al., 2010), but counselors are inadequately trained to support families of SHA (Fox, 2011). Both studies supported findings that the perceived relationship between mental health professionals and parents is still lacking (Nicholls & Pernice, 2009).

Having a negative parental satisfaction was a theme throughout the literature search supporting the findings of McDonald et al. (2007). Parents of self-harming children reported feeling in adequate, shameful, isolated, and as if they had failed as parents (Arbuthnott & Lewis, 2015; Byrne et al., 2008; Oldershaw et al., 2008; Raphael

et al., 2006). Parents reported questioning their ability to parent (Byrne et al., 2008; McDonald et al., 2007; Raphael et al., 2006) and having an increase of parental burden (Oldershaw et al., 2008). Throughout the literature, parents expressed a concern of not knowing how to discipline their self-harming adolescent children and becoming hypervigilant of their behaviors (McDonald et al., 2007; Oldershaw et al., 2008). Accordingly, parents felt overwhelmed with the task of parenting a self-harming adolescent child (Arbuthnott & Lewis, 2015; McDonald et al., 2007; Oldershaw et al., 2008; Tschan et al., 2015). These themes informed my first round of coding. The participants in my study had similar experiences; thus, the codes used to code interviews were informed by themes found by other researchers.

### **Conclusion**

The central research question for the phenomenological study was: What are the lived experiences of parents of self-harming adolescent children? The purpose of this study was to explore the lived experiences, characteristics, and needs of parents of self-harming adolescent children in the United States. Through the intensive literature search, themes in parents' experiences of having children who self-harm appeared such as guilt, shame, isolation, feelings of failure, and a lack of confidence in the healthcare system. However, thus far, the research identified during the literature search has been conducted outside of the United States and of parents with adult children. A possible cause of the lack of attention for the parents and caregivers of self-harming adolescents is a lack of awareness for the possibility of distress, a decreased level of interpersonal relationships, and lower levels of self-trust in parents whose adolescent children are self-harming.

Therefore, what was not known were the experiences of parents in the United States who had self-harming adolescents. The current study filled gaps in the literature and outcomes could potentially inform counselors and counselor educators by providing a current exploration of parents' experiences of having self-harming adolescent children in the United States so that a more formulated and intentional plan for programing and curriculum development could occur to train counselors to be better equipped to support parents.

Chapter three details the research design, rationale, and methodology. I will discuss in detail my role as the researcher and issues of trustworthiness including the overall methodology proposed.

## Chapter 3: Research Method

### **Introduction**

Adolescent self-harm is an epidemic in the United States with over 100,000 adolescent children treated in hospitals each year (Centers for Disease Control and Prevention, 2014). However, these statistics do not demonstrate the depth of the impact self-harm has on a family, specifically parents of self-harming adolescents. The purpose of this qualitative study was to explore the lived experiences of parents who have self-harming adolescent children. There was an extant amount of literature that explored self-harming behaviors from adolescents' perspective. However, there was a lack of literature in the counseling profession that explored parents' experiences of having adolescent children who self-harm. Due to this lack of information, counselors have reported feeling inadequately prepared to work with this specific population (Fox, 2011), and parents have reported feeling invisible and unimportant to the mental health profession (Lindgren et al., 2010; Nicholls & Pernice, 2009; Raphael et al., 2006). The results of the current study have the potential to fill the gap in the counseling professional literature.

In this chapter, I provide a detailed explanation of the research design, methodology, my role as the researcher, and issues of trustworthiness. In the first section, I explain the research design and rationale in great depth. I define central concepts and I discuss the rationale for choosing a phenomenological qualitative design. The second section includes a description as to my role as the researcher and I identify any ethical concerns, including researcher biases. The next section includes a detailed description of the methodology. In this section, I will discuss the population, identify my

sampling strategy, and explain specific procedures in collecting data. In the last section in this chapter, I identify and discuss any potential issues of trustworthiness. I will also discuss strategies that will be used to increase credibility and trustworthiness of the data and findings.

### **Research Design and Rationale**

The overarching central research question for the phenomenological study was: What are the lived experiences of parents of self-harming adolescents? I used the research question to inform my decisions about what questions to ask during interviews with participants.

The central concepts in this project included adolescent self-harm and parents' experiences of having self-harming adolescent children. As previously stated in chapter two, there was not a consistent definition in the literature for self-harm (Fox, 2011; McDonald et al., 2007; Morgan et al., 2013; Rissanen et al., 2011; Tsai et al., 2011). However, for this project, I defined self-harm as deliberate bodily harm with the knowledge that the act would result in some degree of physical or psychological injury to oneself, not an attempt to suicide, and usually does not require medical attention (Fox, 2011; McDonald et al., 2007; Morgan et al., 2013; Rissanen et al., 2011; Tsai et al., 2011). Self-harming behaviors could include, but were not limited to, cutting, poisoning, burning, scalding, scratching to the point it breaks skin, biting to the degree that it breaks skin, not allowing wounds to heal, and hair pulling (Fox, 2011). I delimited self-harm with the intent of suicide from the definition of self-harm because previous researchers had shown a distinct difference between self-harm with suicidal intention and nonsuicidal

self-harm (Fox, 2011; McDonald et al., 2007; Morgan et al., 2013; Rissanen et al., 2011; Tsai et al., 2011). Some of the differences included gender, age of self-harming onset, and overall intent for the self-harm (Ougrin & Zundel, et al., 2012). There was not a consistent agreement in the literature as to the exact ages that defined adolescence. The ages varied in the literature from 12 to 21 years of age (McDonald et al., 2007; Ougrin & Tranah, et al., 2012; Tsai et al., 2011). However, for this project, I defined adolescence as individuals between the ages of 12 and 18 years of age. This range stayed within the ages supported by literature, but also did not intrude on the boundary of adulthood.

### **Research Tradition**

Qualitative methods have received much more attention in recent literature and has become more accepted as a viable research method than in past years (Creswell, 2013; Fox, 2011; Lindgren et al., 2010; McDonald et al., 2007). Multiple researchers who have studied self-harm employed a phenomenological qualitative approach (Fox, 2011; Lindgren et al., 2010; McDonald et al., 2007; Raphael et al., 2006). The decision to use a hermeneutic phenomenological qualitative method stemmed from the lack of information in current literature, the sensitivity that surrounded parents' experiences of having self-harming adolescent children, and the flexibility that hermeneutic phenomenology offered. Researchers use qualitative methods when researchers desire to construct meaning from concepts or phenomena when information is lacking while utilizing inductive reasoning to gain the desired information (Creswell, 2013; Ulanovsky, 2008). For example, in this study, I began with a research question about a phenomenon

that is observable and identified patterns and themes that helped better understand the experiences of parents of self-harming adolescent children.

Another reason the qualitative method was chosen was because of the sensitivity to the topic. I wanted to ensure that I captured the real experiences of the participants during my analysis and interpretation of the data. Maxwell (2013) argued that all observable data is data worthy of being collected. What researchers see, hear, and feel can be included in the data collection process when using qualitative approaches such as hermeneutic phenomenology. Maxwell (2013) stated that there is no such thing as inadmissible evidence when trying to understand issues or phenomena related to human beings. Researchers who adhere to the theory that all data is admissible data report emotions and feelings that are observed as well as what is being said by participants. For example, Raphael et al. (2006) noted observational data of participants' non-verbal responses during interviews. These observable types of data are rarely captured using other research methods (Maxwell, 2013). Furthermore, van Manen (2014) argued that the basic tenet of hermeneutic phenomenology is that our world is full of experiences and the only way to fully understand the world around us is to reflect upon and understand the meaning of our lived experiences. Researchers who employ hermeneutic phenomenology attempt to describe lived experiences as they appear in everyday life (Ulanovsky, 2008; van Manen, 2014). Therefore, researchers who employ qualitative research methods have a unique opportunity to capture the holistic essence of an experience and then have those interpretations checked by participants to ensure the true essence of the experience is accurately captured.

Hermeneutic phenomenological qualitative studies tend to be less structured and rigid compared to other methods (Maxwell, 2013; van Manen, 2014). Researchers who use a hermeneutical phenomenological approach use emergent ideas throughout the research process to drive other decisions (Maxwell, 2013). For example, unlike a survey approach, I could ask follow-up questions to gain clarity or more information from participants throughout the interview. The ability to be more flexible and less rigid in my design, the interview process, and the analysis process fit the purpose of the research project best. The flexibility to add interview questions or follow-up questions when emerging data arose helped capture the full essence of participants' experiences.

Researchers who utilize qualitative methods can use a flexible design, gain information that is lacking in literature through inductive reasoning, and capture the whole essence of participants lived experiences. These three reasons and my research question drove my decision to choose a hermeneutical phenomenological qualitative approach.

### **My Role as the Researcher**

My various roles as the researcher included being the sole author, interviewer, observer, coder, and data analyzer to identify emerging themes and patterns. I interviewed each participant myself. The decision to interview participants myself was informed by literature with similar designs where researchers conducted their own interviews (Lindgren et al., 2010; Oldershaw et al., 2008; Raphael et al., 2006). I also was in the role of observer because I observed participants' non-verbal behaviors during



interviews to capture the whole essence of participants' experiences (Raphael et al., 2006). I also coded and analyzed the data.

It is also worth noting my professional experience in the context of this research. I have been a licensed professional counselor for five years. Within those five years, I served as a school counselor for one year and have been in private practice for four years. I have also supervised master level counseling students within my private practice. I work with clients of all ages with a spectrum of mental health issues, including adolescent children who self-harm.

### **Possible Personal or Professional Relationships**

I did not anticipate having any participants with whom I had a personal or professional relationship. However, even with a low probability, there was always a chance that I might have a relationship with someone who wished to participate in the study. These dual relationships and roles could be confusing to participants and have the possibility to cause harm to the relationship. Therefore, because of the sensitive subject matter, I reminded all participants that participation was completely voluntary and that there was no compensation for participating. I also excluded any participants whose adolescent children were my current clients to avoid any potential power differential or harm to the therapeutic alliance. I did not have any supervisory roles that could impact participants during the data collection, coding, or analysis process. However, in the rare case that I did, I had planned on excluding any participants for whom I supervised their treating therapist to protect the working alliance between my supervisee and myself.

### **Researcher Bias**

Researchers cannot be completely separated from their studies in qualitative designs (Creswell, 2013). Therefore, strategies must be employed to decrease the effects of researcher bias. One strategy that was supported in current literature with similar designs was for researchers to keep a journal throughout the research process (Oldershaw et al., 2008; Raphael et al., 2006). I used the journal as a collection of my own reflections, thoughts, and reactions during the field work phase of the study (Raphael et al., 2006). The journal was also a place where I noted any biases that emerged throughout the research process for further reflection. Any biases that were triggered during the data collection process or coding process were discussed with my dissertation committee. Lastly, the journal will be kept after publication of the final dissertation in case of future dependability audits (Morse, Barrett, Mayan, Olson, Spiers, 2015).

### **Member checking**

I used member checking in a last effort to reduce researcher bias and increase trustworthiness. Member checking occurs when researchers check with participants to make sure that the themes and patterns that are identified capture participants' experiences (Creswell, 2013). By using member checking, I reduced researcher bias in the themes and patterns by having participants review the results. Member checking occurred in two phases. First, I sent complete transcriptions to participants to check that their words are accurately transcribed. They had an opportunity during this phase of member checking to extend or clarify statements that they made during the initial interview. During the second phase of member checking, I sent results of the study to

each participant to check that the essence of their experiences was captured in the themes. I reconciled any inconsistencies between themes identified and feedback from participants about the themes in the results section of the final project with a discussion about the inconsistencies.

### **Other Possible Ethical Issues**

Due to the sensitive nature of the study, there was potential for other ethical issues that must be addressed. Because participants discussed their experiences of having minor children who self-harm, I disclosed in the consent form and at the beginning of interviews that I was a mandated reporter by law and that any evidence or suspicion of child abuse or neglect would be reported to authorities. Participants had to sign a consent form stating that they understood that I was a mandated reporter and that I would report any child abuse or neglect to authorities.

Discussing and reflecting on an adolescent child's self-harming behavior had the potential to bring about emotional distress for participants. Although this study was needed to fill gaps in literature, the possible emotional distress caused by exploring such a sensitive subject had to be addressed and decreased as much as possible. The potential for emotional distress was identified in the consent form that each participant signed. Then, each participant was debriefed at the end of each interview. During the debriefing, I provided each participant with a list of local resources of mental health agencies (Appendix E) that they could use if their emotional distress continued.

## **Methodology**

In this section, I will outline in detail how my participants were selected, including procedures for recruitment and participation. I will also discuss how the use of semi-structured interviews were used to collect data and the data collection process. Lastly, I will discuss my data analysis plan.

### **Participation Selection Logic**

In exploring the lived experiences of parents with self-harming adolescent children, parent participation inclusion criteria were threefold. First, participants had to be at least 18 years of age or older. Secondly, they had to have had adolescent children who self-harmed during the ages of 12 and 18 years of age. Lastly, they must have been English speakers because I am not bilingual and do not have an interpreter.

**Sampling and recruiting procedures.** Nonprobability sampling is used when participants are chosen due to their convenience and availability (Creswell, 2013). Frankfort-Nachmias and Nachmias (2008) explained that nonprobability methods are also useful when there is no way of knowing the size of the population or when a list of the population is unavailable. In the case of this study, a list of the population was not available. Although nonprobability sampling does not result in a stratified sample, the sampling method was supported in literature in similar studies in the social sciences (Frankfort-Nachmias & Nachmias, 2008; Lindgren et al., 2010; McDonald et al., 2007).

Participants for this study were parents of self-harming adolescent children located in the western part of Texas and the eastern part of New Mexico due to my geographical location and traveling for interviews was more feasible within this area. I

used convenience and snowball methods to choose participants. First, I used convenience sampling to gain participants using advertisements (Appendix A; Lindgren et al., 2010; McDonald et al., 2007). Convenience sampling designs are used when participants are selected because of their convenience or ease of access to researchers (Frankfort-Nachmias & Nachmias, 2008). I gave advertisements (Appendix A) for the study to mental health professionals in the area, community mental health agencies, school counselors of local schools, and local medical offices. I also posted the advertisement on my Facebook and LinkedIn pages, in local newspapers, and my professional website. These places were consistent with other studies similar in design (Lindgren et al., 2010; McDonald et al., 2007). I also chose these places because of the high probability that parents of self-harming adolescents seek help there.

Then, a snowball sampling design was used to reach other possible participants (Frankfort-Nachmias & Nachmias, 2008). I gave all participants an additional flier during the debriefing stage. The flier could be given to anyone they knew who might have also been interested in participating, such as a spouse or partner. There was not any incentive for participation or for recommending someone else to participate in the study.

My contact information was on the advertisement and participants were invited to contact me directly to participate in the study. I did not contact potential participants to avoid possible perceived coercion. When participants contacted me, I asked them a series of questions to make sure they met the inclusion criteria. If they did, we scheduled a time convenient for the participant to participate in an interview at my office or in a place that was convenient for the participant and allowed for private and confidential

conversation. I recruited participants and collected data for 12 weeks. However, I continued recruitment and data collection until saturation, or redundancy in the themes derived from the data, was reached.

**Criteria for participation.** Participants must have met a variety of requirements before they were approved to participate in the study. As stated above, the first criterion was that the participants were 18 years of age or older. Secondly, participants must have had an adolescent child who self-harmed during the ages of 12 and 18 years. Participants must also have been English speakers since I am not bilingual and did not have an interpreter. Participants had to agree to voluntarily participate with no compensation and had to agree to participate in an individual interview. Parents were excluded if they were unaware of their child's self-harming behavior (Oldershaw et al., 2008). Participants who contacted me about participation were given the definition of self-harm and the types of self-harm included for this project. Then, I asked a series of questions to ensure that they met the criteria for participation before an interview was scheduled. The questions that I asked to make sure participants met the required criteria included: (a) How old are you currently, (b) are you aware of your child's self-harming behaviors, (c) how old was your child during the time they self-harmed, (d) what type of self-harm did your child use, and (e) are you willing to participate in an interview that will be audio recorded for no compensation? These questions were repeated during the informed consent process before interviews began.

**Size.** Qualitative studies do not have a recommended sample size because statistical analyses are not conducted. However, researchers using qualitative methods

should aim to reach a level of saturation. Therefore, Creswell (2013) recommended that researchers aim to have enough participants with rich experiences until saturation is reached. Other studies similar in design used six to seven participants (Lindgren et al., 2010; McDonald et al., 2007; Nicholls & Pernice, 2009; Vuori & Astedt-Kuiki, 2011). Therefore, the intended sample size of the study was between six to ten participants or when saturation was reached. Researchers are neither unable to guarantee participation from participants nor guarantee that participants will see the data collection process all the way through. Therefore, having a few extra participants would ensure saturation and be a buffer in case some participants dropped out of the study.

### **Instrumentation**

I used semi structured interviews to collect data. The data collection instruments that I used in the study included a participation eligibility sheet (Appendix B), a semi-structured interview schedule (Appendix C), and an observation sheet (Appendix D). Both the participation eligibility sheet and the observation sheet were developed by me and neither were published instruments. I used the participation eligibility sheet to ensure that the same questions were asked to each possible participant to check that they meet the required criteria. I used the interview schedule to ensure that I had a semi-structured interview and that I asked the same questions to each participant during interviews. The interview schedule was a semi structured schedule so that follow-up questions could be asked to gain further insight or clarification when needed. I noted any nonverbal behaviors that I observed on the observation sheet. These sheets were entered as data during the coding process to track any trends in nonverbal behavior. I also used the

observation sheets during the interviews as a point of reference and reminder to inquire about what the emotions meant to the participant exhibiting the behavior. For example, if a participant was crying I might have asked them to explain what the crying meant to them. I recorded each interview with audio only using my Hewlett-Packard computer.

The interview schedule included topics and questions that guided the semi structured interviews. Topics and questions were developed by me and then reviewed by my methodologist who has extensive experience in qualitative research to reduce researcher bias (Oldershaw et al., 2008). I developed the questions and topics to be open-ended and broad enough such that each participant could share their personal experiences (Oldershaw et al., 2008). For example, the first question was “describe how and when you first found out about your son or daughter’s self-harming behavior.”

### **Interviews**

Six semi structured, face-to-face, interviews were conducted at my professional office. Each interview lasted approximately one hour in length. I recorded the audio of the interview for later transcription purposes. Each interview began with the same question: “describe how and when you first found out about your son or daughter’s self-harming behavior” (Oldershaw et al., 2008). I asked follow up questions and questions that I had previously prepared until an in-depth understanding of the participant’s experience of having a self-harming adolescent child had been established through saturation, or redundancy, of the experience. I transcribed verbatim and deidentified all interviews to protect participants’ identities and the identities of their children. I returned



the transcriptions to the participant to give them the opportunity to provide feedback or expand on topics (Oldershaw et al., 2008).

### **Debriefing Procedures**

With the sensitivity of the topic being studied, debriefing was an essential part of my research process. I debriefed each participant at the end of each interview to offset any effects of emotions being stirred within participants as they shared their stories with me. I also provided a written explanation of the purpose of the study, my role as the researcher, and an explanation of possible risks and benefits to participants. They also received a list of local resources to contact in case they experienced distress after the interview (Appendix E). I verbally explained these to each participant and gave them the opportunity to ask questions.

### **Data Analysis Plan**

The hermeneutic phenomenological data analysis process included the use of the observation sheets used during each interview, transcriptions of interviews, and any transcriptions returned with feedback or expanded answers. The coding process took place on a continual basis in between interviews to ensure that a level of saturation was reached before recruitment was terminated (Oldershaw et al., 2008). Saturation was determined when redundancy in themes and patterns throughout the interviews occurred. The process included three stages that were recommended by Pietkiewicz and Smith (2014) which included (a) multiple readings and note taking, (b) identifying emergent themes, and (c) seeking relationships and clustering themes. In the first stage, I read the transcriptions, feedback from participants, and observation sheets multiple times

(Pietkiewicz & Smith, 2014). Using an inductive approach, I then began making notes in the margins regarding possible insights, reflections, and comments of potential significance (Pietkiewicz & Smith, 2014). Then, I transformed those notes into emerging themes during stage two. Pietkiewicz and Smith (2014) suggested that researchers use the notes to conceptualize a concise phrase grounded in the specific details of participants' experiences. The process includes comparing the parts to the whole and the whole to the parts (Pietkiewicz & Smith, 2014). For example, the subtheme of *denial* first began as statements of denial emerged from the first interview. Helen, the first participant, made statements such as, "You think that it's gonna stop" and "this is not my daughter." I wrote in the margins "denial?" Then, later coded these statements as *denial* for her interview transcription. Then, I compared my notes from one interview, the parts, to the notes of all other interviews, the whole, and saw a repeated pattern of participants being in denial of their children's self-harm. Stage three included comparing all the themes, looking for relationships among the themes, and clustering them into mutually exclusive themes (Byrne et al., 2008; Pietkiewicz & Smith, 2014). Each final theme included relevant short extracts from the transcripts which supported the theme (Pietkiewicz & Smith, 2014). Then, I sent the themes to participants for a second round of member checking. Once I received feedback from participants, I reviewed all feedback and noted any commonalities and inconsistencies in the final analysis.

### **Issues of Trustworthiness**

Trustworthiness is developed using specific strategies to increase credibility, dependability, and confirmability (Miles, Huberman, & Saldana, 2014). These strategies

increase the potential for researchers to trust the results of the proposed study and use the results to drive future studies, decisions regarding curriculum in counselor education programs, and protocol for current counselors and other mental health professionals. The strategies for each of these areas are discussed in depth below.

### **Credibility**

Credibility refers to the internal validity of the study. Consistent with other professional counselor literature with similar designs, the credibility of the study was increased using, triangulation, member checks, saturation, and reflection (Byrne et al., 2008; McDonald et al., 2007; Oldershaw, et al., 2008; Raphael et al., 2006). First, as the researcher and the interviewer, I was aware that there is potential for researcher bias. Therefore, I kept a journal during the data collection and coding processes to reflect on any bias that I might have had and any personal responses that occurred for me. Journal entries reflected my thoughts following interviews and during the coding process to check my assumptions about self-harm, parents of adolescent children who self-harm, and the overall process of engaging in a discussion about self-harm (McDonald et al., 2007).

Member checking is a critical technique used to establish credibility within qualitative research (Creswell, 2013). Researchers who use member checks solicit participants' opinions of the findings and the credibility of the findings (Creswell, 2013). I used member checks to increase credibility after each interview was transcribed by sending a copy of the transcription to the participant (Oldershaw et al., 2008). Each participant had the opportunity to provide feedback about the credibility of the

transcription and expand on their answers. I then used member checking a second time after all the data had been analyzed and coded by sending the final themes and subthemes to participants. Each participant had an opportunity to provide feedback about the themes and how the themes related to the participants' experiences. This strategy increased the likelihood that the results of the study represented the actual lived experiences of participants (Oldershaw et al., 2008).

Saturation is achieved when themes and patterns begin to be repeated throughout each interview (Creswell, 2013). Rich stories help achieve a deep level of saturation. In qualitative research, saturation is a key element to understanding the phenomenon being studied (Creswell, 2013). Saturation was reached for this project with six participants.

Triangulation is a technique used by researchers who employ multiple sources of information, theories, and methods to provide support for their findings (Creswell, 2013). Triangulation occurred in my study when I sent themes and patterns to participants and solicited their views on the themes that emerged. This process allowed participants an opportunity to provide feedback about the credibility of my findings and how my findings relate to their experiences. Triangulation occurred a second time when my committee members reviewed the themes and subthemes and the quotations that supported each theme. They had an opportunity to provide feedback about these themes and how, if at all, the quotations from the transcriptions supported the themes.

### **Transferability**

Based on the inclusion and exclusion criteria of the study, results may not be transferable to all populations. The results of the study are transferable to parents of self-

harming adolescent children whose self-harm is identified as nonsuicidal, intentional self-harm defined for this study. However, the results only reflect those experiences of parents of self-harming adolescents in the southwestern region of the United States who meet the inclusion criteria set out in this study.

### **Dependability**

Dependability is the qualitative counterpart to reliability and is used in qualitative research to increase the rigor of a study (Morse et al., 2015). Strategies used to increase dependability address issues of stability and consistency of the overall research process (Morse et al., 2015). The more consistent a researcher is during the data collection and coding processes, the more stable the data, and the more dependable the results of the study are (Morse et al., 2015). I used triangulation during the coding process to increase overall credibility, dependability, intra-coder reliability, and intercoder reliability. One of the most noted techniques for dependability is a dependability audit in which an auditor reviews the processes of the researcher (Morse et al., 2015). Therefore, I will keep all journal articles, notes, and coding processes used during coding for possible audit trails to increase dependability.

### **Confirmability**

Confirmability refers to researchers' ability to remain objective during the research process (Miles et al., 2014). First, during the data collection and coding process, I journaled and reflected on my own beliefs, thoughts, and perceptions about parents of self-harming adolescent children, self-harm, and the analytical process. These journals will also be kept for possible future dependability audits. Secondly, I reflected and

discussed issues of trustworthiness with my dissertation chair, who is an expert in the field. Thirdly, I used member checking after each interview was transcribed and when the results of the study were determined to confirm that the results reflect the true and holistic experiences of participants. Next, I outlined, in detail, my research methods and procedures for future replication (Miles et al., 2014). Lastly, I also discussed these details with my dissertation committee which includes people who are experts in the field and experts on qualitative methodology.

### **Ethical Procedures**

A set of ethical procedures were established that conformed to the policies of Walden University's Research Center and the Institutional Review Board to protect the participants of the study. The procedures used to protect participants and the treatment of data are discussed in detail.

**Treatment of participants.** The first ethical procedure was to receive approval from the institutional review board at Walden University. The approval consisted of the project being approved and accepted by both my dissertation committee and by the institutional review board. Walden University's approval number for this study was 03-14-17-0438167. Other steps that I took to protect participants included avoiding possible perceived coercion and I provided local resources during the debriefing process. For example, I excluded any current client, current clients' parents, and supervisees from participating to prevent perceived coercion. I provided a list of local resources to participants during the debriefing process in case distress continued after the interview

was over. Participants were also given the opportunity to end the interview at any time without question to minimize distress.

There was a possibility that participants would want to withdraw from the interview early because of the sensitivity of the topic being discussed or for other reasons. Because of this potential of early withdrawal, I continued to recruit participants while conducting interviews until saturation was reached. I analyzed and coded data in between interviews so that I would know when saturation was reached and I did not stop recruitment prematurely.

**Treatment of data.** All interviews were conducted face-to-face, recorded, and transcribed verbatim. I deidentified the transcriptions to protect the confidentiality of participants and their self-harming adolescent children. I saved data, including audio recordings and transcriptions, on a portable flash drive that was password protected. My committee members and I were the only people who had access to transcriptions. Results included brief descriptions of observed behaviors. Any quotes from participants that are used as examples of themes were deidentified and anonymous.

**Other ethical issues.** The topic of this study had the potential to be distressing and included a discussion about minor adolescent children. Therefore, there was a possibility that child neglect or abuse could be discussed during the interview process. I told participants during the consent process before interviews began that I was a mandated reporter and that any suspicion of child neglect or abuse would be reported to the appropriate authorities. Participants had to sign a consent form stating that they understood this ethical issue.

## **Summary**

In this chapter, I have outlined in detail the research design and methodology. I have also identified my role as the researcher and the ethical concerns of the variety of roles include. Issues of trustworthiness were identified and strategies to increase the rigor of the proposed study were discussed. Lastly, I identified ethical issues pertaining to treatment of participants and data, and I discussed strategies to reduce ethical concerns.

In chapter four, I will discuss the implementation of the research methods set out in chapter three including data collection and analysis processes. The results of the proposed study will be presented and discussed in detail.



## Chapter 4: Results

### Introduction

Adolescent self-harm is a growing phenomenon in the United States (Centers for Disease Control and Prevention, 2014; Hay & Meldrum, 2010; Tsai et al., 2011). In 2012, Ougrin, Tranah, et al. found that 13.2% of adolescents reported engaging in some form of self-harm during their lifetime. The Center for Disease Control and Prevention (2014) found that 30,000 adolescents were treated for cutting alone. However, these statistics do not represent the full impact self-harm has on the family unit. Parents and guardians are often affected by having a child who self-harms (Lindgren et al., 2010; McDonald et al., 2007; Oldershaw et al., 2008; Tschan et al., 2015). Yes, despite awareness that self-harming behavior is a systemic problem affecting everyone in the family (Lindgren et al., 2010; McDonald et al., 2007), a detailed review of the professional literature showed little attention has been given to parents' experiences of having adolescent children who self-harm. Due to this lack of information, counselors have not received adequate training to help this population and have reported feeling unprepared to work with self-harming clients and their families (Fox, 2011). This lack of training has resulted in parents of self-harming adolescent children feeling invisible to mental health professional and left being uninvolved in their children's treatment (Lindgren et al., 2010). Therefore, the purpose of this study was to explore the lived experiences of parents of self-harming adolescent children. My goal was to gain a better understanding of parental experiences with hope that the research outcomes could possibly provide the mental health professionals a deeper awareness of those experiences

and could potentially inform better treatment, education, and training. Accordingly, the overarching central research question for this study phenomenological study was: What are the lived experiences of parents of self-harming adolescents?

In chapter four I provide a detailed description of the setting, demographics, data collection procedures, and data analysis procedures. I also identify the steps that I took to increase the overall trustworthiness of this project, including detailed steps taken to increase credibility, transferability, dependability, and confirmability. Lastly, I provide the results of the data analysis process.

### **Setting**

All interviews were conducted at my professional office. The office was a private, confidential, and convenient setting for participants. All the participants were given a choice to meet at my office or somewhere of their choosing. They all chose my office as a place to meet. The office was set up so that the desk was clear of anything that might have been a distraction. The only thing on the desk was my computer, the interview schedule, and the observation sheet. The participants sat on one side of the desk while I sat on the other side.

### **Demographic**

The participants self-reported demographic information during the onset of the interviews. Participants reported being mothers of self-harming adolescent children. The participant's ages ranged from 37 years of age to 58 years of age. The parents reported that the children used self-cutting as the primary form of self-harm, however, one participant had a child who occasionally burned herself with a cigarette lighter. Five of

the participants were mothers of daughters who self-harmed and one participant was a mother of a son who self-harmed. All the participants were English speaking and lived in the Southwestern region of Texas. One participant identified as African American, one identified as Hispanic, and the other four participants identified as Caucasian. Table 1 is provided as a quick reference to these demographic characteristics for participants. I also assigned pseudonyms for participants to protect their privacy and anonymity.

Table 1

<i>Demographic Information</i>				
Pseudonym of Participant	Age	Gender of Parent	Ethnicity	Gender of Child
Helen	41	Female	Caucasian	Female
Angela	58	Female	African-American	Female
Heidi	40	Female	Caucasian	Male
Amber	37	Female	Caucasian	Female
Judy	48	Female	Caucasian	Female
Ira	32	Female	Hispanic	Female

### **Data Collection**

There were six participants total, five were mothers of daughters and one was a mother of a son. Each participant was first asked a series of questions (Appendix B) over the phone to make sure they met the inclusion criteria. After inclusion criteria were verified, a date and time was set for the face to face interview. Each participant chose to participate in a face to face interview in my private office. The interviews ranged from 45 minutes to 90 minutes in length. I recorded the audio of each interview using my professional HP laptop computer and then later I transcribed each interview verbatim. The interviews and transcriptions were saved on a thumb drive that is password protected. All the interviews followed the semi-structured interview schedule (Appendix

C). Some questions were asked to clarify, draw meaning, or follow-up on an answer.

For example, many of the participants did not understand what I meant when I asked if their worldview had changed. So, I would follow up with a clarifying statement such as “tell me how your view of people or circumstances has changed because of having a child who self-harms.” Then, the participants could provide an answer or description. In the first four interviews, a theme emerged regarding how the participants’ experiences changed their view on mental health. So, in the last two interviews I asked the two participants how their experiences impacted their view of mental health issues to see if this theme was in fact true for all the participants. That is the only question I initially added to the interview schedule that was not originally on the schedule. Recruitment and data collection occurred over a 12-week period. The data was transcribed, coded, and analyzed on an on-going basis to ensure saturation was met and recruitment would not be stopped prematurely. The first round of member checking was also done during data collection so that coding could take place. I gave each participant one week to respond to the first round of member checking before I began coding and data analysis. Only one of the six participants responded. She responded by phone and told me that the transcription “looked good to her” and that she did not have anything to add.

The original plan was to recruit and collect data for six weeks. However, at the end of the six-week mark, I only had two participants. So, I had to extend recruitment another six weeks and made visits to the recruitment sites to make sure the recruitment information was easily noticeable and accessible. I also made weekly phone calls to each site asking if they needed additional information or recruitment fliers. The extended six

weeks and consistent check-ins gave me enough time to get six participants total and to reach saturation.

### **Data Analysis**

Coding and data analysis was conducted using hand coding and included three stages recommended by Pietkiweicz and Smith (2014). The first stage included multiple readings and note taking of each individual transcription. I read each transcription in its entirety multiple times to make sure that I did not miss or overlook an important concept or idea. I made notes in margins while reading the transcriptions and would connect my notes to one another during additional readings. For example, the concept of not understanding the etiology of the self-harming behavior came up for each participant. However, some of the participants verbalized this idea differently. Some stated that they did not understand what circumstance caused the child to self-harm, while others might say they did not understand why the child would self-harm because “there’s no reason to do this”. So, my first marginal note might have been “misunderstood” with a question mark. However, as I kept reading the transcription it became clearer that these were two different concepts. One being that the parent tried to justify the behavior by blaming an outside source such as school, a parent, or friends. While the other statement is the parent being in denial about the emotional turmoil the child was in during the act of self-harm. So, I would tie other statements together to support these ideas. The multiple readings helped me gain clarity on concepts that emerged during the first reading and helped me better understand the participants’ experiences.

In the second stage of the data analysis process I identified emergent themes for each individual transcription. I took all the marginal notes that I made and all the observation notes that I took during the interview and clustered them in to themes. Major themes that began to emerge in interviews were themes such as guilt and shame, denial about the behavior, attempts to justify the behavior by blaming others or self, change in parenting styles, hypervigilance about the behavior continuing, fear, change in how parent perceives mental health issues in other people, and change in parent child relationship. I listed each theme that emerged for each participant. Then I read through the lists of themes and began color coding themes that were repeated in each interview between participants. For example, the theme of guilt and shame emerged in all the interviews. When reading through the list of themes I color coded “guilt and shame” as green so that I could easily identify the theme. This step lead to stage three of the data analysis process: seeking relationships and clustering themes. I clustered the themes together that were similar or related. Under the clustered theme I listed multiple quotes from the transcriptions that supported the theme. I read through the themes, the clustered themes, and the quotes multiple times to ensure that I accurately captured the essence of my participants’ experiences. I also used their own words to support the themes to accurately capture their experiences and reduce any biases that I might have by using my own words.

### **Themes and Subthemes**

Six main themes emerged from the data from all the interviews with the participants. The six themes are: (a) reaction to behavior, (b) change in self, (c) change

in parenting style, (d) impact on relationships, (e) change in perception of mental health issues, and (f) support system. Some themes have subthemes that also emerged and were worthy of separating into their own subtheme versus clustering them all together under one main theme. These themes and subthemes are discussed in detail.

### **Theme 1: Reaction to Behavior: Denial and Blame**

Each participant had two main reactions to finding out about their child's self-harming behavior, denial and an attempt to blame someone or something for the self-harming behavior. First, participants experienced *denial*, the first subtheme that emerged under this category. Then, they experienced blame, the second subtheme that emerged. These reactions seemed to occur in stages like the stages of grief that people experience after losing a loved one. Each participant experienced both denial and blame, however they did so at different levels of intensity and for different lengths of time. These are discussed in detail below.

**Denial.** Almost all the participants were first in denial about the self-harming behavior. Some participants thought "it would just go away" while others thought their children were just "doing it for attention." When asked to describe how she first found out about her son's self-harming behavior, Heidi stated,

I thought he was just goofing around. Then when he would come home (from school) there would be more of them (cuts). I just, I don't know, I don't know. I mean, it was like my brain just did not want to comprehend the fact that he felt like he had to hurt himself.

Judy stated, “I was like, what are you doing? Is this an attention thing? Are you doing this for attention?” Helen summarized what most of the participants felt when she stated, “You think that it’s gonna stop and then you realize it doesn’t. You don’t know what to do. You’re at a total loss for how to approach it, how to help.” Ira explained her disbelief when she stated, “My daughter would never do this. That’s not the type of kid she is. That doesn’t happen to my family. That happens to other families. They have family troubles. They don’t have a two-parent household.” Angela stated,

We just didn’t understand it. It’s just a bunch of confusion. It’s just something I don’t think I’ll ever understand. What could be so bad that you have to turn it in. I mean, we always tell her we love her, she’s smart, she’s beautiful, this and that. There’s no reason to hurt herself.

**Blame.** After the denial stage, participants described feeling a need to *blame* the self-harming behavior on someone or a circumstance. As the subtheme of *blaming* emerged, it became clear that each participant used blame as a coping strategy and as a strategy to better understand the etiology of the behavior. For example, five of the six participants blamed the need to self-harm on an absent parent with whom the child had a strained relationship. The five participants justified the behavior because of the strained relationship and blamed the absent parent for the child’s need to self-harm. Angela described it like this, “How can you throw away something that you bonded with? It’s beyond anything in this world I can do. You know, I love her and I gave her everything, but I cannot be daddy.” Helen stated,



I knew that there had been tension between her and her dad. Her biological father. I knew that things had gone on but I didn't realize what had been done to her. You're constantly telling her I love you. You're amazing. You're fantastic. You're beautiful. And even being with me 90% of the time, with me giving her that affirmation, the other 10% was stronger.

Heidi blamed circumstances at school. Heidi said,

I was like, but why are you doing this? I mean ours was all connected to school because he was struggling in math and the more I looked into it, the more I was trying to get help for him, the more the teacher was ignoring me. He was considered to be a goof-off because he always, you know, told jokes and things like that to make people laugh and he didn't understand what to do in class so he started telling more and more jokes. So, she (the teacher) thought he was a jokester instead of struggling, and under the table he's over here poking himself and cutting himself.

Although Heidi's description seems like an outlier, her need to blame someone or something for the reason for the self-harm was the same as the other five participants. Heidi was blaming something or someone else for the reasons behind the self-harming behavior to justify and better understand the reasons for the self-harm. Therefore, her attempt to justify her son's self-harming behavior really was no different than the other participants' attempt to justify their daughters' self-harming behaviors.

## **Theme 2: Change in Self**

All the participants identified changes in themselves as a result from having a child who self-harms. The three subthemes that emerged from this theme included *feelings of guilt, living in constant fear, and hypervigilance.*

**Feelings of guilt.** Feelings of guilt seemed to be the strongest subtheme that emerged from the interviews and was the topic that was most discussed. Participants experienced tremendous feelings of guilt about not recognizing how badly their children were really hurting inside. Helen described the guilt she felt when she stated, “Why didn’t I step in and help her? Why didn’t I see it? I’m her mom. I’m supposed to know these things and you don’t, but as a parent I just don’t know how I didn’t see it.” Amber described the reason for her guilt, “You feel like you did something wrong, like you failed as a parent somewhere down the line.” Heidi mirrored Amber’s sentiments about feeling like she had failed as a parent when she stated,

We had felt like if we had done something wrong then, then it was our fault and that we felt guilty about. Then later I felt guilty for, you know, getting onto him for the cuts. Then, Tom (her husband) and I both felt guilty because we were, we both were like Hey you quit messing around. You’re gonna hurt yourself or whatever. We didn’t realize how serious it was.

Angela stated, with tears in her eyes, that her guilt surrounded that fact that there was little she could do to stop the emotional pain her child was feeling. She stated, “This kid is hurting and there is nothing I can do to stop the hurting. It’s like, how can I make it better, and you can’t really. You can’t take away the pain.” Most of the parents cried

during the interview when they spoke about their guilt surrounding the self-harm. I found it obvious that the guilt was still very heavy for most of them, even after their children had stopped self-harming.

Some of the parents felt guilty because they felt as if they passed on their own mental health issues to their children. When asked to tell me about her experiences with having a daughter who self-harmed Judy explained,

I remember being her age and suffering with depression. We didn't call it that back then, we didn't have a name for it back then, but now I know that's exactly what I dealt with. So, maybe she gets it from me and there is nothing I can do about that. It's just in our family. I wish I would've known before she started cutting so I could watch for signs or something.

Amber's experiences with anxiety mirrored Judy's. Amber said,

My anxiety's pretty...I don't think I realized how bad my anxiety was until seeing her get treatment for hers and now I see, I mean, she gets it honestly, because I, I see it in me now, seeing her. I mean, always before I guess I just dealt with it, but now seeing her handle and deal with it, and the things, you know, I'm like well, that makes a lot of sense, because that is me all the time. So, hers I think is triggered by anxiety. The thing is, when she gets really anxious, a small problem turns into a big problem and she just can't handle it. She gets that from me.

These parents felt guilty for seeing the same struggles they deal with in their children. They felt as if it were their fault that their children suffered from mental health issues and were choosing to self-harm. So, not only did these mothers face mental health

challenges that were increased because of the stress of their children's self-harming behavior, they also felt immense guilt for passing on the struggle of mental illness. They were almost stuck in a vortex that they could not escape from.

**Living in constant fear.** The subtheme of fear emerged less obviously than other themes. However, after reading the transcriptions multiple times, I began to pick up on idiosyncrasies that sounded like parents were living in constant fear that their child might self-harm again, no matter how much time had gone by since their last episode. For example, when asked how having a daughter who self-harmed affected her Helen stated,

I didn't sleep for a good six months. I would nap. I was afraid to close my eyes. I was afraid to not be awake if something happened. I'm scared every day. Still. Is something going to happen and I'm not going to be there? And she is in college now and hasn't cut in years.

Heidi stated, "At any time he could start it back up again. It was like a constant watching him. And of the fights we had over it. He would say, "No Mom, I'm not doing it." Ira explained her fear of the self-harming behavior returning. "I never knew what was going to trigger her. I could tell her no about something and it would be fine, but the next time I told her no it would set her off. So, I was always afraid of how she was going to react to something." Angela explained that her fear was driven by not understanding the behavior.

It was confusing, very confusing. Uh, I never had heard of cutting. To me it was... I thought it was suicidal...she was trying to commit suicide. I'm still

scared that she could cut the wrong way or too deep and do something she didn't mean to do.

Parents of self-harming children live in fear that the behavior might be triggered by something or someone even after years of not having an episode. This constant fear that "something might happen" again causes many of them to become hypervigilant about the self-harming behavior. So much so that hypervigilance became a subtheme that emerged out of the data about fear.

**Hypervigilance.** Parents of self-harming children became hypervigilant about their children, the self-harming behaviors, and their children's overall emotional state. Helen stated, "I went through her room every day looking for sharp objects." When asked how having a daughter who self-harmed impacted her parenting style Judy said, "When she shaved, I made her do it in front of me and then I took the razor and locked it up because I was afraid that she might use that to cut herself later." Amber described how she tried to be discreet about their hypervigilance. "I feel like I'm being sneaky. Like, she'll walk through the house in shorts and I'm just kind of like checking out her thighs and arms." Other parents described worrying if their children took too long in the bathroom or were in their bedrooms for long periods of time. Heidi said,

I'm always looking at his arms and stuff...I'm looking for marks. I watch for it. I watch for signs of it. Like, when he's talking about the other kids cutting themselves, we talk about it. We have, we have a discussion about why does he think they're doing that and what's gonna happen to them if they keep doing that, and how they feel. And so, we, we keep talking about it because I, I want him to

remember. Even though I don't want him to remember the feeling inside of how depressed he was and upset he was.

All the parents stated that this change only occurred after they learned of the self-harming behavior and the hypervigilance did not go away over time. Parents of children who had not had a self-harming episode in years were still hypervigilant of their children's behaviors and emotional state.

### **Theme 3: Change in Parenting Style**

Another overarching theme that emerged from the data was a change in the way participants parent their children who self-harm. Many of them became less rigid. Judy described the experience of parenting as "walking on egg shells" and Angela mirrored that statement by saying, "we were always just waiting for the other shoe to drop." The parents were constantly worried about how their children may react to discipline or to a rigid boundary. Helen stated, "As far as putting my foot down and this is how you should do things, no, that all stopped." Parents with multiple children stated that they parent the self-harming child differently than they parent the other children in their home. Amber explained her change in parenting,

She gets away with a lot more. It's like, I'll let her get away with the behavior if she's not cutting. She has attitude and so I let her, you know, she'll mouth off and it's just kind of like, I pick my battles way more. I mean, you don't want to push too hard. She's like, she starts in 'That's why I hate living here, at the house,' and all this stuff. The biggest majority of me just rolls my eyes, like wants to roll my eyes because I'm like 'Give me a break. Your life is so terrible.' Then there's that

other little part of me that's like, I can't. What is she going to do? So, again, she gets away with some stuff that maybe she really shouldn't get away it. That's terrible.

Heidi questioned her parenting style and said, "We first tried to look at the situation...are we being too tough on him? Maybe we should back off." Angela stated "You didn't want to upset her cause you didn't want her to cut. We didn't want to rock the boat because anything that overloaded her, her emotions, you didn't want to get into it." Helen described her change in parenting when she said,

Instead of necessarily addressing the behavior I would just usually give an alternative. Let's, you know, maybe that wasn't the best choice. How about, how, maybe this would have worked better. You know, and so not, not using the words disappointed, not sounding angry. I mean because I think she already knew that the choice she made wasn't the best choice to make, you know. But for me to come down on her for that, I don't think at that point in time wasn't what she needed. A lot of times I had to let her come to me. I couldn't go to her.

This change in parenting style occurred with all six of the participants and the change was only directed towards the self-harming child. Parents change in parenting style was driven by fear of the possibility that the child might potentially self-harm again. The participants watched what they said, how they said it, and who they said it around. This change in parenting style seemed to be stressful for the parents. As Amber described, "I should be able to parent my teenage daughter like anyone else parents their teenager."

**Theme 4: Impact on Relationships**

The participants described major changes in their relationships with the self-harming child and their spouses. The parents described closer relationships with their self-harming children and contributed much of the change to better communication. The parents softening in their discipline and not being so rigid with rules and boundaries seemed to open doors of communication that were not previously there. Heidi stated,

I would say our relationship got much, much better because he realized that he could come to me and tell me anything. So, we ended up with a much stronger relationship after that happened. And even now, at the age that he is now, he pretty much tells me everything because he knows that I'm going to try to look at it from a perspective of, okay I'm gonna try not to judge. Let's look at this situation first and then figure out what to do.

Helen echoed that statement by saying, "I think we got closer. I think through all of this she realized my mom's not gonna leave. No matter what I do, where I go, what I've said, what I've done, my mom, will always be there."

Judy also stated that she and her daughter have gotten closer because of better communication.

After she knew that I knew about the cutting, there wasn't any reason to hide it anymore. So, when she would do it again we just talked about it and I told her to talk to her counselor about it. I think she realized that I wasn't going to overreact in front of her or punish her for it. I mean, I don't understand hurting yourself, but I understand the depression part.



Participants also described strained relationships with their spouses. After first learning about their child's self-harming behavior, Heidi described "heated conversations" and Ira stated that she and her husband had "lots of fights." Most parents related the fights to differences in parenting styles. Amber stated, "He thinks I baby her too much, but I think he is a little bit too hard." Angela was most vocal about how the self-harm put strain on her relationship. She stated,

It (the self-harming behavior) caused so much damage with me and my husband. I think we took it out on each other. He accused me of being too lenient, and I accused him of being too harsh. And I think she, she rode in the middle. It's like 'as long as I can keep them fighting, then, then, uh, I'm okay.' And she played us good. She knew what she was doing just to get her own way. It made us see each other's point of view. I knew he was being hard, but I understand him being hard. and yeah, you were soft, but I can understand you being soft. It made us talk more. It made us exhale and say, wow, life, life ain't so bad.

However, over the course of the self-harming episodes, the relationships seemed to transform into closer, deeper relationships because all the participants described their spouses as people who supported them through the experience. "We had to communicate a little better with each other because obviously we were doing a poor job at it." Judy described her relationship with her husband, "We had to rely on each other. I couldn't do it all and he couldn't do it all. We had to talk about stuff, even the hard stuff."

### **Theme 5: Change in Perception of Mental Health Issues**

This theme emerged out of data because of nuances in the way the participants described their overall experiences with having a self-harming adolescent child. Helen stated, through tear filled eyes, this change in perception when she said,

I just thought she's not that type of kid. That doesn't happen to my family. That happens to other families. They have family trouble. They don't have two-parent households. They don't have...coming to the realization that it happens to anybody.

This awareness that mental illness can happen to anyone was felt with all the participants. They became more aware of mental health challenges experienced by other people.

Heidi echoed that similar thought process by stating, "That's somebody else's kid. That's somebody else's parent. It's not your house." Amber noted her change in perception by saying,

It's hard for me knowing the things that she has but I see it now. I mean, that's something she's going to have to keep on top of her whole life. You know, her depression and anxiety. She has to be able to take care of herself.

Some of the parents went as far as to advocate for others who self-harm. Heidi stated that other kids have started coming to talk to her because they know she will understand and really listen. Helen, a grade school teacher, said that she has become more cognizant of students in her classroom that might be suffering from mental health issues. When asked how having a daughter who self-harmed impacted her perspective of

the world around her Angela stated that she is less judgmental towards other parents who have children who are suffering from mental health issues. She said,

It makes me look different at parents. You assume, well you've gotta be a bad parent because look, you're not even paying attention to what your child is doing to himself. When your kid starts doing it, then you, you feel completely different and you see it in a completely different light.

The change in perception about mental illness was evident in each participant. They seemed more empathic, more understanding, and slower to criticize other parents and other children who might suffer from a mental illness. They were also quicker to step in to help others who were self-harming and even spoke to other parents about their own experiences.

### **Theme 6: Support System**

Parents' support systems were key in coping with the impact of having a self-harming adolescent child. Although there were some differences in how each person coped and used their support system, three subthemes emerged from the data. First, spirituality and religion played an important role in helping parents cope with the distress caused from having a self-harming child. Secondly, family support was the main support system used by the participants, and thirdly, a lack of support from mental health professionals.

**Religion and spirituality.** All six participants made a point to identify the role that their spirituality played in helping them cope with the distress and impact of having a self-harming child. Religion and spirituality gave participants hope for the future, peace

about the situation, and comfort in times of great despair. Judy stated, “I would just cry and pray. I prayed a lot.” When asked to describe her support system, Heidi repeated this idea by saying, “A lot of praying, a lot of talking to people. That’s kind of how I deal with things is, is talking to other people about it and praying a lot about it.” Angela, the most upfront about her spirituality, said,

To be honest with you, that’s all I had was me and God. You stand on all the scriptures. You know, ‘as for me and my house, we’ll serve the Lord.’ You pray and you say, well, you know, you, you stand on the all the scriptures, you know, that you know...and you pray and you say, ‘You know what? One day, you know, God can fix this here. He’s the only one that can.’ I’m a worshiper. That’s where your joy is at, and not only that right there, but that’s where your, uh, your answer is. I mean, it made me a deeper worshiper. It took me deeper into worshiping and praising God. So, it actually strengthened my relationship with God.

Helen described how her faith helped her when she said,

I pray a whole lot. I mean my, my faith I guess is...because it’s, it’s several times a week I say ‘God, you gotta take it. I won’t. I can’t.’ When I find myself not sleeping at night, I pray. I don’t know how people cope when they don’t have a faith. I also have the church. I just pretty much went in and said this is what’s happening. They prayed with me, they cried with me.

Spirituality played a big role in helping these mothers overcome stress, marital tension, fear, and overall emotional exhaustion. Prayer helped them have hope that they

could survive the experience. Their spiritual journeys, although different in religion, was what helped these women have motivation to keep pushing forward for their children. I found it interesting that it was not about which religion each mother followed, but that she used her belief system to draw strength and hope.

**Family support.** Another subtheme that emerged from asking participants to describe their support system was the need for family support. Most of the participants' inner support system consisted of a spouse. When asked to describe their support system all the participants identified their spouses immediately. They leaned on one another for support, carried one another through tough times, and listened to one another when they were at their lowest point. Helen stated, "My husband was very patient. He let me cry even though I knew he didn't understand how I felt." Heidi stated, "He was the only one that knew all the details. We didn't tell anyone else all the details." Ira added, "He was there for me when no one else understood. Sometimes he just sat and let me cry and didn't say anything. I just needed to know that he was there." Amber's experience confirmed the other mothers' experiences. She stated,

I can talk to him. He is so logical I guess. So, like I'll get going about something and he's just like, 'Calm down. You're jumping two steps ahead, and this here hasn't even happened yet.' So, he just kind of grounds me back.

This support system was key in helping the participants cope with heavy emotions and difficult times that seemed endless.

**Lack of support from mental health professionals.** The participants in the study described a lack of support from mental health professionals in a variety of settings.

All the participants' children received services from counselors or psychologists, and all but one participant had spoken to school counselors. Two participants' children were admitted into a hospital for treatment for the self-harming behaviors. However, none of these parents received support from these mental health professionals. Angela expressed her frustration with the mental health professionals when she said,

You were totally invisible. You were the money bag. That's what you were.

That's all you were. You was the insurance card or the money bag. Other than that, right there, it was nothing. You had nothing to do with nothing. So that was the only contact that was ever made. 'We need her insurance, and we need more money.' At that moment, it's, it's hurtful, but it's like, whatever it takes to get this kid fixed.

Ira echoed that sentiment by stating, "The only contact from the counselor was when they need insurance information or to set the next appointment." None of the parents were offered family or individual counseling by these mental health professionals. Little consideration was given to the parents. As Heidi put it, "I'm not sure we would have even recognized that we needed it at the time if it was offered because we were so focused on getting him help." The families' resources and focus were on getting the children help for the self-harming behaviors. Amber stated, "I just wanted to fix the problem." When asked what type of support they would have liked, the participants stated they would have liked to have had an option to attend a parent group with other parents going through similar situations. As Heidi described,

It would've been nice to have heard somebody else say I felt helpless. I felt out of control. I was angry. I was upset. I felt guilty. My pride hurts. Having somebody there that went through what I went through.

Judy repeated the need to have someone truly listen to her. She explained that having someone hear her out would have been very helpful during her experience.

I know for me, like I said, it helps me to talk it out. If I have a problem, if I can talk it out...I don't even know that I need somebody to bounce back at me. I just need somebody to listen to what I'm saying, and if I can get it out then I, for me, feel better.

### **Discrepancies/Nonconforming Data**

As in all lived experiences, everyone's experience may have their own nuances. Therefore, discrepancies and nonconforming data are to be expected in qualitative research. There were only a few slight discrepancies that emerged during the interviews. These discrepancies were later confirmed or denied as a trend with additional participants. For example, Heide stated that when she first learned of her son's self-harming behavior she took him to a medical doctor. The other five participants stated that they immediately sought help from counselors. These slight differences were noted and coded in the initial readings during stage one of the data analysis process. However, they were not supported as a trend or theme when compared to other interviews during stages two and three of the analysis process.

### **Research Question**

The overarching research question was: What are the lived experiences of parents who have self-harming adolescent children? The interview questions on the interview schedule (Appendix C) were developed in a way to draw out these experiences from participants. As interviews took place, themes emerged from the interviews. For example, one of the first themes that really stood out was the change in parenting style. Most of the participants described being more flexible rules and discipline to avoid triggering their children to self-harm. So, in additional interviews, I made sure I addressed changes in parenting styles to either confirm or deny this pattern as a theme. So, I would say, “Other participants have described changes in the way they parented their child after learning about their child’s self-harm. How did your child’s self-harm impact your parenting style?” With this, I could confirm the theme with the last few interviews and I was able to understand deeper how these parents felt about adjusting parenting styles and how adjusting impacted them, their marriages, and other family members living in the home. I also had to expand the question regarding change in world view. Some of the participants did not understand what I was trying to ask. So, I had to adjust the question to be more specific. For example, I would ask, “How has this experience changed the way you view other people with mental illness, parents, and the world around you in general?” Being more specific helped the participants understand what I was asking and they were more easily able to answer the question. All of the categories and themes that emerged addressed the research question and gave an insight



into the lives of the participants as they experienced having adolescent children who self-harm.

### **Evidence of Trustworthiness**

#### **Credibility**

The credibility of this phenomenological qualitative project was multi-layered. First, I kept a journal through the data collection and coding process. I made a habit of writing in my journal after each interview. I documented any biases or questions that came up for me during the interview. I also made note of any questions that I might have for my committee members. For example, Heidi's interview triggered the most bias for me. She was the only participant with a son that self-harmed and she had a background in counseling. Even before the interview, I thought to myself that her experience was probably going to be different than the other participants because she would probably draw from her counseling experience and counseling theoretical orientation to deal with her son's behavior. I also expected her experience to be quite different than the other participants because her child was a male. However, her experience was very much like the other participants' experiences and there seemed to be little, even no, difference regarding how his gender played a role in her experiences. Heidi also responded to her son's self-harm very much like the other parents regardless of her professional counseling experience. I was even more triggered by bias during Heidi's interview when she told me that she first took her son to a medical doctor instead of mental health professional. My initial thought was that she had all the resources and knew people who could help him,

why take him to a medical professional? After hearing her explanation, I better understood where she was coming from. She had stated,

I wanted to rule out any nerve damage that he may have caused to his arm. I also wanted to rule out a need for him to be hospitalized in a short term residential facility. Hearing the doctor tell me that he didn't have any major nerve damage and that he did not think he needed hospitalization was a relief. Then, I could move forward with finding a counselor for him to see to learn different coping skills. I knew that was what he needed, but I also knew that I couldn't be the one to do it. I was mom.

I understood in that moment that she was operating from the side of her brain that was mom, not professional counselor and that both parts of Heidi's brain could not operate at that same time. Nor should it. Her son probably need mom in the moment too, not another counselor.

My bias was also triggered when I interviewed Judy. She was one of two participants that was still married to her daughter's father. So, my bias was that her experience of trying to blame the behavior on someone would be different than the other participants' experiences because there was not an absent parent to blame. However, although she did not blame an absent parent, she did blame kids at her daughter's school in an effort to justify the self-harm. Her need to blame someone or something was the same need as the other participants. I found that interesting because it verified for me that blaming to justify the behavior was a way for parents to cope with the behavior.

I was also triggered when Helen, the first participant, started explaining her frustration with mental health professionals and again when Angela, the second participant, said that she just felt like the “money bags.” I found myself first feeling defensive when Angela said that she felt like the counselors did not do enough for her daughter. I felt like I was a child in trouble. Like I was holding the microscope in which the world was viewing the counseling profession in a negative light. However, after journaling about my bias, I realized that the microscope that I was holding was exactly what the counseling profession needed to gain awareness so that better training can be developed and organizational guidelines can be changed so that parents of self-harming children are better served. I realized that these comments about parents’ experiences with mental health professionals were not personal and not directed at me. Helen’s and Angela’s comments made me rethink some of my own protocols in my professional counseling practice and I made changes that I implemented almost immediately after their interviews. Journaling played a huge part in being able to reflect on where these biases were coming from for me and helped me bracket, or set aside, these biases so that I could move forward with interviews.

Secondly, I sent each transcription to the participant for the first round of member checking. Each participant was asked to provide any feedback, clarification, or corrections that they wanted to make to the transcription. Heidi was the only participant that responded and she said that there were no changes that she wanted to make. A second round of member checking was done after the themes were developed. I sent all

the themes to each participant and asked them to provide feedback if they would like. No one responded to the second round of member checking.

### **Transferability**

These results should not be transferred to populations outside of the inclusion criteria. Readers of this study should take caution that transferability is limited to parents of self-harming adolescent children whose self-harm is identified as nonsuicidal, intentional self-harm defined for this particular study. Demographic characteristics of the participants and details of the setting were provided with the intent to help potential readers make an educated decision about transferring these results to other populations.

### **Dependability**

Dependability was achieved by being consistent through the inquiry process. The interview questions were reviewed and approved by my committee. The interview schedule was used during interviews to assure consistency in each interview. I will also keep all journal articles, notes, and coding processes used during the data analysis stage for five years in case of any possible audit trails to increase dependability. Then, I will properly dispose of all the data after the five years by shredding the paper files and deleting any electronic files per my protocol.

### **Confirmability**

Confirmability was achieved using journaling and two rounds of member checks. As previously stated, I kept a journal through the interview process and data coding process. I also used member checking after each interview and after themes were

identified to confirm that the results of the study reflect the true experiences of participants.

### **Summary**

The purpose of this qualitative phenomenological study was to explore the lived experiences of parents who have self-harming adolescent children. Six participants from the Southwestern part of the United States took part in this study. Interviews were conducted, transcribed, coded and analyzed for themes and patterns. Six main categories, or themes, emerged from responses to interview questions. Those include: (a) reaction to behavior, (b) change in self, (c) change in parenting style, (d) impact on relationships, (e) change in perception of mental health issues, and (f) support system. It is evident that the self-harming behavior did have an impact on the parents, their relationships, their parenting styles, and the way they viewed the world around them.

In this chapter, I described the research setting, demographic characteristics of participants, data collection methods, data analysis methods, evidence of trustworthiness, and results of the study. In chapter 5, I will summarize the findings, limitations of the study, and recommendations for future research. I will also discuss potential implications of positive social change could occur because of this study.

## Chapter 5: Discussion, Conclusions, and Recommendations

### Introduction

Over the last few years self-harming behaviors amongst adolescent children in the United States has only increased. The most recent findings from the Centers for Disease Control and Prevention (2014) found that 30,000 adolescents were treated for self-cutting and 45,711 adolescent children were treated for self-poisoning. These statistics only represent the children who were reported receiving treatment at hospitals and doctors' offices, and they do not show the full impact self-harming behaviors have on adolescent children. Ourgin, Tranah, et al. (2012) found that 13.2% of adolescents reported engaging in self-harm at some point in their lifetime. Yet, despite awareness that self-harming behavior is a systemic problem affecting everyone in the family (Lindgren et al., 2010; McDonald et al., 2007), a thorough review of the professional literature shows a lack of attention has been given to parents' experiences of having an adolescent child who self-harms. Due to this lack of information, counselor educators and supervisors are not prepared to train counselors to meet the needs of parents of self-harming adolescent children. Counselors have reported feeling inadequately prepared to work with this specific population and their families (Fox, 2011) which has implications for how they are trained in their counselor preparation programs. Due to this inadequate training, parents of self-harming adolescent children are not receiving the support, treatment, or services they need (Lindgren et al., 2010). Therefore, the purpose of this qualitative phenomenological study was to explore the lived experiences of parents' who have self-

harming adolescent children and gain insight into how the counseling profession can better serve parents who need additional support through this stressful experience.

### **Key Findings**

As I noted in the previous chapter, six participants in the Southwestern part of the United States shared their stories of having a child self-harm. Their responses to interview questions gave a rich, in-depth exploration into their experiences of having a self-harming adolescent child. Six themes emerged from the interviews.

#### **Theme 1: Reaction to Behavior: Denial and Blame**

The first theme was a reaction to the self-harming behavior. Participants were first in denial about the self-harming behavior and then attempted to blame the cause of the self-harming behavior on external factors such as a specific circumstance or an absent parent to explain and understand the behavior.

**Denial.** Parents experienced a stage of denial first. They made excuses for what they saw and denied the seriousness of the self-harming behaviors. Many of them thought the behaviors would just go away on their own. Some of the parents thought the behavior was just for attention. As Angela explained,

... it was just confusing. It was something that I never...my generation never did... It was just about her trying to hurt herself, and it's still hard, you know, to hear that someone's trying to hurt themselves. It just confusing. It's a bunch of confusion.

Heidi thought that her son was just goofing around with someone friends. She explained,

He would come home and there would be more them, I just, I don't, I don't know.

I mean, it was like my brain just did not want to comprehend the fact that he felt like he had to hurt himself.

Ira described her experience when she said,

I saw the marks but didn't really know what they were. It wasn't until we got a call from the school counselor who said that she had cuts all over her arms and legs. Even then, I was in shock and really didn't believe it.

This denial was profoundly experienced by each mother. They wanted to believe that self-harm did not impact their children. There were initial fears of suicidal ideation. These mothers wanted to believe that mental illnesses happened to other children in other homes. Helen demonstrated this viewpoint when she said,

I was like, no this is not my daughter. My daughter would never do this. She's, that's not the type of kid she is. That doesn't happen to my family. That happens to other families. They have family troubles. They don't have a two-parent household. They don't have...coming to the realization that it happens to anybody.

However, as the data confirmed, parents soon realized that mental illness does not discriminate.

**Blame.** The need to justify the behavior through blaming someone or a circumstance emerged next. Parents needed to know why their children were hurting themselves. Blaming the behavior on someone or something helped them attempt to understand the reasons for the behavior better. For Judy, her daughter cut because of



peers at school. “She struggled making friends. Always has. I think she was getting bullied or made fun of at school. She didn’t know what to do except turn it (the pain) inwards.” For Heidi, her son was struggling with academics and cut because he was frustrated with school.

Ours was all connected to school because he was struggling in math and the more I looked into it, the more I was trying to get help for him, the more the teacher was ignoring me. He was considered a goof-off because he always, you know, told jokes and things like that to make people laugh and he didn’t understand what to do in class so he started telling more and more jokes. So, she thought he was a jokester instead of ‘I’m struggling’ and under that table he’s over here poking himself and cutting himself.

Some parents blamed absent or uninvolved parents. For example, Helen felt that her daughter was struggling with an absent father. She explained,

I knew that there had been tension between her and... her biological father. I knew that things had gone on but I didn’t realize what had been done to her because my thought was she lives most of her time with me. She sees him every other weekend and on some holidays. She doesn’t even see him during the week... (I was) constantly telling her I, I love you. You’re amazing. You’re fantastic. You’re beautiful, and even being with me 90% of the time, with me giving her that affirmation, the other 10% was stronger.

Angela explained her struggle when she said, “You know, it’s, it’s beyond anything in this world I can do. You know, I loved her and I gave her everything, but I cannot be daddy.”

## **Theme 2: Change in Self**

The second theme that emerged was a change in self. Parents felt an immense sense of guilt surrounding the self-harming behavior. They also live in constant fear of the self-harming behavior reoccurring, even after years of the behavior being absent. The constant fear resulted in the parents becoming hypervigilant about the behavior. They would constantly check for marks, razors, or signs of emotional distress.

**Feelings of guilt.** Feelings of guilt was one of the strongest subthemes that emerged and one that was talked about the most in interviews. Parents felt an immense sense of guilt, even after years of the self-harming behaviors were absent and often blamed themselves even though they struggled to find a discernable reason. Helen’s daughter has not self-harmed in about four years, yet she explained through tear-filled eyes, “As a parent, I, you just don’t know how you didn’t see it. So, a lot of guilt. A lot of helplessness.”

Angela described the root of her guilt in feeling that it was her fault. She said, “You just don’t hear about it. So, I think, I see this as a reflection on us and we, we just think we are doing something wrong to cause this thing.”

**Living in constant fear.** Living in fear was a subtheme that emerged less obviously than other themes. However, after reading the transcriptions multiple times, I noticed that each mother described being terrified that their child would self-harm again,

even after years of the behavior being absent. For example, Helen, whose daughter has not self-harmed in four years said, “Oh, I’m scared every day. Still. Is there something gonna happen and I’m not gonna be there?” Angela described how her fear drove her change in parenting. She said, “I felt it was a fear. You didn’t want to upset her cause you didn’t want her to cut.” Heidi said, “I knew that at any time he could start it back up again.” Living in constant fear was also the driving force behind parents becoming hypervigilant about the self-harm.

**Hypervigilance.** The fear that parents live in caused them to become hypervigilant. They watched for signs that their child had self-harmed, they kept all things locked away that their children could use to self-harm, and even went as far as taking doors off bedrooms. For example, Angela said, “My husband said, ‘Take her door off. She don’t have right to privacy. Take the door.’ But what do we do? What do we do?” Heidi stated, “I knew that at any time he could start it back up again. It was like a constant watching him. Oh the fights we had over it.” Amber described her hypervigilance as trying to be sneaky. She said,

I still am just, kind of feel like I’m waiting. I feel like I’m sneaky. Like she’ll walk through the house in shorts and I’m just kind of like checkout out her...cause she would do her thighs, so I feel like...or she gets out of the tub and I see her walking through with like just like a shirt and her underwear, I’m always checking her leg. Even still.

Judy explained, “We hid all of the things that we thought she could use to cut. So even our kitchen knives were put up and locked away. I had to hide my razors and

everything.” The hypervigilance that the parents experienced was driven by the fear that their child would self-harm again.

### **Theme 3: Change in Parenting Style**

The self-harming behaviors also resulted in a change in parenting style, the third theme that emerged. Parents became less rigid in rules and boundaries. Amber described her change by stating, “She gets away with a lot more, the attitude. I mean, she’s a 16-year-old girl, she has attitude. She’ll mouth off and it’s just kind of like, I pick my battles way more.” Parents calculated everything they said and did to not trigger self-harming behaviors. Amber continued, “It’s a fine line I feel like I walk all the time. Trying to keep her in a good place mentally.” Angela described it as walking on egg shells. She said, “Everybody walked on egg shells, you know. We not going to rock the boat cause she might go in there, and you know, cut. Anything that overloaded her, her emotions, you didn’t want to get into it.” They also parented the self-harming child differently than other children in their homes. Amber stated, “I should be able to parent my teenage daughter without her cutting herself.” Judy explained,

She’s different than my other girls. I didn’t have to do this with my other kids. I could just tell them no and there wasn’t a fear that they would cut. With her, I have to be careful of what I tell her no to and when I tell her no. I pick my battles.

### **Theme 4: Impact on Relationships**

The fourth theme that emerged was a shift in their relationships. The participants identified a closer relationship with the self-harming child because of better, more open,

communication. Heidi stated, “I would say our relationship got much, much better because he realized that he could come to me and tell me anything.” Helen felt the same way about her and her daughter’s relationship. She stated, “I think we got closer. I think through all of this she realized my mom’s not gonna leave. No matter what I do, where I go, what I’ve said, what I’ve done, my mom, will always be there.” Judy described her relationship with her daughter when she said, “This opened up communication and I can share with her my struggles when I was teenager. I think it helps her know that she isn’t alone.”

However, they also noted a negative shift in their relationships with their spouses when first learning of the self-harming behaviors. Angela described this change when she said, “It (the self-harming behavior) caused so much damage with me and my husband. I think we took it out on each other. He accused me of being too lenient, and I accused him of being too harsh.” Heidi said that she and her husband had lots of “heated conversations” about how to respond to their son cutting. Ira described “lots of fights” between her and her husband. However, these relationships evolved into deeper, more meaningful, relationships through the course of the self-harming behaviors due to being committed to open communication, relying on one another, and experiencing the distress together. The participants identified their spouses as an important source of support, which will be discussed in theme six.

### **Theme 5: Change in Perception of Mental Health Issues**

Participants reported a change in their perception of mental health issues which was the fifth theme that emerged. They shared their awareness that self-harm and other

mental health issues can affect anyone and that the mental health issues do not discriminate. Helen's explanation of this insight depicts this theme perfectly. She stated,

I was like, no this is not my daughter. My daughter would never do this. She's, that's not the type of kid she is. That doesn't happen to my family. That happens to other families. They have family troubles. They don't have a two-parent household. They don't have ... coming to the realization that it happens to anybody.

Amber described a similar thought process when she said,

It's hard for me knowing the things that she has but I see it now. I mean, that's something she's going to have to keep on top of her whole life. You know, her depression and anxiety. She has to be able to take care of herself.

The participants became more empathetic towards others dealing with mental health illnesses and their parents. They also became more cognizant of people who might be in distress and were more willing to help those individuals. Heide explained how her perception of parents changed through her experience. She stated,

It makes me look different at parents. You assume, well you've gotta be a bad parent because look, you're not even paying attention to what your child is doing to himself. When your kid starts doing it, then you, you feel completely different and you see it in a completely different light.

The change in perception about mental illness was evident in each participant. They seemed more empathic, more understanding, and slower to criticize other parents and other children who might suffer from a mental illness. They were also quicker to

step in to help others who were self-harming and even spoke to other parents about their own experiences.

### **Theme 6: Support System**

Lastly, a theme surrounding types of support system emerged from the data. Religion or spirituality was the most noted form of support while family members were the second most noted form of support. Interestingly, as previous literature supported (Lindgren et al., 2010; McDonald et al., 2007), parents did not find support in mental health professionals and did not seek out the support for themselves.

**Religion and spirituality.** Religion and spirituality played a major role in how parents coped with their children self-harming. Their specific religion or denomination was never discussed, but the hope and peace that they received because of church, prayer, and belief systems was discussed. Angela was the most vocal about the role religion played in her ability to cope with her daughter's self-harm. She said,

To be honest with you, that's all I had was me and God. You stand on all the scriptures. You know, 'as for me and my house, we'll serve the Lord.' You pray and you say, well, you know, you, you stand on the all the scriptures, you know, that you know...and you pray and you say, 'You know what? One day, you know, God can fix this here. He's the only one that can.' I'm a worshiper. That's where your joy is at, and not only that right there, but that's where your, uh, your answer is. I mean, it made me a deeper worshiper. It took me deeper into worshipping and praising God. So, it actually strengthened my relationship with God.

The other participants echoed these statements. Helen said, “I pray a whole lot. My faith I guess is...it’s still several times a week I say God, you gotta take it. I won’t. I can’t.” Judy explained, “We go to church together as a family. It helps me get through the tough week.” It was obvious that the participants’ faith, regardless of denomination, helped them through trying times.

**Family support.** Although the participants first described heated arguments and lots of fights with their spouses, when asked about their support system they all identified their spouses first. They leaned on one another for support, carried one another through tough times, and listened to one another when they were at their lowest point. Helen said, “My husband was very patient. He let me cry even though I knew he didn’t understand how I felt.” Judy stated, “I couldn’t have done it without him and he couldn’t have done it without me. We need each other.” Heidi stated, “He was the only one that knew all the details. We didn’t tell anyone else all the details.” This support system was key in helping the participants cope with heavy emotions and difficult times that seemed endless.

**Lack of support from mental health professionals.** The participants in the study described a lack of support from mental health professionals in a variety of settings such as residential treatment facilities, counselors, and school counselors. Angela felt like she was completely invisible by mental health professionals until it was time to pay. She said,

You were totally invisible. You were the money bag. That’s what you were.

That’s all you were. You was the insurance card or the money bag. Other than



that, right there, it was nothing. You had nothing to do with nothing. So that was the only contact that was ever made. ‘We need her insurance, and we need more money.’ At that moment, it’s it’s hurtful, but it’s like, whatever it takes to get this kid fixed.

Ira echoed that sentiment by stating, “The only contact from the counselor was when they need insurance information or to set the next appointment.”

However, they did state that they did not recognize at the time that they needed the additional support from mental health professionals and noted that they would have potentially benefited from the additional support. Heidi said, “I’m not sure we would have even recognized that we needed it at the time if it was offered because we were so focused on getting him help.” Helen said,

I was too focused on her. Not totally realizing until later that while I was in the thick of things, it would’ve been good for me to have someone to talk to too. I wish there was something that, I wish the counselors at the high school were more proactive in talking to kids about these things. Then perhaps have a parent meeting, well honestly it needs to start in junior high, that’s where it starts. Just so parents understand what to look for because you have no clue. I had no clue.

The participants did state that they would have liked to have had a support group that included other parents who were experiencing similar issues so that they would have had someone that could validate their feelings and experiences. Heidi said,

It would've been nice to have heard somebody else say I felt helpless. I felt out of control. I was angry. I was upset. I felt guilty. My pride hurts. Having somebody there that went through what I went through.

The participants had great ideas about having parent-led support meetings with counselors available in case someone needed additional assistance, school counselors holding parent education meetings, and providing parents with brochures for resources and what to expect. These will be discussed in more detail when I discuss future recommendations.

### **Interpretation of the Findings**

#### **Theme 1: Reaction to behavior: Denial and Blame**

In many ways, the findings confirmed and extended much of what has been reported in previously published literature. The theme of *reaction to the behavior* was supported by previous literature in that parents sought to blame an outside source or search for a reason for the cause of the self-harm (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006). Oldershaw et al. (2008) found that parents in their study also felt an extreme sense of guilt and needed to justify the behavior somehow, often doing so by blaming outside sources. In their study, most parents blamed the self-harm on peers influencing the adolescent child. McDonald et al. (2007) found that parents searched for a reason for the self-harm. The results of my study supported their findings in that most participants blamed marriage breakdowns, absent parents, and strained relationships. My findings in this area extend previous research by acknowledging and noting that the need to blame outside sources, or search for a reason

for the self-harm, was driven by the immense guilt that the parents felt and was used as a coping mechanism. I think the guilt parents experienced originated from the inability to save their children. They could not control the situation. I believe that my participants needed to understand the behavior and needed to have a reason for the cause of the behavior. Only then, did they feel as if they could “fix the problem.” Blaming something or someone for the self-harm also gave them a sense of being able to control something that appeared uncontrollable. Parents were often confused about the self-harm and did not understand the behavior. I think their attempt to justify the behavior gave them a sense of understanding the reasoning behind the behavior; something tangible that they could relate to; something they could change.

The subtheme of *denial* was not found in the literature that I reviewed and extends the findings of other researchers. Other researchers categorized these emotions into themes such as “emotions” (Byrne et al., 2008, p. 498) and “psychological impact of self-harm on parents” (Oldershaw et al., 2008, p. 7). My participants reported feeling shocked after discovering the self-harming behaviors, but they also took it a step further by stating that they were in denial about the true severity of the behavior. As described in chapter four, many parents thought it was just their child playing around or that the self-harm was a onetime occurrence. The acceptance of the self-harm as being a real problem did not happen for parents until much later. Many times, the acceptance did not occur until a school counselor called them into the office or a friend of the child told them about how often the self-harm was occurring. This subtheme confirmed Oldershaw et al.’s. (2008) findings. Oldershaw et al. (2008) found that acceptance of the child’s self-

harm was a gradual and ongoing process. My participants still struggled with accepting the fact that their child had self-harmed, even some after years had passed. However, denial is a basic coping mechanism that individuals use to protect their own mental and emotional stability (Wood, Wood, & Boyd, 2014). I found it natural that parents would first be in denial about their child's self-harm until they were more emotionally ready to begin accepting the behavior. I believe parents go through a process, like Kubler-Ross's five stages of grief (Kubler-Ross, 1969), where they first experience denial, then justify the behavior by blaming, and can finally move to a stage of acceptance.

### **Theme 2: Change in Self**

The subthemes of guilt, fear, and hypervigilance confirmed the results found in the professional literature. Guilt was identified as a primary psychological impact on parents in almost all the literature that I reviewed (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006). Parents in my study felt an immense sense of guilt about the self-harm. They often felt as if the cause of the behavior was their fault, something they did, or did not do. They also felt immense guilt about not recognizing the self-harm sooner. Many of them felt guilty for not knowing their child was in distress. McDonald et al (2007) found similar results in their participants. Participants stated that they felt as if they had failed their children somehow. Parents in my study and in previous literature seemed to turn the self-harming behavior inward. They took the self-harm as a direct reflection of themselves and their ability to parent. In return, they began questioning their abilities. This inward reflection exacerbated the feelings of guilt.

Participants in my study also experienced a constant state of fear that the behavior would reoccur, even after years of the behavior being absent. This fear of repeated behavior was confirmed only in one research article that I read. Raphael et al. (2006) also found that their participants lived in fear that the behavior would be repeated in the future. The subtheme of fear extends current literature and provides a more in-depth understanding of the constant state of emotional distress that these parents continue to live. The fear never goes away. This is an important aspect to the parental experience that researchers have missed in past literature. Living in chronic fear could result in other physical and mental health issues if not dealt with properly (Wang, Strosky, & Fletes, 2014).

The subtheme of hypervigilance confirmed and extended previous knowledge found in the current literature. Parents had increased and intensified overt attention and, were constantly aware of what their children were doing, and both discreetly and obviously watched for signs of self-harm (McDonald et al., 2007; Oldershaw et al., 2008). Oldershaw et al. (2008) also noted the significant stress and pressure the hypervigilance added to parents. Many of them changed their lifestyles to be around their children more. I believe that the hypervigilant behavior of parents was driven by the constant fear these parents perpetually lived in. Fear of the unknown, fear of what might trigger another relapse in behavior, fear of not recognizing the distress again. This fear is so immense for my participants that it drove many of the changes that they made in lifestyle, parenting, and the way they viewed the world around them. I think that the

vicarious trauma that they experienced and the deep fear that their children might relapse and self-harm changed these parents' schemas.

### **Theme 3: Change in Parenting Style**

The responses from my parents confirmed a key aspect to much of the current literature, a change in their parenting style. This shift in parenting style and techniques was noted in almost all the literature that I read (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006). Participants changed their parenting styles from rigid boundaries to softer, more flexible boundaries. They also described picking their battles carefully to not cause an emotional response that could potentially trigger the child to self-harm again. Many parents in my study stated that they had to parent the child that self-harmed differently than other children in the home. This difference in parenting styles created stresses in the other children because siblings found it unfair that one child got away with things that they could not get away with. My participants echoed what one parent said in Oldershaw et al. (2008) by saying they constantly “walked on eggshells” around the adolescent child, fearful of triggering another episode of self-harm. Again, I believe this change occurred because fear was driving every decision. Parents were willing to bend on rules that were once rigid if it prevented their child from self-harming. I think this shift is what caused marital problems between my participants and their spouses. They identified having heated discussions and numerous fights. From a Bowen's family systems perspective, I believe that the shift that occurred caused a disruption in the equilibrium. I think it was not until everyone in the system adjusted to the shift that a new equilibrium was established and relationships started to mend.

Therefore, the shift made in parenting style does indeed cause distress on the micro and macro systems functioning within a family system.

#### **Theme 4: Impact on Relationships**

Not all the data that came from the responses was negative. The self-harming behaviors had some positive impact on the family system. Participants in this study reported that the experience brought the child and them closer, and that the participants and their spouses had deeper, more meaningful relationships. This confirmed Oldershaw et al.'s. (2008) findings. However, my study explored these relationships in further detail than Oldershaw et al. (2008). My participants identified that change in communication and a deeper level of trust from the child as causes for the closer relationships.

Oldershaw et al. (2008) did not explore these relationships in-depth and only reported that the self-harm had some positive changes on the family dynamics. The results of my study both confirm and disconfirm the findings from Byrne et al. (2008). They stated that the self-harming behaviors disrupted the family unit and impeded family functioning. I found this to be true with my participants also. However, Byrne et al. (2008) did not report the positive impact on relationships that I found in my study. Other studies did not even mention the impact on the family unit. My study also extended the positive impact on the family unit by including the shift in marital relationships that other literature does not report. My participants reported feeling closer with their spouses and felt that they had more meaningful relationships after going through the experience of having a child who self-harmed. Participants reported feeling closer to their spouses. I believe this occurred because the experience forced them to improve their communication skills and

they had to rely on one another for emotional support. They also felt closer to one another. I believe this change happened because they began having courageous, challenging, and intimate conversations about their emotions, their beliefs, and their children. These open conversations allowed them to become vulnerable with one another. Being vulnerable with one another seemed to have a positive impact on the relationship and the relationship proved to play an important role in the coping strategies of the participants.

### **Theme 5: Change in Perception of Mental Health Issues**

Theme five emerged out of the subtle nuances that participants described as they talked about mental health throughout the interviews. Most of the participants described their perception of mental health issues prior to having a child who self-harmed as being closed minded and ignorant. They believed mental health problems happened to other people and other families. They believed mental health illness occurred because parents were not paying enough attention to their children or that the children came from broken homes. However, these perceptions changed as they experienced having a child who self-harmed and dealt with mental health issues such as depression and anxiety. I did not find where this change in perception was noted in any other literature. I believe this positive shift in perception revealed participants' own biases about mental health and the people that suffer from mental health illness. I think there continues to be a stigma that surrounds mental illness. The stigma that mental illness only impacts people that have been through something terrible is embedded in society's collective perception. However, these parents experienced mental illness in their own homes and their



experiences, again, changed their schema and the way they view the world around them. They described being more empathetic to the individual suffering from a mental illness and their parents. They also became more aware of the signs of distress in others and responded with deep empathy. For example, Helen described how she felt that the experience made her a better teacher because she became more understanding towards her students who struggled with distress. Heidi became an advocate for children who self-harm and Judy became a support for other parents who had a child who self-harmed. I think this change in awareness, empathy, and perception of mental health issues has the potential to have a positive ripple effect on a population that lacks resources and support.

### **Theme 6: Support Systems**

Support systems included three main subthemes; two of which were actual systems of support and one of which was a lack of support. All the participants identified either their religion or their spirituality as the main support system. Some participants received support from their church groups who prayed with them, helped them with transportation, or baby sat other children while they took the child who self-harmed to appointments. Other participants described their own prayer and reliance on religious scripture to help carry them through the tough days. Many of them believed that their relationship with a higher power was the only thing that helped carry them through the toughest days. Their spirituality and belief systems gave them hope for the future, peace about decisions that had to be made, and courage to keep pushing forward. The reliance of spirituality or religion extended current literature regarding parents' experiences of having a child who self-harms because I could not find any literature that identified this

area of support within this scope of context. However, literature does support spirituality and religion as a main source of support (John, 2010), self-care (John, 2010), and a way to prevent vicarious trauma (Trippany, White Kress, & Wilcoxon, 2004; Wang et al., 2014). The findings of my research connect the experiences of having a self-harming child and the potential benefit of having spirituality as a means for self-care. I think people's belief systems can be used to develop and drive hope, faith, resilience, and peace in what feels like a chaotic and disruptive situation. I think that the participants' spirituality, regardless of denomination, gave renewed strength and determination that helped decrease their fears and anxiety and always gave them hope that they could survive the situation and sustain the belief that their children would get better. Counselors need to engage clients' belief systems as a therapeutic tool to decrease stress and anxiety and increase self-care and hope, this strengthens a resilience and strengths-based perspective.

The second subtheme from my findings that extends current research is the support the participants received from their spouses. Although some literature discussed the negative impact the self-harming behavior had on the family unit (Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008), the literature that I reviewed did not discuss the support that participants received from family members. My participants reported receiving the most support, outside of spirituality, from their spouses. They stated that their spouses were the only ones who knew all the details about the self-harm, and that their spouses listened to them when they needed to talk. I think that the open communication improved their relationships with their spouses which directly impacted

the level of trust they had in one another. The participants were vulnerable with their spouses by sharing their fears, their worries, and their concerns. Their ability to be vulnerable, and experience their spouses' gentle ways of handling those moments, formed a deeper bond and a deeper trust in one another. I think vulnerability allowed these relationships to move beyond the mundaneness of everyday life. None of these factors happen in isolation and all are interrelated. For example, vulnerability made these mothers more open to hope and faith which strengthened a positive outlook and helped engage their inner strength to persevere even though the way to do that was not always clear. Through this orientation of persevering, spouses and possibly other family members could also be strengthened and their hope restored. This is family system's theory in action.

The last subtheme for this category was the lack of support from mental health professionals. The consistent response from my participants during the interviews was that they received no support from mental health professionals. All the participants' children received services either from a psychologist, psychiatrist, a counselor, or a combination of the three. However, none of these professionals reached out to support the parents. Often, the only time parents heard from the mental health professionals was when they need insurance information or to schedule another appointment. Participants seemed frustrated with the mental health professionals when discussing their experiences during the interviews. One participant going as far to say that "something has to change." Another parent expressed her frustration even with the interactions with school counselors. My participants' experiences confirmed the current literature in that there is

a lack of resources and services provided by mental health professionals for this particular population (Ewertzon et al., 2010; Raphael et al., 2006; Lindgren et al., 2010). Parents in my study felt invisible and alienated by the helping profession, like the ways past participants have reported feeling (Ewertzon et al., 2010; Raphael et al., 2006; Lindgren et al., 2010). However, I found that my participants did not seek out help from the mental health professionals, which confirmed the findings of Lindgren et al. (2010). When asked, they stated that they did not realize how much they were impacted by the self-harming behavior and that they were so focused on getting the child help that they did not realize they could have potentially benefited from counseling themselves. I think that their feelings of alienation and isolation by the mental health professionals exaggerated their fear for asking for help themselves. It is plausible that if parents felt more involved in their children's treatment, more empowered, and less isolated, that they would be more proactive in seeking out counseling for themselves.

All participants stated that in retrospect, they would have benefited and appreciated the additional support from a mental health professional either in the form of individual or family therapy. Therefore, counselors should be more proactive in offering individual or family therapy to parents of self-harming children, including advocating for them the type of support they may not even know they need initially. I found it even more interesting that all my participants suggested a support group where other parents could share their experiences as well. My participants stated that the support group would have been helpful in receiving validation for their own emotions and experiences. I believe this stems from feeling isolated in their experiences, even by counselors. I think

hearing others talk about their experiences would make the parents feel less isolated and more empowered to hope. However, I think it is possible that if counselors included parents in family sessions or even met with parents individually they might not have the intense need for validation from their peers.

### **Interpretation of the Findings in the Context of Family Systems Theory**

Family systems theory focuses on understanding and interpreting family interactions and the system that is at work within a family. According to family systems theory, families are interrelated and interconnected (Cottrell & Boston, 2002). The family is an emotional unit and members within the family change and adjust behaviors to maintain equilibrium within the system (Cottrell & Boston, 2002). The emotional dysfunction of an individual within the system disrupts the family system because the other members must adjust to maintain homeostasis (Cottrell & Boston, 2002; Haefner, 2014; MacKay, 2012). This adjustment often is stressful and causes emotional distress to those individuals making the shift (Cottrell & Boston, 2002; MacKay, 2012). The idea that a member's emotional dysfunction could potentially negatively impact the family unit is supported by Byrne et al. (2008). Byrne et al. (2008) found that self-harming behaviors impacted the entire family, disrupting family dynamics, and impeding family functioning. My data also suggested that family dynamics and functioning was disrupted in the beginning of the self-harming behavior. Family members adjusted by making parenting changes, they became hypervigilant, and decisions were constantly driven by fear. Participants described having emotional and physical responses to the self-harm such as crying all the time, not sleeping, being irritable, feeling frustrated. Family

dynamics were also impacted. Participants reported having more heated arguments with their spouses and their self-harming children. Other children in the house had difficulty adjusting to the differences in parenting styles. These shifts in dynamics and the emotional responses described by the participants all support framing these findings within a Bowen's family systems theory.

However, what family systems theory fails to support until now is the positive impact the self-harming behaviors had on the family system. The results of my study indicated the shift in parenting style, communication, and level of support resulted in closer, more meaningful relationships within the family system. Although the shift was indeed stressful, the shift often had a positive outcome. The family unit adjusted to the new equilibrium and the system could maintain homeostasis under the new rules and boundaries for the system. This positive shift was one that I did not expect when viewing the data through a family systems lens. So, counselor educators and supervisors could train counselors to help families through these difficulty adjustments so that the family could return to a new equilibrium. Counselors could also work with parents and family members to help make the adjustment less stressful until equilibrium is maintained and even incorporate a resilience model to help frame the challenges experienced by parents and families from a strengths-based perspective. The quicker the family returns to a homeostasis state, the less distress the members will experience.

### **Limitations of the Study**

One of major limitations of this study is transferability. As discussed in chapter one and chapter four, the ability to transfer the results of this study is limited to the

specific characteristics of my participants. In addition to the limitation of transferability that I have already discussed, I had hoped to recruit fathers as participants. However, no fathers contacted me for participation. Therefore, the transferability is further limited to only mothers of adolescent children who self-harm. Researchers and counselors should take caution when transferring the results of this study to population excluded from the sample.

Another possible limitation that I discussed in chapter one was the potential for participants to answer interview questions in such a way that they appear socially acceptable. However, after working with the participants I believe their reported experiences were true and accurate. I do not believe they responded with apprehension or with a desire to please me, the researcher. All the participants had similar stories and experiences, with only slight differences in the details. Since their experiences were so similar, I am apt to believe that they did not respond in ways that they thought would be socially acceptable but instead responded to questions with openness and honesty.

### **Recommendations for Future Research**

My study only begins to touch on the surface of an epidemic occurring to families in the United States. Further research is needed on a much larger scale to gain transferability across parents of all ethnicities and cultures, including same sex parental units. Further research needs to include parental units so that counselors can fully understand the impact of self-harm on the parental unit and the relationship. My research also did not include parents in same sex relationships, so future research needs to explore the experiences of self-harm on same sex couples because self-identity may play a role in

how the parents perceive the experience. Future research is also needed to explore counselors' experiences, training, and perceptions of parents of self-harming adolescent children. I find it somewhat disconcerting that research dated as far back as 11 years ago (Raphael et al., 2006) reported similar findings as my study and that my study confirmed that parents' still have the same responses to the lack of support from mental health professionals. Future research should focus on the where the breakdown of communication and training is within the mental healthcare system so that parents receive adequate services.

My study was also limited to only mothers of self-harming children. Although I recruited both mothers and fathers, I did not have any fathers participate. Future research needs to include fathers, their experiences, and their perceptions of parenting an adolescent child who self-harms. My assumption is that males tend to internalize their emotions and my study required that they talk overtly about their experiences and their emotions with me face to face. Society has taught men that vulnerability is equivalent to weakness. However, women tend to be more relational and typically talk about their emotions and experiences more easily and more frequently. I wondered if I would have had more male participants if my study allowed for complete anonymity such as a private survey. The anonymity might help men feel more comfortable participating because it would allow them to save face. Because my study also illuminated the impact of self-harm on non-self-harming siblings, further research on how other children in a family with a self-harming child are impacted would provide some important data on what all members of a family system face in these challenging situations.



### **Implications for Positive Social Change**

The results of this study have the potential to impact positive social change on both micro and macro levels. Gaining a better understanding of parents' experiences of having a child who self-harms, their needs, and ways that mental health professionals can better support them has the potential to drive changes in training, supervision, and curriculum development for future counselors. For example, the results of this study provide vital information that counselor educators and supervisors that could be used to inform program changes and training to better prepare counselors for working effectively with children who self-harm and their parents and families. For example, helping novice counselors understand the importance of family systems when working with children and helping them understand the function of the family unit, even outside of family therapy courses will help broaden essential awareness. Understanding how the behavior of one family member impacts the other members will hopefully help counselors understand the importance of proactively extending services to parents when the child is the client. Supervisors can help counselors and counselors in training view a client through a systems lens so that they can consider who else in the family system might also need support services. Counselors also need to be aware of how they interact with parents when the child is the primary client. Parents should never feel that counselors are only interested in them when the counselor needs to get paid, or marginalize their importance in supporting the self-harming child as the primary client. Parents have also been the "experts" for the life of their children and to suddenly have that role subsumed by an outside entity is a bewildering, frustrating, and disempowering experience. This

knowledge and understanding in turn has the potential to drive changes in protocol and treatment plans when current counselors work with children who self-harm. For instance, mental health professionals can be proactive in helping parents realize that they also experience distress and offer individual or family services instead of waiting for the parent to initiate the conversation. Direct intervention from a counselor to parents and the family is important, but counselors can also become active in helping activate the deep learning and empathy they have gained from their experiences and reach out to support other families experiencing such a devastating life event. This takes getting counseling students to see themselves as active and engaged in the therapeutic process beyond the therapy room. One of the obvious findings of my study was that what was intended not to be therapeutic was indeed therapeutic as participants described their experiences in open, genuine, and vivid detail and felt a shift in their own perspective in the process. They felt empowered, they seemed to gain a sense of renewed strength in hearing themselves share out loud their stories. They were energized when they left our interview sessions. In parallel form, counselors can potentially help facilitate a similar sense of empowerment within their clients and think about their family and social context in a different way.

On a microlevel, this study has already driven positive social change within my participants. They were all eager to tell their stories. They were excited that someone finally wanted to listen to their experiences. These participants are already impacting social change by being advocates for other children who self-harm and their parents. Thus, they have become social change agents themselves. Their participation could also

drive others to advocate for parents of self-harming adolescent children, resulting in a small but powerful ripple effect of social change. By telling their stories they have also validated the feelings and experiences of future parents who have an adolescent child who self-harms. Those parents will hopefully feel better understood and supported because of the stories told in this project.

### **Recommendations for Practice**

Knowledge is nothing without fruitful practice. Therefore, counselor educators, supervisors, and practicing mental health professionals are encouraged to be proactive in offering their services and support to parents of adolescent children who self-harm. Educational handouts about self-harm and the possible ways parents might feel would be very helpful for parents who feel alone in their experience. School counselors could also provide parents a list of local resources including mental health professionals and medical doctors. Individual or family therapy could potentially lessen the distress caused by guilt, fear, and hypervigilance. Family therapy could be a safe format that drives open communication between the family members and could potentially help parents have a better understanding of what caused the self-harm. Family therapy could also help parents establish better boundaries with their children so that they do not feel as if they are “walking on egg shells.” Counselors and other mental health professional can also remain vigilant for opportunities to offer support groups for parents and families experiencing the challenges inherent in a child or sibling who self-harms which would expand services to a population with significant need. Counselor educators and supervisors could use the information presented here to comprehensively train counselors

to work with parents of self-harming adolescent children and their families.

Organizations such as community mental health agencies and residential treatment facilities could develop treatment protocols for children who self-harm and their families. This could potentially help counselors feel more supported by their organizations when working with self-harming children and their families.

### **Conclusion**

Self-harm amongst adolescent children is on the rise in the United States (Hay & Meldrum, 2010; Tsai et al., 2011). Over the past few years, the number of children treated for self-harm has only increased in number (Centers for Disease Control and Prevention, 2014). The epidemic not only impacts the self-harming child, but also impacts the family system. Parents of self-harming adolescent children experience distress due to the self-harming behaviors, yet they rarely seek services from mental health professionals. Instead, parents are left feeling frustrated, invisible, and alienated because of the lack of support from mental health professionals. I found that parents struggle to understand the self-harming behavior and try to understand the behavior by blaming outside sources such as a situation or an absent parent. They also experience immense guilt, live in constant fear, and are left trying to change their parenting styles with very little guidance or support.

Counselor educators and supervisors need to begin training counselors on how to better work with parents of self-harming adolescent children. Being proactive in offering services is only one step in providing the support parents need. Counselor educators and supervisors also need to help counselors be more aware of the experiences of parents of

self-harming children and methods for best treatment practices when dealing with the feelings and experiences the parents portray. Family systems theory is one theory that counselor educators can use to help their students better understand the shifts that are made by the parents and why the changes cause such distress.

I believe it is imperative that counselor educators, supervisors, and counselors stay educated on the trends happening in the daily lives of our clients. Self-harm is one area that continues to lack information and attention. I hope that this study begins a conversation within these communities that result in positive outcomes for parents of self-harming adolescent children and their children.

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## Appendix A: Advertisement for Participation



Are you a PARENT of a self-harming adolescent child?

Research is being conducted to explore the experiences of parents who have adolescent children who self-harm (i.e. cutting, burning, scratching until skin breaks, not letting wounds heal, head banging). Participation requires a brief telephone interview to determine eligibility and a face to face interview.

Are you 18 years of age or older?

Do you have an adolescent child (12-18 years of age) who self-harmed?

If yes to the above, then you may be eligible to participate!

If you are interested or would like more information, please contact Nikki Russell\*

\*Nikki Russell is a Doctoral Candidate at Walden University. This study is being conducted to meet partial fulfillment of the requirements for the degree of PhD Counselor Education and Supervision.

## Appendix B: Participation Eligibility Sheet

How old are you currently? \_\_\_\_\_

Are you aware of your child's self-harming behavior(s)? \_\_\_\_\_

How old was your child during the time they self-harmed? \_\_\_\_\_

What type of self-harm did/does your child use?  
\_\_\_\_\_

Was your child also suicidal during the time that they self-harmed? \_\_\_\_\_

Are you willing to participate in an interview that will be audio recorded for no compensation? \_\_\_\_\_

What day and time would be most convenient for you to participate in a face to face interview? \_\_\_\_\_



## Appendix C: Interview Schedule

1. Tell me about your experiences with having a child who self-harms.
2. Describe how and when you first found out about your son or daughter's self-harming behavior.
3. Describe how having a child who self-harms affected you.
4. How does having a child who self-harms affect your view of yourself?
5. Describe how having a child who self-harms impacted your relationships with others (i.e. your child, your spouse, friendships, co-workers, etc.).
6. Explain how having a child who self-harms impacted your parenting style.
7. How does having a child who self-harms impact your worldview?
8. Describe what you did to cope with having a child who self-harms?
9. Tell me about your support system through this experience?
10. Explain what support you wish you would have had that might have been helpful.
11. Is there anything else you would like to tell me about your experience with having a child who self-harms?

Appendix D: Observation Sheet

Emotions observed:

Non-verbal behavior/non-emotional behavior observed:

Other notable observations:

## Appendix E: Local Resources

West Texas Centers for MHMR  
Crisis Hotline: 800-375-4357

Christi McCasland, LPC (TX License #62596)

Dawn Irons, MA, LPC (TX License #68173)  
Hope Harbor Counseling  
[www.hopeharbortx.com](http://www.hopeharbortx.com)

## Appendix F: Debriefing Handout

Thank you for participating in this study. Your participation is very appreciated and I am grateful for your willingness to share your experiences with me. Your participation will help add important information to the counseling profession.

Talking about your experiences of having a child who self-harms could cause you some distress. Common stress responses could include anxiety, sadness, trouble sleeping, and anger. If you notice that you are having these responses and they do not subside within a short time frame, you may need additional help to address them. You may refer to your insurance plan's directory for counselors in your network or use the local resources included in the consent form.

Thanks again for your participation,

Nikki Russell

Doctoral Candidate, Doctor of Philosophy in Counselor Education & Supervision  
Walden University