Supporting the Supporters:

How Adolescent Females Respond to a Friend Who Engages in Non-Suicidal Self-Injury.

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Abstract

Non-suicidal self-injury (NSSI) is a maladaptive coping strategy employed by young people in response to feelings of distress. Adolescents are more likely to communicate engagement in NSSI with their peers whom they turn to for support. How young people respond to peers engaging in self-harm, how this impacts the friendship, and how these supporters cope with assuming and administering this role are largely unknown. A qualitative methodology, Interpretative Phenomenological Analysis (IPA), was chosen for this project in order to explore and understand the sense-making experiences of participants. Five female, Year 10 students from a single school in the Hawke's Bay were interviewed. Five themes were identified including NSSI and relationships, burden and responsibility, the helping response, costs of caring, and supporter needs.

The results highlighted the complex nature of this helping relationship and emphasised the need for increased and multifaceted forms of support to be provided to those responding to a peer engaging in self-harm. Young people indicated several factors that would be helpful to assist support providers to continue to help peers in distress including access to information about effective ways to support a friend engaging in NSSI and to be providing this support within a network that functions to resource and support the supporters. High schools are challenged to engage young people in the design and structure of student health and well-being services in their school, and the implementation of a student-led mentoring programme that caters for the support needs of the supporter is advocated.

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To my husband and my family - my safe harbour. With you by my side no sea is too stormy to sail, no goal impossible to reach. Thank-you for going above and beyond in the childcare department allowing me all those uninterrupted hours at the library, and for the lengthy stays in Taupo for the grandchildren while I power-wrote chapters at the dinner table. Your encouragement and interest in the research process was truly valued.

To my supervisor Dr John Fitzgerald – your direction, humour, and timely advice have been immensely appreciated.

Finally, I dedicate this thesis to the adolescents who participated in this project, sharing their experiences and insights with such honesty and openness, and to all the other brave supporters out there. Kia kaha!

Hope is like a road in the country;

there was never a road, but when many people walk on it,

the road comes into existence

– Lyn Yutang

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Introduction

Non-suicidal self-injury (NSSI) is the intentional destruction of body tissue that occurs outside of cultural acceptance and without suicidal intent (Nock, 2009). This behaviour is considered a maladaptive coping strategy used by a significant proportion of the adolescent population, with reported prevalence rates between 12-21% (Favazza, DeRosear, & Conterio, 1989; James, 2013; Ross & Heath, 2002). NSSI is a risk factor for adolescent suicide (Klonsky, May, & Glenn, 2013). Thus, effective support provided early with individuals engaging in this behaviour is of utmost importance.

Providing robust strategies and support for young people engaging in NSSI can be challenging, as can accessing this particular adolescent population. Research shows that the majority of adolescents who harm themselves do not seek help (Evans, Hawton, & Rodham, 2005; Fortune, Sinclair, & Hawton, 2008b). There is consensus in the literature that of those who do, most will turn to a peer rather than a family member or helping professional (De Leo & Heller, 2004; Fortune et al., 2008b; Michelmore & Hindley, 2012).

Despite peers being favoured for disclosure and support provision, peer relations between young people who engage in NSSI and those who do not, can be a cause of worry due to concerns regarding the contagion aspect of self-harm within a social context. Interpersonal factors have been connected to the initiation and repetition of NSSI behaviours (James, 2013; Muehlenkamp, Brausch, Quigley, & Whitlock, 2013). McAndrew and Warne (2014) feature an excerpt from a participant interview describing how a friend's narrative impacted on a participant's decision to self-harm by informing the participant of the apparent benefits self-harm brings.

> *"she (friend) just said… it just relieved the stress. It relieves my stress, but it's not really a good thing. I mean the reason I done it was 'cos someone else was talking about it and saying how good it was" (p. 573).*

There are mixed results in the literature regarding the quality of support adolescents provide peers with mental health concerns, and engagement in NSSI in particular (Mason, Hart, Rossetto, & Jorm, 2015; Nada-Raja, Morrison, & Skegg, 2003). Young people engaging in NSSI rate their conversations with peers as being "slightly more helpful relative to health professionals, but …were still perceived as not being very beneficial" (Muehlenkamp et al., 2013, p. 77). Perceived lower social support has been linked to NSSI as a risk factor for engaging and maintaining this behaviour, (Heath, Ross, Toste, Charlebois, & Nedecheva, 2009; Muehlenkamp et al., 2013), and James's (2013) research on social contagion would suggest that being exposed to NSSI has a negative effect on adolescents who do not have a history of NSSI. This finding is of concern given that those who self-harm will most likely confide in a peer, who may or may not have prior personal experience with this behaviour. For example, a large study of 6,020 adolescents in England discovered that 59% of participants were aware of peers engaging in NSSI (Fortune et al., 2008b).

Armiento, Hamza, and Willoughby (2014) draw attention to the positive side of peer relations between young people engaging in NSSI and their non-NSSI peers stating that positive peer responses to a disclosure of NSSI "may reduce the self-injurer's psychological distress, facilitate greater understanding and acceptance and promote relationship equality between the self-injurer and confidant" (p. 530).

So how do young adolescents respond to and support a friend engaging in self-injury, and what effect does this have on the young supporter?

Relevance of this Research

The voice and perspective of the adolescent 'supporter' has remained largely unheard in the NSSI literature so far. This study explores how young females make sense of a peer disclosure of NSSI, how they respond, what support they provide, and how this process affects the supporter's well-

being. This information has implications for school policies concerning NSSI, how school staff respond to students engaging in self-harm and their peers affected by this knowledge, parents, and helping professionals in the community. The answers to these questions contribute to an informed approach of how best to 'support the supporters' to maintain their psychological well-being, whilst resourcing supporters to provide effective support to their peers. As Armiento et al. (2014) point out, if peers respond in a supportive manner to a disclosure of NSSI, this positive response may encourage the young person engaging in NSSI to seek more specialised, formal help. Thus extending the young person's support network and perhaps relieving some of the support burden from the shoulders of their peer.

To embed this study in what is currently known about young adolescents supporting peers engaging in NSSI, a review of relevant literature both internationally and within New Zealand is provided in the next chapter. NSSI is defined and prevalence rates of NSSI for the adolescent population are given. There are conflicting findings regarding NSSI and prevalence rates between genders. The reasons for these differences are discussed and the functions that NSSI serves are described. Characteristics of friendships are detailed within the social and developmental context of early adolescence, and gender differences as they apply to friendship functions are noted.

Where adolescents seek help from in times of distress and specifically for support regarding NSSI, is explored. There is a wealth of information regarding barriers to adolescent help-seeking, but upon examining the helping relationship from the adolescent supporter's perspective, the dearth of information detailing this experience becomes evident. There is however, relevant research regarding general support strategies that young adolescents apply concerning a distressed peer. Support provider's goals for this interaction, their level of mental health literacy, and gender all affect the type and quality of support provided. The literature review concludes with an

examination of New Zealand research in this area, emphasising the scarcity of studies concerning young adolescents and NSSI.

The Method chapter describes the recruitment process along with general information about participants and the process undertaken to explore the topic under research, including an account of how the data was analysed. Past research in the field of NSSI has predominantly adopted a quantitative approach. This study is underpinned by a qualitative methodology, Interpretative Phenomenological Analysis (IPA; J. Smith (2004)). IPA promotes the gathering of detailed insights from participants, rather than the more superficial information that a quantitative approach would provide. IPA as a research methodology is expanded upon in more detail before ethical considerations of exploring such a sensitive topic with a vulnerable population is discussed.

The Results chapter provides a detailed analysis of themes that were interpreted from the data collected from participants, including excerpts from participant transcripts as per the IPA paradigm. A Discussion chapter embeds these themes within the existing literature available, notes limitations to the study, and suggests future directions for research in this area.

Literature Review

NSSI, adolescent friendships and the process of both seeking and providing support offer relevant strands of information that woven together present an understanding of how adolescents support friends in distress. Relevant New Zealand research is then outlined regarding NSSI and an adolescent population, including indigenous youth.

Non-Suicidal Self-Injury

NSSI is the intentional destruction of body tissue that occurs outside of cultural acceptance and without suicidal intent (Nock, 2009). The presence or absence of suicidal intent is used to differentiate between NSSI and more general terms such as self-harm, deliberate self-harm, self-injury, or self-mutilation. Some adolescents engage in NSSI to manage their distress and thus avoid ending their lives, (Breen, Lewis, & Sutherland, 2013). However, engaging in NSSI is also viewed as a risk factor for future suicidal behaviour, (Klonsky et al., 2013; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006) .

Definitions of self-harm and the terms used to describe this vary throughout past research, as have research methodologies (Swannell, Martin, Page, Hasking, & St John, 2014), which make comparisons between results challenging. For example, Muehlenkamp, Claes, Havertape, and Plener (2012) in their systematic review of 53 studies of participants aged between 11-18 year olds in community settings, concluded that assessment using single item questions led to lower prevalence rates than using specific behaviour checklists to gather this information. The inclusion of an NSSI disorder within the DSM-5, albeit as a 'condition requiring further study' (American Psychiatric Association, 2013) may assist in streamlining approaches for further research. Incorporating a standalone diagnosis of NSSI in future editions of the DSM would indicate that it can exist in isolation from other mental health diagnoses. For the purpose of this thesis the terms self-

harm and NSSI will be used interchangeably to refer to the same behaviour and to imply the absence of suicidal intent.

Internationally prevalence rates have been reported between 15-20% (Muehlenkamp et al., 2012). Lifetime prevalence rates for NSSI in adolescent community samples in NZ range from 18-55% and in Australia rates vary between 12-23% (James, 2013; M. Wilson et al., 2015). Breaking this down further into early to middle and middle to late adolescence, a recent large survey of young Australians found 11% of 12-15 year olds had self-injured compared to 23% of 16-17 year olds (Lawrence et al., 2015). Whereas a longitudinal study underway currently in New Zealand established that 18% of 13 year olds had engaged in NSSI at some point compared to 28% of 15 year olds (M. Wilson et al., 2015). In terms of a clinical population Fortune, Seymour, and Lambie (2005) completed a random sample of 100 client files at a Child, Adolescent and Mental Health Service in Auckland, New Zealand, finding just under one half of adolescents who presented for an initial assessment were recorded as having engaged in self-harm. Perhaps the prevalence rate could have been higher still, as the assumption here is that all young people in the sample were asked questions about NSSI and that the practitioner recorded their responses accurately.

This difference in prevalence rates between New Zealand and Australia can be partially explained by the unique social, economic and cultural milieu of each country, but also understood in relation to inter-study characteristics such as the age of participants surveyed, definition of self-harm and methodology adopted. Although the prevalence rates for NSSI drop dramatically in early adulthood (M. Wilson et al., 2015), the numbers of adolescents self-harming results in significant costs for individuals, the family system, and society. Substantial financial costs are also incurred when support services are engaged.

Historically female prevalence rates for NSSI have been documented as higher than prevalence rates for males engaging in this behaviour (Andover, Morris, Wren, & Bruzzese, 2012; Brown, 2015; De Leo & Heller, 2004; Fortune, Sinclair, & Hawton, 2008a). Coggan, Bennett, Hooper, and Dickinson (2003) in their sample of 3,265 high school students discovered that females were significantly more likely to have both thought about self-harming and to have self-harmed than males. However, Garisch (2010), with a sample of 593 participants (mean age 19.7 years), found no significant gender differences in the reported lifetime prevalence rates of NSSI. Differences in methods of NSSI used between males and females, with females more likely to cut and males more likely to engage in self-battery, has led to the insight that methodologies measuring NSSI purely through cutting behaviours may have reduced recorded prevalence rates for males, and thus account for this gender difference (Swannell et al., 2014). Jose, Ryan, and Pryor (2012) found prevalence rates for NSSI between the genders to be similar until the transition into adolescence, at which point they noted prevalence rates for females increase. The authors suggested possible reasons as the earlier onset of puberty for females which has been connected to an increased vulnerability to mood and other difficulties, and that females report more interpersonal difficulties with family and friends than males (Jose, Ryan, et al., 2012). Conflict between a young person and her/his family or friends is a contributing factor for engaging in NSSI (Fortune et al., 2008a; McAndrew & Warne, 2014), and managing emotional distress is a function of NSSI for many (Klonsky, Victor, & Saffer, 2014; Nock & Prinstein, 2005).

NSSI can serve many other functions including self-punishment, or meeting interpersonal needs such as influencing others to achieve a particular end or signalling of distress, but overwhelmingly it is used to regulate affect (Klonsky, 2007; Klonsky et al., 2014; Muehlenkamp et al., 2013; Nock & Prinstein, 2005; M. Wilson et al., 2015). Age of onset is typically found to be approximately 13-14 years of age (Klonsky et al., 2014).

Satisfaction with social support has been identified as a protective factor against the onset of NSSI (Wichstrom, 2009). Research shows that social support can be influential in improving general mental well-being and support successful coping, especially in times of distress (McGrath, Brennan, Dolan, & Barnett, 2014). This buffer or protection that social support can afford has led some in the mental health field to recommend that supportive peers as well as family members are identified and co-opted by support services in order to maximise therapeutic effectiveness for the adolescent engaging in NSSI (Bresin, Sand, & Gordon, 2013; Klingman & Hochdorf, 1993).

Friendships in Adolescence

Adolescence is a period of immense physical, emotional and social change. No other life stage sees such vast development occurring in the mind, body and social arenas of human life. Having moved through childhood with 'play mates' (Buskirk-Cohen, 2012) in adolescence peers become confidants who, in many cases, take over the role of providing the greatest levels of emotional and social support from a parent figure (del Valle, Bravo, & Lopez, 2010). In adolescence peers depend more on each other for intimacy, self-disclosure, and help in solving problems. Intimate disclosure becomes more central to friendships. As young people share more both in breadth and depth about themselves and their lives, peers become closer and friendship bonds become stronger (Buskirk-Cohen, 2012).

According to Furman and Buhrmester (1992) reasons for this increase in closeness and support are an attraction to those with similar concerns such as self-exploration, uniting against conflict with authority figures such as parents or teachers, and an interest in sexuality which may be difficult to express with adults. The development of interests that are not shared by other members of the family, and the task of forging alliances with like-minded peers in anticipation of conflict within and outside the peer group, also provides motivation for this change in friendship function (Furman & Buhrmester, 1992). Although parents still retain primary responsibility for providing instrumental

support and tangible help such as transportation and financial assistance, adolescent peers increase provision of this practical assistance alongside emotional and social forms of support (Helsen, Vollebergh, & Meeus, 2000).

Hartup (1992) described four functions of friendships during adolescence. Friendships enable the development of social skills; afford young people knowledge about themselves, others and the world; offer emotional support when faced with adversity; and provide a blueprint for all future relationships as intimacy and mutual regulation are experienced during early friendships.

Friendships fulfil different purposes for females than males in adolescence. Girls tend to have more friends, place more importance on affirmation and connectedness, and report more intimacy and support within friendships than boys do (Buskirk-Cohen, 2012; von Salisch, Zeman, Luepschen, & Kanevski, 2014). They rate their relationships as more positive and of higher quality with greater levels of disclosure than male adolescents rate their friendships (Hill & Swenson, 2014; Kenny, Dooley, & Fitzgerald, 2013). Females attend more to their own and others' feelings, are more likely to report that a friend's problems matter to them compared to boys, and both offer and receive support more frequently than males do (Barton, Hirsch, & Lovejoy, 2013; Swenson & Rose, 2009; von Salisch et al., 2014). It is hypothesised that this may be due to the more developed social perspective-taking skills females display (R. Smith & Rose, 2011).

However, participating in close relationships where personal disclosure is the norm does have some disadvantages for females. Higher intensity relationships can provide an opportunity for co-rumination to occur. Co-rumination is the "excessive discussion of problems within a dyadic relationship" (Buskirk-Cohen, 2012). This can include discussing the same issue over and again, focussing on negative feelings, and encouraging each other to engage in this practice. Co-rumination creates further emotional distress and adolescent girls co-ruminate more than any other

age group (Rose, 2002). Jose, Wilkins, and Spendelow (2012) completed a six-month longitudinal study of 575 adolescents aged 13-16 years and discovered females reported higher levels of both rumination and co-rumination than males.

It is also possible for peer support networks to be ineffective at providing the assistance a young person needs specific to their situation if those peers are ill-equipped to cope with such a situation. That is, a well-intentioned friend might not possess the skills to recognise or adequately respond to a young person in distress. So-called support networks can contain weak connections between members which are not conducive to providing effective support. Or, these networks can cultivate and sustain a negative culture that is permissive of friends belittling each other, thus leading young people to avoid seeking further support (McGrath et al., 2014). Conflict with close friends is more prevalent in early adolescence than late (Kenny et al., 2013). This suggests that the early to mid-stages of adolescence can be troubled with peer challenges and disagreements, changing alliances (or the strengthening/weakening of existing ones), at the same time that support is desired to negotiate these sometimes difficult periods.

Therefore, female friendships entering the period of adolescence can develop an intensity and closeness (positive or negative) unmatched by their male counterparts. When this development is positive the increase in both depth and frequency of personal disclosures and the accompanying increase of emotional support, can lead to a close attachment between friends far beyond that of childhood comrades. The provision of mutual support has many benefits such as increasing social connections and developing perspective-taking skills and empathy, but also disadvantages such as the negative outcome of excessive co-rumination between friends. Despite the ever-changing and at times conflicting wider context of peer relationships that close friendships sit within, these friendships are viewed as an important source of comfort, assistance and aid when problems occur, such as NSSI and the associated distress. It is at these times that friendships are utilised for support.

Help-Seeking

The World Health Organisation defines help-seeking as "any action or activity carried out by an adolescent who perceives himself/herself as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way" (Barker, 2007, p. 2). There is an element of secrecy that pervades NSSI generated by feelings of shame, guilt, confusion, as well as fear that a disclosure will lead to negative consequences such as confidentiality being breached, being labelled as an attention-seeker, or being considered mentally unwell (Fortune et al., 2008b; Klineberg, Kelly, Stansfeld, & Bhui, 2013; McAndrew & Warne, 2014; Rowe et al., 2014). These concerns contribute to low levels of disclosure and help-seeking attempts from any source (Evans et al., 2005; Klineberg et al., 2013). However, it is also evident that some young people want help in some form for their NSSI (Idenfors, Kullgren, & Renberg, 2015). Evans et al. (2005) discovered in their large survey (6,020 participants) of 15-16 year olds in England that adolescents engaging in self-harm were most likely to feel the need to access help but less likely to attempt to find this compared to adolescents not engaged in NSSI. Seeking assistance from formal sources such as a GP, mental health practitioner, or a religious leader occurs less frequently compared to informal connections (De Leo & Heller, 2004), but can be encouraged or facilitated by the informal helper (Idenfors et al., 2015). A large school-based survey in England with 5,293 participants aged 15-16 years found that only 8% of females had contacted a GP after an episode of self-harm and 8% had accessed assistance from a psychologist or psychiatrist (Fortune et al., 2008b). This was in contrast to 49% of female participants who sought help from a friend and 25% who made contact with a family member for this support.

Help-seeking from informal sources such as a peer group, parent, or an adult in the community are consistently shown in the literature to be an adolescent's first choice of support (Evans et al., 2005; Hawton, Rodham, & Evans, 2006; Mason et al., 2015). The report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Lawrence et al., 2015) established of the nearly

two thirds of adolescents who had accessed informal help for a range of emotional or behaviour problems, 62.2% of females had received some help from a friend.

Past research on help-seeking as a result of NSSI overwhelmingly demonstrates that adolescents will reach out to their peers over and above any other form of help, formal or informal (Goodwin, Mocarski, Marusic, & Beautrais, 2013; Hawton et al., 2006; Michelmore & Hindley, 2012; Ryan, Heath, Fischer, & Young, 2008). For example, Bresin et al. (2013) found that 65% of people who engage in NSSI talk with their friends about their experience. Adolescents providing support to a young person in distress are also more likely to approach a peer for assistance, either a friend or a mutual friend of the support and distressed person, rather than approaching an adult for this assistance (Fortune et al., 2008b; Sharkin, Plageman, & Mangold, 2003). Friends do indeed appear to be the "resource of choice during times of emotional distress" (Barton et al., 2013).

There are several possible explanations as to why this might be. Research conducted in Australia by C. Wilson and Deane (2001) found that adolescents are more likely to approach someone for support if they have a strong and open relationship with this person and perceive them to be trustworthy and easy to relate to. A member of an adolescent's peer group would most often fit these criteria. Peers are also easily accessible and can provide support in a timely manner that is non-threatening, non-stigmatising, can occur in a familiar environment (Barton et al., 2013), and is free. As adolescents begin to draw more emotional support from friends than parental figures (del Valle et al., 2010) it may be that choosing a friend for support attains more than one goal. That is, accessing support from a trusted friend may have the added benefit of further cementing this relationship (Sullivan, Marshall, & Schonert-Reichl, 2002). Past experiences of help-seeking may predict future help-seeking behaviour (Klineberg et al., 2013; Zeman & Garber, 1996). As friends have been rated as more helpful than other sources (Ryan et al., 2008), this may in itself motivate repeat requests for assistance as required on future occasions.

Regarding gender differences and help-seeking, past research has presented mixed findings as to whether males or females are more likely to seek help. According to Lawrence et al. (2015) adolescent females are more likely to solicit help for emotional or behavioural problems whether this is from a formal source (23.6% of females compared to 12.7% of males) or informal source (74.3% of females compared to 52.1% of males). Females are more likely to access informal support than males (74.3% of females compared to 52.1% of males); and are more likely to access this support from a friend (62.2% compared to 35.1% of males) (Lawrence et al., 2015, p. 125). However, Michelmore and Hindley (2012) in their systematic review of help-seeking for suicidal thoughts and self-harm in adolescent and young people up to age of twenty-six, discovered that only four of the eight studies that compared gender rates found this difference to be significant. The authors concluded that the type of help measured (informal of formal) influenced this gender difference: women were more likely than men to seek help from their social network, whereas men were significantly more likely than women to seek assistance from emergency services (Michelmore & Hindley, 2012).

What kind of assistance are those seeking help in search of? According to Derlega and Grzelak (1979) there are five functions of a disclosure of distress:

1. Receiving social validation
2. Gaining social control (or managing others' impressions of the self)
3. Achieving self-clarification
4. Exercising self-expression
5. Enhancing relationship development

A web-based survey found that young female adults (18 years of age and older) engaging in NSSI preferred their friends to help by acknowledging the severity of their distress, directly asking how they might be helpful, and offering their time and availability (Ryan et al., 2008). Sullivan et al.

(2002) suggest that adolescents in distress are either seeking emotional support or instrumental support (tangible help such as transportation or financial assistance) and will choose their support person based on these goals (a parent for instrumental support or a friend for emotional support). Confidentiality, respect, and help to address precipitating factors for self-injury are also desired by those seeking assistance (Klineberg et al., 2013)

There are many obstacles that prevent youth in distress from accessing any form of help. The following barriers are commonly mentioned in literature concerning self-injury and adolescent help-seeking:

1. Attitudinal barriers - a sense of independence and autonomy which correlates to developmental tasks at this life stage
2. Belief that the problem will resolve itself, and/or that no one can help
3. Practical barriers such as a lack of time or money
4. Lack of knowledge of services or there being no appropriate service available
5. Lack of transport
6. Presence of fear or stigma that prevents the pursuing of support (Nada-Raja et al., 2003).

Rowe et al. (2014) in their systematic review of 20 studies concerning help-seeking behaviours and self-harm in adolescence divided barriers into two thematic categories – interpersonal and intrapsychic. Interpersonal barriers included the belief that others would not understand their self-harming behaviour, that confidentiality may be breached, being seen as 'attention-seeking', that others would react negatively or would not be able to help, and a fear of being stigmatised. Intrapsychic barriers included the presence of depression, anxiety and suicidal ideation; the minimisation of self-harm as a problem; and the belief that one should be able to cope on his/her own. A perception of self-injury as something done on the spur of the moment and so not serious, important or to be dwelt on, fear that seeking help would create more problems for the person

and/or hurt people they cared about, and past negative experiences of help-seeking have also been identified as obstacles to seeking help (Fortune et al., 2008b; Klineberg et al., 2013).

A report prepared by Horwood and Fergusson (1998) for the New Zealand Ministry of Health noted that young people with mental health disorders most often gave one of three reasons for failing to seek help: 1) it had not occurred to the young person to seek help; 2) they did not believe they needed help and could handle any problems on their own; and 3) they thought the problem would get better on its own. The following three barriers were of particular concern to young females in the research: concern for the opinions of others (C. Wilson & Deane, 2001), trust and confidentiality issues (Fortune et al., 2008a). Therefore the act of seeking assistance is a dynamic rather than static process determined by factors such as fluctuating perceptions of the problem, reasons to seek help (or not) that change over time, and changes within the context that help is being sought (Klineberg et al., 2013).

In view of the propensity for adolescents to reach out to their fellow peers over other sources of help available and the many and varied obstacles that require navigation to make this contact, it is extremely important that young people receive adequate support once this connection has been made. As complicated as the process of help-seeking can be, providing support is also not a straightforward transaction between the adolescent help-seeker and provider. There are certain benefits but also costs to the support provider particularly when attention is turned to the provider's emotional health and wellbeing.

Help-Providing

Given there are a significant number of young people turning to peers for support in times of distress including assistance in response to NSSI, it is troubling that there is a dearth of research

exploring the young support-provider's experience in responding to this call for help. This is especially surprising given research that indicates a positive correlation between young people in distress (including those engaging in self-harm) who access informal assistance from peers, and access to formal help services (Idenfors et al., 2015; Nada-Raja et al., 2003; Pinto-Foltz, Hines-Martin, & Logsdon, 2010). If informal peer support has a positive effect on a distressed person's wellbeing, and can increase connections to health services, there may be an opportunity here to further enhance this support by understanding the process of providing support from the supporter's perspective. The majority of existing research in this area focusses on late adolescence or young adulthood with methodologies that capture intention to provide support rather than examples of actual support provided (Barton et al., 2013; Clark, MacGeorge, & Robinson, 2008; Jorm, Wright, & Morgan, 2007; Kelly, Jorm, & Rodgers, 2006; MacGeorge, 2001). These responses are for a range of distress signs rather than specifically for a peer engaged in self-harm (Denton & Zarbatany, 1996; Mason et al., 2015; Yap, Wright, & Jorm, 2011). However, this information does provide some insights into the support that is provided and how this is delivered; whether this assistance is helpful, unhelpful, or of mixed value; and importantly how the support-provider is affected by this experience and their relationship with the distressed recipient.

Peers have been described as 'gatekeepers' (Isaac et al., 2009), 'on the front lines' (Sharkin et al., 2003), and the 'resource of choice' for young people in distress (Barton et al., 2013), and we know that the greatest increase in peer support strategies occurs between middle childhood and early adolescence (ages eight to fourteen) due to a surge in mastery of a variety of verbal strategies (Clark et al., 2008). But what do these support strategies look like? The literature offers a range of techniques commonly employed by youth to meet the needs of a distressed peer including talking and listening, which may include offering sympathy and advice (Sharkin et al., 2003), companionship (Clark et al., 2008), distraction from the distressing issue (Denton & Zarbatany, 1996), telling and/or asking advice from someone else (Jorm et al., 2007); to strategies that require more advanced

cognitive and emotional skills such as giving or seeking information, assessing the problem and risk of harm, encouraging the person to tell someone (Jorm et al., 2007), displaying optimism by way of reassuring or predicting a positive outcome (Clark et al., 2008), and providing excuses for the distressed person's behaviour or validating those offered by the person in distress (Denton & Zarbatany, 1996).

It would appear that in response to a distressed peer young to mid-aged adolescents most commonly provide general emotional support in the form of talking and listening while showing understanding and sympathy and offering companionship (Clark et al., 2008; Jorm et al., 2007; Sharkin et al., 2003; Yap et al., 2011). Variables such as the help-provider's gender and age, help-seeker's gender, and the type of distress exhibited, all have an impact on the kind of support that is provided to a peer (Yap et al., 2011).

Denton and Zarbatany (1996) suggest that the type and effectiveness of support provided depends in part on the young provider's sensitivity to a peer's distress, interpersonal skills, and experience meeting the needs for which the peer is seeking help. Their findings suggest that adolescents are in a period of transition and lack many of the relational skills required to construct a "more psychologically comfortable reality" for those in distress, (p. 1371). However, despite this age-related lack of ability Denton and Zarbatany (1996) found adolescent girls still felt better after their conversations with adolescent friends. Perhaps reinforcing the notion that companionship accompanied with an opportunity to air one's worries with someone who is similar and trustworthy affords enough validation and signalling of care and concern to alleviate at least some distress.

Clark et al. (2008) found in their evaluation of peer comforting strategies that 10-15 year olds overwhelmingly assessed companionship ("let's do something together") as the preferred option to attend to a distressed friend (55% of participants) out of the six strategies investigated, with offering

advice (13%) and sympathy (9%) rated second and third respectively. Taking part in activities with others for the age group studied is an important part of what it means to be friends at both an abstract and practical day-to-day level, which may help account for why companionship was such a popular choice. The authors also surmised that companionship was highly regarded because children and young people may have a stronger expectation of compensatory nature of companionship from friends in times of difficulty due to having these modelled by adults at a younger age. Compensatory behaviours are actions that present something to make up for the distress experienced, such as "I'm sorry you are so sad. Will an ice-cream cone cheer you up?" (Clark et al., 2008, p. 335).

MacGeorge's analysis of the literature exposed two broad goals that support-providers seek to achieve when engaging with a support-seeker; 1) alleviating emotional distress; and 2) determining what action(s) the support-seeker can or should take in response to the difficulty or crisis. The literature also suggest ten additional more defined goals of support provision, five of which are emotion-focused, three are problem-focused, and the last two concern the influence of attributions of responsibility.

These support-provider goals are listed as follows (adapted from MacGeorge (2001)):

Emotional distress goals.

1. Communicating sympathy
2. Making the support-seeker feel cared about
3. Helping the support-seeker understand his/her feelings
4. Suggesting activities that distract the support-seeker from their feelings
5. Dismissing the support seeker's feelings

Problem-focussed goals.

1. Assisting the support seeker to understand the problem

2. Encouraging a positive perspective on the problem
3. Helping the support-seeker to prevent subsequent problems

Attributions of responsibility.

1. Assisting the support-seeker to recognise his/her own responsibility for the problem
2. Others' responsibility for the problem

If a young person assuming a support-provider role believes their support-seeking peer is responsible for their own distress, their motivation to assist may decline. That is, willingness to help declines as perceived responsibility increases (Weiner, 1995). If the support-provider attributes responsibility more to the help-seeker, the provider becomes less concerned with showing empathy and instead their interest turns to making the distressed person assume more responsibility. This could lead to communication that contains more blaming or criticising and less expressions of care and concern, and thus less sensitive and effective support being provided (MacGeorge, 2001).

Young people may also respond in ways that recipients and mental health practitioners deem inappropriate and ineffective. Many of these responses fall into the following categories: minimisation - treating the problem or associated feelings as insignificant (Clark et al., 2008); providing the distressed person with drugs and alcohol, using violence, or manipulation (threats to withhold friendship until behaviour changes), telling the person to "get over it", or ignoring problem (Kelly et al., 2006). Therefore not all actions taken throughout the duration of a helping relationship may be defined by either party as 'helpful' (Rissanen, Kylmä, & Laukkanen, 2009), and nor would this be a realistic expectation.

Some researchers have concluded that adolescents are ill-equipped to recognise signs of distress and to respond to these due to a low level of mental health literacy (Jorm et al., 2007) and due to developmental needs at this stage which conflict with carrying out this task. Pinto-Foltz et al. (2010)

studied female participants aged 13-15 finding that whilst adolescents think about mental health concepts similarly to adults, their emotional responses to a peer with mental illness often prevented an effective response being given. Curiously, adolescents have been found to have less sophisticated knowledge about identifying signs of distress and responding effectively compared to young adults, yet are more confident about providing this help to their peers (Jorm et al., 2007).

However, simply not doing anything at all in response to a peer's distress is a startling reality for many in need (Sharkin et al., 2003). Kelly et al. (2006) conducted a large mental health literacy survey with 1,137 Australian adolescents aged 13-16 years in order to determine how young people are likely to respond to a peer with mental illness or severe behavioural problems. One fifth of participants indicated they would not take any form of appropriate action to help a friend. Possible reasons suggested by the authors for this inaction were fear that one could worsen the situation by doing the wrong thing or simply lacking the ability to empathise (Kelly et al., 2006). Young people may also lack the capability (sensitivity, interpersonal skills, and experience) (Denton & Zarbatany, 1996) and/or the motivation to respond in an effective manner.

Bringing our attention to gender differences and the provision of support, generally adolescent females are more knowledgeable of their friends distress due to higher levels of positive friendship quality and disclosure in their friendships (Swenson & Rose, 2009). Australian research demonstrates that females in early to mid-adolescence are more likely to provide support to a close friend or family member than males (Yap et al., 2011). In terms of helping styles, females are more likely to provide general social and emotional support, more likely to engage an adult to help, are less likely to provide inappropriate help, and less females (10.2%) than males (30%) are 'ineffective helpers' (no help provided or only inappropriate help offered) (Kelly et al., 2006). Males show less flexibility in their helping style, offering the same responses to different mental health issues (Kelly et al., 2006). These significant gender differences may be due to gender socialisation effects, and to

females placing more value on person-centred approaches to helping and supporting others than males do (Barton et al., 2013; Yap et al., 2011).

Clark et al. (2008) state that the provision and receipt of peer support leads to positive outcomes for both parties. Higher positive relationship quality, an increase in the frequency of social support provided, lower negative friendship quality, and higher rates of disclosure occur for both parties when one member experiences a low to medium level of internalising symptoms of distress (emotional and behavioural difficulties directed inwards such as symptoms of depression and anxiety) (Hill & Swenson, 2014). A positive response to a disclosure of NSSI may facilitate deeper understanding and acceptance within the friendship (Armiento et al., 2014). As well as friendship benefits there may be personal benefits to offering support in times of distress including enlarging one's capacity for empathy, and honing social, emotional and problem-solving skills.

Conversely, there are possible disadvantages to providing this support that arise when we consider the cognitive, social and emotional maturity that exists at early to mid-adolescence. The need for independence at this stage can prevent the help-seeker from accessing support believing "it is one's own responsibility to get better" (Idenfors et al., 2015). This age-appropriate requirement for individuality and self-governance may also prevent the help-provider from engaging adult assistance, leaving the adolescent to assume high levels of responsibility for caring for a distressed peer. Sharkin et al. (2003) and Fortune et al. (2008b) found that college students and mid-aged adolescents were far more likely to consult another student to aid in helping a peer in distress than an adult or health service provider.

Helping others can involve other costs such as effort and the foregoing of rewards (Sierksma, Thijs, Verkuyten, & Komter, 2014). Assuming high levels of responsibility for another person in distress could be detrimental to the help-provider's wellbeing in many ways including an increase in stress

(Coggan, Patterson, & Fill, 1997), neglecting other relationships or commitments, with potential for significant detrimental effects to the help-provider's mental health. Empathetic distress or being unable to emotionally distance oneself from a distressed friend, although related to high positive relationship quality and high social perspective taking skills, does have an emotional cost (R. Smith & Rose, 2011).

The promise of secrecy that some distressed peers place on support-providers can be upsetting and add further worry to the help-provider. Coggan et al. (1997) completed focus groups with New Zealand youth aged 15-24 to examine responses to high-risk peers. One of the study's findings was the isolation and compromise young people experience when required to keep a disclosure of suicidality to themselves. Young people may feel duty-bound to keep this disclosure a secret and forced to assume a support role in the perceived absence of any other choice.

The opportunity for social contagion to occur (in this instance when NSSI is communicated by the help-seeker to the help-provider and the help-provider then engages in this behaviour to attempt to manage their own difficulties) and modelling, can also result in negative outcomes for the provider of support. De Leo and Heller (2004) established in their large Australian sample of 15-17 year old students that a significant predictor of increased self-harm for females was being exposed to a friend or family member who had self-harmed in the previous year.

If assistance is being provided consistently and/or over a long period of time, supporter burnout can occur. Research on depression and interpersonal rejection has demonstrated that a continuation of problems and distress by the support-seeker can result in support-providers responding in a less supportive way (MacGeorge, 2001), which forecasts poor outcomes for an over-burdened provider and may leave the help-seeker's needs unmet.

Despite the possible disadvantages incurred when providing support to a friend there are many adolescents that choose to offer this assistance regardless of the personal sacrifices they may be required to make. People who choose to help a peer in distress when others choose to abdicate responsibility for intervening are referred to by Zimbardo (2009) as 'heroes'. Zimbardo defines the construct of 'hero imagination' as a focus on one's duty to help and protect others, which forms the basis for a hero's actions in difficult circumstances. There may be 'hero-like' traits or characteristics that prompt some adolescents to help others, whilst others refrain from providing this assistance.

In summary, based on the literature presented the following general picture emerges - the young adolescent support-provider has a narrow range of strategies at their disposal to meet a variety of goals directed at regulating the support-seeker's emotions, assisting with the problem(s) at hand, which also depend upon the support-provider's perceptions of responsibility. Confidence in ability to assist is high, although actual ability would appear to be less robust, particularly for males. Along with benefits to the support provider of engaging in this helping relationship, there are also many pitfalls to the individual. Furthermore, the lack of research regarding the adolescent help-provider's experience of helping is conspicuous in its absence. This scarcity is also reflected within the wider topic of NSSI and related topics within the Aotearoa/New Zealand context, particularly concerning the adolescent population.

Aotearoa/New Zealand Context

There are significant gaps in the literature regarding NSSI and the adolescent population of Aotearoa New Zealand. Whilst there has been a dramatic increase in research on NSSI internationally over the past decade, there has been no research published from the peer supporter's perspective. However, the small number of studies drawing from New Zealand samples and containing findings relevant to the current study are outlined below.

There are mixed findings regarding prevalence rates of NSSI for rangatahi Māori (indigenous youth of New Zealand). M. Wilson et al. (2015) suggest prevalence rates for Māori are similar to the rest of the New Zealand adolescent population. However, Garisch (2010) found Māori rangatahi were more likely to engage in self-harm than non-Māori (Māori participants made up 9% of the study's sample). Nada-Raja et al. (2003) in their population-based longitudinal study of help-seeking for self-harm in young adults aged 26 years discovered that Māori women were most likely to self-harm (17% compared with 6% for all other ethnic groups). The Youth '07 Survey (Fortune et al., 2010) of secondary school students established that a greater proportion of Māori students (25.3%) reported engaging in self-harm over the last twelve months compared to New Zealand European students (19.4%). Coggan et al. (2003) with a sample of 3,265 high school students reported a lifetime prevalence rate for self-harm as 17.2%. The authors also found that those aged 13-14 years were more likely to engage in self-harm and both Māori and Pacific Island students were more likely to have self-harmed than Asian and NZ/European students.

Concerning NSSI and help-seeking Nada-Raja et al. (2003) found informal sources of support were accessed more frequently than formal services (GP, psychiatrist, emergency services, psychologist/counsellor, and other hospital services) with friends the preferred source of support. Garisch (2010) surveyed high school students regarding self-harm behaviours. Forty-eight percent of the sample (538 young people) answered a question about help-seeking before their last occurrence of self-harm, with 85% indicating they had not sought help, 11% had sought help on one occasion, and 4% had sought help more than once. Participants indicated seeking help from a friend (81%), family (32%), teacher (10%), school guidance counsellor or psychologist (2%), telephone helpline (2%), or another source not defined (15%).

James (2013) explored social influence and deliberate self-harm, specifically the differences between those who endorsed social reasons for harming and those whose self-harm was motivated by other

factors. A school-based survey of 387 adolescent girls aged 13-16 across five Auckland schools was undertaken. A prevalence rate of 20% was found which is comparable to that discovered in similar samples internationally. Although the thesis was not exploring peer support for those self-harming, one finding in particular is relevant to the current study. The belief that engagement in NSSI is shrouded in secrecy was challenged as 23% of the 84 students with experience of self-harming having engaged in the behaviour in front of other people, and 12% had harmed in conjunction with others. The author suggested that high levels of secrecy were desired in relation to parents rather than peers. This finding adds further weight to the idea that young people are confronted by peers engaging in NSSI, at least some of whom are seeking assistance.

Summary

The substantial prevalence rate for NSSI in the adolescent population, alongside a lack of insight and understanding concerning NSSI and adolescent supporters of peers engaging in this behaviour both nationally and internationally, led to the creation of the current study. Current research underlines the connection between help-seeking adolescents and the informal support of their peers but not much else about this relationship is known. Accessing informal support has been documented by several sources as increasing connections to formal support services. Knowing more about this support relationship may enable enhanced support to be provided for those engaging in NSSI and also improved support for the supporters. To explore the support provider's experience a qualitative research methodology was required. Interpretative Phenomenological Analysis (IPA) was selected to inform the current study as IPA allows the gathering of insights into people's experiences and their reflections about these encounters.

The Current Study

The aim of this study is to explore how adolescents make sense of a peer engaging in NSSI and their own role in responding to, or supporting this person. The following questions informed the research process:

1. How do young female adolescents respond to or support a female peer engaging in NSSI?
    a) Response at point of disclosure
    b) Response or support provided thereafter initial disclosure
2. How does the process of responding or providing support affect the supporter?
3. How does a disclosure of NSSI and the support process affect the peer relationship?
4. What does the adolescent supporter need to continue to fulfil this role?
    a) To provide effective, age-appropriate support to a peer engaging in NSSI
    b) To maintain their own state of well-being

Method

Design

This research project was designed to assist the researcher to explore how young females support a female friend engaging in NSSI from the supporter's perspective. The research questions were framed to aid investigation into what support is provided and how this provision, and the disclosure that a friend is engaging in NSSI, affects the supportive peer. Succinctly put, what does it mean to be a young female adolescent experiencing this role, interacting with this added dimension to a peer relationship?

Interpretative Phenomenological Analysis

IPA (J. Smith, Flowers, & Larkin, 2009) is the methodology framework applied to this study. IPA is a qualitative research method which enables the researcher to explore a participant's lived experience in detail, by creating a space (usually within an individual interview) where the participant is guided or prompted by the researcher to reveal and reflect upon aspects of his or her day-to-day life relevant to the topic at hand, in this case NSSI. IPA is founded on the belief that there is "a chain of connection between embodied experience, talk about that experience and a participant's making sense of, and emotional reaction to, that experience" (J. Smith, 2011, p 10). Capturing these experiences and their meaning to the participant is the primary goal of IPA. This involves the engagement in a double-hermeneutic process as "while the participant is trying to make sense of the world around them, the researcher is trying to make sense of the participant trying to make sense of the world around them" (Aisbett, 2006).

IPA enables the undertaking of research that is participant-centred, where data-gathering results in rich in-depth accounts of participant experiences. The assimilation of participant knowledge, beliefs,

understanding and the emotion attached to these constructs is designed to be informal, flexible and to allow the participant to be centre-stage in their commentary. Thus data-gathering is most commonly via semi-structured face-to-face interviews containing open-ended questions and minimal prompts where proficient interview technique requires a 'gentle nudge' rather than an explicit directive (J. Smith, 2005). Participants are regarded as the expert of their experience and any reflections that result from this.

Those proficient in IPA recommend recruiting small sample sizes to enable a deeper focus on individual experience and to avoid overwhelming the researcher with large amounts of data (Hefferon & Gil-Rodriguez, 2011; J. Smith et al., 2009). Therefore a purposive homogenous sample is required in order for particular themes to be revealed from those who have relevant experiences. Results are representative of the issue being studied rather than claiming to be representative of the population the sample is drawn from. J. Smith et al. (2009) state the case for 'theoretical generalisability' where the reader is encouraged to "assess the evidence in relation to their existing professional and experiential knowledge" (p 4).

IPA also provides the scope to go beyond a deficit-focus regarding distress and difficulties, concerning peer support for NSSI in this case, to tease out the benefits and strengths of participants assuming this role. IPA supports this positive psychology function "for participants to be given a chance to express their views about strength, wellness and quality of life" (Reid, Flowers, & Larkin, 2005).

Setting up the Data Collection

This section is included for the purpose of illustrating the difficulties that surround researching with a vulnerable adolescent population. Complications include the age of the sample population and thus gaining the consent of a parent/caregiver in such a way that the confidentiality of would-be

participants' friends engaging in NSSI is not breached; NSSI is a sensitive matter usually hidden from adults; the associations between NSSI and suicide in terms of risk to student safety; and stigma regarding NSSI and other mental health issues in the wider community. As a result of these issues leadership staff, who function as gatekeepers to the execution of research within the school setting, can be cautious in their approval of studies related to NSSI. Parents and caregivers may be inquisitive as to the details of their daughter's friend who is engaging in this behaviour. These issues regarding the recruitment process were anticipated in advance, however, changes were required to the recruitment plan in order to successfully navigate the recruitment process within the school setting.

This project was approved by Massey University's Human Ethics Committee: Southern A. The recruitment plan for the study was to gain consent to carry out the research at a local high school, and recruit a sample of students by facilitating a research briefing and education session to 12-16 year old students in Years 9 and 10. Details about the study were to be communicated to parents and the wider school community via a mixture of the school's communication channels. Student participation was via an opt-in process (self-identification and volunteering) with parental consent gained via an opt-out (passive consent) process. This latter process involved all parents of girls in the year groups being asked to indicate if they did not want their daughter to participate in the study, whether the young person had volunteered or not.

Initially the local Guidance Counsellor network was utilised to identify a high school willing to take part in this research project. Guidance Counsellor's operate as gate keepers to the school community and would be playing a vital role in the research process by providing a safe introduction of the researcher to students and accepting any referrals for participants deemed a safety risk at the interviewing stage. One Guidance Counsellor responded to this invitation and the Principal was sent a formal letter introducing both the researcher and project (see Appendix A) and a School

Information Sheet (see Appendix B) that covered details about the study including aims and rationale for the research, expectations of the school's involvement, participant rights and the consent process. Unfortunately, at this stage for access to be granted the school required the recruitment strategy to be significantly altered to allow pastoral staff to recruit students without a research briefing/education session presented to students. After considering other options for the recruitment of participants via other schools, and the possibility that the proposed changes could bias the project's results and potentiality jeopardise student safety the decision was made to revise the design of the study to allow for the option of purposive recruitment by only the Guidance Counsellor on behalf of the researcher.

The Ethics Committee approved an amendment to the recruitment strategy allowing Guidance Counsellors to approach students they were aware would fit the study's inclusion criteria to inform them about the project and offer the opportunity to participate. Two other amendments were requested: an increase in age range from 13-14 years to 13-15 years, and the ability to provide participants with a small gratuity payment in recognition of time given for interviews ($20 ITunes or mobile phone top-up voucher). These amendments were subsequently approved.

It is acknowledged that recruiting via Guidance Counsellor' records may have biased the recruitment process somewhat as only students who have accessed support in this way were contacted to take part in the research. Other students with experiences supporting a peer engaging in NSSI would unfortunately not have the opportunity to participate in the project, meaning their voices remained unheard.

Given the addition of a Guidance Counsellor to instigate the recruitment process with direction from the researcher (as approved by the Ethics Committee), consent was provided for the study to occur at the school. This was a decile four state co-education secondary school in an urban area of a

provincial town in New Zealand. At the time of interviewing the school roll was approximately 880. There was no strong pre-existing relationship between the researcher and the school prior to commencement of the research.

The Guidance Counsellor reviewed her files for names of students who fit the study's criteria. Five names were noted. The Principal phoned the parents of students identified to gain verbal consent for these students to be approached by the Guidance Counsellor to take part in a research project concerning student well-being. All parents contacted agreed for their daughters to be briefed about the project. Although parents were not given details about the project during this phone call, they were informed that student participation was voluntary, that information about the study for parents/caregivers would be brought home by the student if the student was willing to participate, and parental permission was required for participation to occur.

The researcher provided the Guidance Counsellor with a recruitment sheet to base her interaction with these five students upon. This sheet included details of the study (aims and rationale) and the researcher (Guidance Counsellor at a local high school), what participation would involve (interview process), participant rights, and the consent process (including the requirement of parental consent). Students were provided with a Participant Information Sheet (Appendix C), Parent/Caregiver Information Sheet (Appendix D), and a Parent/Caregiver Consent Form (Appendix E). They were advised that parental consent was required to take part and how to contact the researcher if they had any further questions about the study or taking part.

Once a student communicated to the Guidance Counsellor that they wanted to take part in the study, the Guidance Counsellor liaised with both student and researcher to set up a mutually convenient time for an interview.

Participants

A small sample of five participants was recruited in order for detailed attention and appreciation to be given to each individual's account of their experiences as fits the chosen methodology (Hefferon & Gil-Rodriguez, 2011). IPA also recommends purposively selecting a homogeneous sample in order to uncover themes from a group of people with experiences of a particular phenomenon (Roberts, 2013). Therefore a sample of participants was required that, through particular shared experiences, could increase understandings of the topic at hand.

To this end female students were the focus population for this project for two reasons. Firstly, research shows prevalence rates of NSSI are significantly higher for females than males in early adolescence (De Leo & Heller, 2004; James, 2013; Jose, Ryan, et al., 2012; Lawrence et al., 2015; Ross & Heath, 2002). Therefore it was hypothesised that based on these higher prevalence rates, participants would be more likely to come across same-sex peers engaging in NSSI than their male counterparts.

Secondly, females and males differ in key aspects of support provision within their friendships. As detailed in the previous chapter adolescent female relationships have been found to include more intimacy and emotional support than male friendships (Buskirk-Cohen, 2012). Smith and Rose (2011) discovered adolescent girls have greater social perspective-taking skills than boys, thus enabling increased insight into another's distress. Therefore, it was proposed that adolescent females would offer more detailed descriptions of the emotional forms of support they provide to friends in distress. Thus it was again hypothesised that females would provide the rich in-depth accounts of responding to a peer engaged in NSSI that an IPA analysis requires (J. Smith et al., 2009). An age range of 13-15 years old was selected as this is the typical age of onset for NSSI in females generally agreed upon in the literature (Jacobson & Gould, 2007; Klonsky & Muehlenkamp, 2007; Nock et al., 2006). At this stage of development peer relationships are of great importance, and

their influence in problem-solving and evolving identity is becoming more pronounced. This age group was also chosen to explore how the support-provision process unfolds given those unique characteristics of the stage of personal and social development in early adolescence.

Prospective participants were required to have an experience of supporting a peer who had engaged in NSSI within the last twelve months. This timeframe was stipulated to ensure students were exploring in the interview events, thoughts and feelings that had occurred in the not too distant past in order to reduce the possibility of distortion.

To enhance the safety of students, any young person who expressed an interest in participating but who indicated they currently engaged in NSSI or had within the last six months would not interviewed, but instead would be reminded of different forms of support they could access if required. Students were also excluded from participating if their parent/caregiver did not provide written consent for the young person to take part. Students were able to take part in the study if they matched the following inclusion criteria:

1) Female
2) 13-15 years of age
3) Recent experience supporting a peer who had been or was currently engaging in NSSI over the last twelve months
4) No engagement in NSSI over the last six months
5) Obtained parental consent to take part

The five students who participated were from a single secondary school. They were all female, in Year 10, and of European or New Zealand/European descent. What they had in common was having a close social contact with someone who self-harms. Some have personal experiences of trauma in their own lives and others have experienced difficulties such as separated parents, bullying, and

poor mental health. All engaged in the typical activities of day-to-day school life, exhibiting talent across the cultural, sport and academic domains. In various ways these girls were linked within the school community.

Ethical Considerations

There are a number of ethical issues which are of importance to this study and impacted on the design of the recruitment strategy and the process of collecting information from participants. The issue of engaging with a vulnerable population due to the sensitive nature of the topic and the age of participants, required careful negotiation in order to ensure the safety of the participant was paramount.

Participants in this study were recruited because of their experience as a friend and/or supporter of someone engaging in self-harm. However, the distress caused by the relationship of participants with those adolescents engaging in NSSI could also cause participants to be vulnerable within this research process. This is despite the inclusion criteria stipulating only those who had not been self-harming within the six-month period prior to data collection, would be eligible to take part.

There are negative associations to interviewing a facet of NSSI. Research concerning NSSI has been impeded at times by difficulties gaining ethics committee approval due to committee members fearing negative consequences for participants taking part in the research process (Pearson, Stanley, King, & Fisher, 2001). Lakeman and FitzGerald (2009) found that despite ethics committee members' beliefs that suicide-related research is important, over 65% of members who participated in the online survey regarding risks, benefits and ethical problems concerning suicide research, said such research had great potential to cause harm to participants. Specific concerns included accessing the population, potential harm to participants and researcher, researcher competency, maintaining confidentiality, providing support to participants, and responding sensitively to the

needs of family members involved in the research. Specifically, potential harm to participants centres on concerns that the act of attending to an NSSI related experience, and recalling the emotions and thoughts associated with this behaviour, could raise participants' distress levels and leave them in a more fragile position than when they began the interview.

However, research has also discovered advantages to exploring NSSI-related topics for participants. Specifically that enquiring about distressing events or incidents of intense negative emotion via survey or interview method is most likely to be beneficial for those who participate (Whitlock, Pietrusza, & Purington, 2013). Enquiries into participants' interview experiences regarding personal self-harm or suicide attempts across multiple studies found that 50-70% of participants reported improvement in their wellbeing as a result of taking part (Biddle et al., 2013). Many attributed this benefit to the cathartic value of talking and although 18-27% of participants reported a lowered mood post interview, most anticipated that this distress would be short-lived and was outweighed by their motivation to contribute to the research (Biddle et al., 2013).

It was anticipated that any distress caused by interviewing would be lower relative to interviewing a young person about a direct experience of NSSI. However, the risk of any discomfort or distress occurring was mitigated by: 1) inviting participants to bring a support person to the interview; 2) building into the consent process a mandate for the researcher to pass on information to the Guidance Counsellor concerning any student mentioned in an interview at risk of harm; 3) holding interviews on school grounds which was both a familiar place for participants and provided a supportive context for the interview; 4) monitoring participants' emotional state throughout the interview and being prepared to move on from a question prematurely if this was either causing distress to the participant or the participant indicated they did not wish to speak about this topic; 5) communicating about NSSI in a 'low-key, dispassionate' way as advocated by Walsh (2006); and 6)

providing participants with a resource sheet detailing local sources of support and strategies for self-care at completion of the interview.

Researching a youth population also raised ethical issues regarding gaining consent. Secondary schools were approached to recruit participants for this study. Schools' administration required parents to provide consent to students' participation in this research project. The issue of obtaining parental consent in a way that did not cause negative consequences for either the prospective participant or the success of the recruitment process required some navigation.

Past research points to the fluidity of NSSI communication that can occur between friends but is often deliberately kept a secret from parents (James, 2013). There was concern that if students were required to gain active consent from their parents, that parents or caregivers may have placed pressure on these potential participants to find out information concerning who their daughter knew who was self-harming and details of this behaviour. This method of achieving parental consent could have resulted in distress for the student and for the peer who was engaging in self-injury as well as a loss of privacy.

Other disadvantages of requiring students to establish parental consent in order to participate in research are that the responsibility to gain consent lies solely with the student. There are several factors that may make approaching parents regarding the research difficult: difficult family relationships; parents that are overly-committed or frequently absent; and lack of a trusting relationship and inability to confide in parent. Even if a student feels relatively at ease to discuss their proposed involvement in the research project with a parent, there are also the practicalities of ensuring the required Parent/Caregiver Information and Consent forms make it home and then back to the researcher.

Layte and Jenkinson (1997) noted that when families are invited to manoeuvre through an active consent process to consider providing permission for their child to take part in research, those from higher socio-economic backgrounds and with higher levels of education are more likely to engage in the recruitment process than those from lower socio-economic groups. This selection bias may result in a lack of voice from participants in lower socio-economic classes. Dent et al. (1993) concluded that young people excluded from research due to parents not responding to the consent process were more vulnerable to a range of health and social problems as well as being more likely to be risk-takers, less likely to live with both parents, lower in self-esteem and assertiveness.

These challenges to gaining active parental consent were somewhat mitigated in this study by the Principal contacting parents/caregivers of the potential sample to gain consent for students to be briefed about the research. This alerted parents/caregivers to the study and thus may have lead parents to assume more responsibility for initiating a conversation about the project and ensuring the required paperwork was read and returned.

Procedure

Upon meeting each student the following process was observed. The researcher introduced herself and the project to the participant, including an explanation for why the researcher was interested in this topic. The participant was asked to read through the Participant Information Sheet despite having done this prior to our meeting. This request was made to ensure participants were aware of all details of student participation as the researcher had not been privy to the first conversation that occurred between the student and Guidance Counsellor. Reading through the Information Sheet again also acted as a catalyst for further questions pertaining to the research to be asked and attended to. The researcher double-checked the student matched the study's recruitment criteria and collected the signed Parent/Caregiver Consent form. At this point the student was invited to

read and sign the Participant Consent Form (see Appendix F), and the interview commenced in a private room on school grounds. Each interview took between 30-60 minutes to complete and was audio-recorded using a digital recorder. Participants provided separate consent to the use of the recording device and were informed that at any time this could be turned off at their request. Participants were informed that during the course of the interview if they disclosed information regarding an imminent threat to their safety or the safety of another student, this information would be passed on to the School Guidance Counsellor in a timely manner. Participants were informed of this exception to their confidentiality as part of the consent process.

The method of data collection was a semi-structured, individual and informal interview. This method fits within the philosophy of IPA as semi-structured interviews allow for the capturing of interviewee's experience and her reflections on this experience (J. Smith, 2011). Interviewees are also valued as the expert of their own experience (Shaw, 2011). Interviews offer the advantage of enabling more detailed responses to be obtained, an opportunity to gain further clarification, and the collection of additional information such as tone, speed, and volume of speech, and body language (Pietkiewiez & Smith, 2012).

The interview schedule (see Appendix G) was created with the purpose of providing an exploratory map for the interview conversation with general topics listed to promote participant discussion (J. Smith, 2005). It was recognised that questions provide a general structure or map only, and that 'detours' would most likely occur (J. Smith et al., 2009). These detours may lead to the uncovering of information and understandings that were more valuable than the planned route would have provided. As Roberts (2013) asserts the purpose of an interview schedule is to "facilitate the researcher and participant engaging in a dialogue" which means set questions may be modified as the interview process unfolds in light of the participants' responses, (p216).

Throughout the interview process the researcher used minimal prompts such as 'can you tell me more about that?', 'how did you feel?', and 'what did you think about that?' to encourage the participant to divulge further about the topic at hand or to reflect back on this experience. Direction was provided by the researcher if participants became stuck and requested clarification of the question. Throughout the interview the researcher engaged active listening skills and occasionally gave brief summaries of the participant's words. Sometimes summaries were requested by the participant when they intermittently became lost in the detail of their story and could not recall the point they were trying to establish. Perhaps attributable to the age and cognitive stage of adolescence which the participants were at, but it is also possible these infrequent moments were caused by some anxiety due to being interviewed.

At the closure of each audio recorded interview, the participant was thanked for their time and asked how they felt given the nature of what they had discussed. Each participant was provided with a Resource Sheet (see Appendix H) that included a selection of support services for youth both in the community and online, along with contact details. The Resource Sheet also included suggestions for supporting young people engaging in self-injury and self-care strategies for the supporters.

The gratuity payment and an individualised thank-you letter were provided to participants within a week of each interview's completion. The letter reminded participants of the Resource Sheet should they require support and how to contact the researcher to have further questions about the research answered.

Participants were also given the opportunity to read through the transcription of their audio-recorded interview. Four of the five participants requested to do so. Once the audio recordings had been transcribed the researcher met with the four students individually and they were provided

with a quiet and private space to read at their leisure. All participants who did so were satisfied that the recording was accurate. This second meeting allowed the interviewer to enquire as to participant wellbeing post-interview. All participants re-buffed the notion that they were affected in any negative way by the interview or topics discussed during this process.

Analysis

The purpose of the IPA analytical process is to do more than merely describe, but to move beyond the spoken word (Reid et al., 2005), to reveal deeper levels of participant cognition and belief that make up both connecting and contrasting themes when participants' stories are read together. To achieve this aim transcripts were analysed in stages. Starting with the most revealing and expansive interview, the audio version was reviewed to remind the researcher of the nuances of the interview such as the tone and rhythm of speech, the pauses and longer periods of silence, body language, and displays of emotion from the participant (Brocki & Wearden, 2006). Then the transcript was read through once from beginning to end with anything obvious that struck the researcher as of interest being noted on the transcript. The researcher continued to engage with the data by repeated readings of the transcript noting anything of descriptive, linguistic or conceptual interest (J. Smith et al., 2009).

Themes were identified from this added layer of information gathered on the transcript, consistently ensuring that key threads of meaning highlighted connected back to participants' responses (J. Smith, Jarman, & Osborn, 1999; Storey, 2007) . After an analysis of individual narratives, thematic analysis was performed across the participants' transcripts in order to link themes and identify thematic clusters. These cross examinations provided a master list of superordinate themes, with their related sub-themes and examples of illustrative quotations (J. Smith et al., 1999).

Familiarisation with the data and theme development were based on Smith's recommendations to 'be interpretative not just descriptive' and demonstrating 'both patterns of similarity among participants as well as the uniqueness of the individual experience'. At this point the categories of themes identified were discussed with the researcher's supervisor to provide a validity check and thus a rigorous and transparent process of analysis. Osborn and Smith (1998) describe the aim of such validity checks as not to prescribe to the 'singular true account' (p 69) but to ensure the credibility of the final account.

Unique characteristics of each individual's story were captured through the inclusion of participant quotations in the final research report. This is important as it allows the reader to check for credibility between the researcher's interpretations and the participant's actual words; creates depth and allows themes to resonate with the reader; and as J. Smith (2004, p 43) suggests when advocating for the use of IPA with small samples 'the very detail of the individual brings us closer to significant aspects of a shared humanity'.

The interpretative role of the researcher.

The research topic was formulated as a result of my experiences supporting young people self-harming and their friends in a school guidance counsellor role. I sought to both suspend the body of knowledge I had accumulated on the subject of NSSI and related counselling experience in an attempt to be as open as possible to the different experiences and insights of participants. At the data collection stage I aimed to step into the participant's shoes as far as possible and during analysis to layer these observations with my interpretations. As viewing data from an outsider's perspective allows the opportunity to develop other levels of insight than the participant might have access to (Pietkiewiez & Smith, 2012).

I am also a qualified social worker practicing from an ecological framework. The contextual layers that wrap around participant's individual perceptions of events, their sense-making, was attended to during the interview stage and highlighted in the extraction of themes. The symbiotic partnership between environment and individual was captured and emphasised as one of the super-ordinate themes resulting from this project.

The role of guidance counsellor provided me with prior knowledge of the secondary school setting, which afforded an understanding of the nuances of how this system operates, the pastoral structure, and general policies and procedures implemented in this setting. This 'insider knowledge' assisted in understanding aspects of participants accounts. Equally participants were aware that I was a guidance counsellor. Perhaps this role and its associated parameters, for example the provision of confidentiality and expectance of a talking interaction, influenced those students interviewed to feel more comfortable to both engage with me and reveal personal experiences.

My gender may have also moulded the interpretative framework applied to the data. Nurturing is historically viewed as a feminine quality and females are socially influenced to demonstrate caring characteristics such as those required to support a friend through difficult times. I could have been tempted to view the data in an overly sympathetic manner given my gender aligns with that of the participants, and there was overlap between participants' experiences and that of my clients in my function as guidance counsellor. Having an awareness that these factors, including gender and other roles performed, contribute to my own interpretative framework makes it less likely that their impact on the research process will be negative. As Salmon states 'results of psychological research reflect the researcher as much as the researched' (2003, p. 26).

Results

The purpose of this study is to explore how young adolescents make sense of a friend engaging in non-suicidal self-injury (NSSI) and how they respond to this person. A qualitative methodology, IPA (J. Smith, 2004), underpins the structure of the research and guided decisions about how the population was sampled, the procedure applied to gain information, and how this data was then analysed to understand participants' sense-making. The data was analysed to extract units of meaning across the individual transcript and then compared to units identified across the transcripts as a group. This analysis required attention to minute detail within the transcript whilst retaining a focus on the transcript as a whole to ensure this detail was interpreted within the context of the entire transcript.

The engagement of this method resulted in five super-ordinate themes being identified - NSSI and relationships, burden and responsibility, the helping response, costs of caring, and supporter needs. Each theme is described and explored, locating related sub-ordinate issues within this narrative.

Theme 1: NSSI and Relationships – The Unwelcome Intruder

Relationships provide the foundation for support during difficult times in life. Young people will make use of peer connections when distressed. Those engaging in NSSI connect with peers more frequently for support, usually before approaching other support options such as family members and helping services. However, disclosure of NSSI has the potential to intrude into this peer relationship with sometimes striking results. The first theme, *NSSI and Relationships*, is focused on the observations and explorations of participants as they map out the impact of NSSI on their friendships, both with the person engaged in NSSI behaviour and their wider friendship network. There can be struggles and severe consequences for the wider peer group. A disclosure of NSSI can hinder the support person's wider relationships with adults and other potential support people. At

times, in the current study, there was evidence that this prevented the accessing of further and more specialised help for participants. There seems to be three main subordinate threads to this theme including a) the influence NSSI has on the relationship between the young person and their friend engaged in self-harm, b) the impact a disclosure of NSSI has within the peer group, and c) consequences that occur for wider relationships.

a) Impact on the friendship.

Disclosing NSSI to a friend affected the relationship in two main ways. For the supporter, once this disclosure was made or confirmed, as sometimes the behaviour was suspected long before there was an open admission, the person engaging in NSSI appeared different. Even those who were careful to comment that they did not treat their friend differently because of this disclosure confided that the relationship changed in some significant ways.

Mikayla: *"She said she was fine and that she wouldn't do it again but she did…because she wasn't herself at home"*
Interviewer: *"She wasn't herself?"*
Mikayla: *"Like she was sad and changed a lot. She wasn't like her happy self, she was real sad"*
Interviewer: *"How was that seeing her not herself?"*
Mikayla: *"It's hard to reach her like talk to her because we didn't know what to do"*

"…but I found out one day because I could see it. So I asked her how she was doing and what was wrong, what was upsetting her but she wouldn't tell me"

(Diara)

"When they are self-harming they tend to be quite disconnected I guess from everything usually, like they'll put up a front of just being fine…"

(Sarah)

The adolescent engaged in NSSI could become distant, might insist they were okay despite evidence to the contrary, or assume a different persona. This persona was adopted to reassure friends that the person was coping, yet what was offered was no more than a false sense of comfort as friends witnessed the bodily signs of NSSI continuing. Engaging in NSSI results in some choosing to project a

healthy image where personal difficulties remain hidden. Promises to discontinue harming oneself are made on false pretences, a mask of happiness is assumed in public, and in this context offers of help are sometimes rejected. This observation and the comments above from Mikayla hint at the confusion and uncertainty that occur when the young person engaging in NSSI adopts this stance. Adolescents in this study struggled to connect with friends behaving in this way, perplexed by patterns of behaviour and bodily signs that did not match nor make sense. There were also differences noted in how friends engaging in NSSI appeared in private conversation compared to their behaviour in the public arena. Perhaps in their bewilderment and a search for understanding, young people may be prone to grappling for simple constructs to provide understanding and name the friend's behaviour in public 'fake' and that which seems more like their usual friend when in private, their 'real' self. In fact both projections of the friend are real but the adolescent supporter struggles to marry the inconsistencies between the two. Prior research from the perspective of the adolescent engaged in NSSI point to issues of stigma, a belief that engaging in NSSI is not maladaptive behaviour, and a desire to independently attend to one's own problems. These beliefs may contribute to a new way of presenting and relating to others, emphasising the adolescent's struggle to integrate self-harm into their usual day-to-day tasks of life.

> *"She was putting up her own wall of protection and she acted happy, but when we were talking about the subject she was sad about it …but then when that other person walked over she goes ah, and her eyes lit up and she smiled and she went all sassy again and I was like, she's being fake, that's just all I could think about is how she was being fake"*
>
> (Lola)

> *"… I know people get quite shocked when they find out that someone is self-harming and that can be very hard for the person who is self-harming because they don't want to tell anyone because they're worried about what they're going to think and what they're going to do I guess"*
>
> (Sarah)

> *"She wanted to be known as someone completely different, she didn't want to be that girl that people looked down on and think, she's so weak she can't help but hurt herself, she's depressed, she's always sad. Why would I want to be her friend…"*
>
> (Lola)

Lola has an understanding of why her friend engaging in NSSI 'acted happy' but witnessing the sudden and stark contrast between her friend appearing differently was startling to her. This fluidity of a friend's presentation then became a tell-tale sign for noticing self-harming behaviours in other friends.

The young person in response to a friend's disclosure of NSSI may adopt the role of supporter. Grappling with this new role, which goes beyond that of the usual tasks of friendship, is overwhelming and challenging for many. The usual patterns of interacting in a friendship at this stage of development, for example the mutual discussing of concerns or issues of interest and taking part in shared activities, no longer occur as they once did. Instead this time is consumed with discussions between friends about the person's current state of wellbeing, possible next steps of support, discussing difficulties with the friend engaged in NSSI, removing implements used to self-harm, attempting to distract from worries, or researching strategies they may help them abstain from self-harm.

> "*…we talked about it when she [friend engaging in self-harm] wasn't there and what to do and I'd tell her first…"*
>
> (Mikayla)

> *"I liked the page for supporting people that cut and it has helpful things to say to people… some people they draw, I got XXX to draw…"*
>
> (Samantha)

> *"…I just cracked jokes to try and distract from the situation because I didn't really like to talk about it I suppose… and I didn't really know what to do"*
>
> (Sarah)

The supporting adolescent is uncertain at times how to interact with their friend, both wanting to continue the friendship and wanting to help their friend. In effect, NSSI becomes a barrier to the give-and-take of a typical adolescent same-sex friendship.

> *"…when you know that someone is self-harming I guess you always have to be **careful** when you're around them, like you might offend them or you might hurt them in some way… you kind of have to like **censor** yourself when you're talking about things or just kind of not talk about it at all."*
>
> (Sarah - emphasis added)

Sarah's interaction is underscored by caution and a sense of vigilance to avoid additional harm to her vulnerable friend. That she feels the need to "censor" herself indicates a concern that particular words or actions might trigger her friend to harm herself. Such a belief could contribute to the supporter experiencing heightened levels of worry and feelings of anxiety for the friend's wellbeing. Sarah's words regarding censoring also suggest that the supporter actively changes the way they behave in the relationship with the person engaging in NSSI. That they modify the way they interact and respond to this person in such a way that the support needs of the friend assume higher status than the friendship needs of the supporter.

Other participants also spoke about their friend's support needs overtaking their own requirements for companionship and problem-solving. For some this was an overt development that sparked a sudden change in the relationship and for others a more implicit and gradual process occurred.

> *"Even if it was something that I needed to tell her about me. It seemed like it was all about her"*
>
> (Lola)

> "*It's uncomfortable… it's not easy, it's hard to not be able to talk about something that you want to talk about with a friend… you can't say anything that might offend them in any way because then you're worried oh my God they're going to cut themselves or something"*
>
> (Sarah)

> *"It was hard but we did it somehow and then we became closer when she got really bad and then got better… she's a lot happier now which makes me happier"*
>
> (Mikayla)

The first two excerpts refer to the unmet needs of the supporters. Difficult emotions arise, such as frustration and resentment, when the relationship feels like it is a one-way street with no or little interest, recognition, or support being received in return. Mikayla's comment provides reference to the enmeshment that can occur in this situation. If a support person forgoes their own relationship needs and focusses their attention solely on assisting a friend engaging in NSSI there is a risk that the support person's emotional experience can become dependent upon that of the friend's. The

supporting adolescent then becomes vulnerable to experiencing an array of tumultuous negative emotions which she has little control over.

Sarah later makes a direct comment regarding the obstacle NSSI presents for friendships.

> *"I think it does put a kind of barrier against the friendship because you feel like you can't help them because I know friends are there to support each other and it's quite difficult when there's that like self-harm in the way I guess of the friendship…"*
>
> (Sarah)

However, some participants reported receiving support in return. Mikayla gained companionship after her friendship group disbanded, a sense of achievement and gratitude for her place in life from supporting her friend.

> *"It was hard but we did it somehow…I was grateful for what I had and how I felt about things"*
>
> (Mikayla)

Perhaps one reward the adolescent supporter is provided in this helping transaction is the opportunity to also vicariously experience the emotional highs of their friend, alongside a sense of value for their helping role even if their efforts are only ever recognised by themselves in this way. As Mikayla alludes to above, feeling strongly connected to a friend engaged in NSSI can open oneself to not only vicariously feeling negative emotion but also experiencing enjoyable feelings too.

Samantha gained companionship also, important given her admission that she finds it hard to make friends especially with girls. Her support creates a symbiotic relationship where the friend she was supporting now helps her after disagreements with her mother. Samantha values this relationship and is almost in awe of the intuitive connection she has with this friend.

> *"I talk to her about it and she helps me out… she knows when I'm upset, like I'll walk into school and she'll be like you're upset, come here, what's wrong and yeah she just knows"*
>
> (Samantha)

Perhaps these positives helped to offset the challenges encountered within close friendships when one person is engaged in self-harm and at times the balance between give-and-take in the relationship can feel out of kilter. It is notable that many of the positives experienced within a friendship with someone engaging in self-harm were infinitely greater once the person engaged in self-harm ceased this behaviour (i.e. NSSI was replaced with other forms of coping). The benefits of mutual friendship appeared to be valued more than the benefits accrued from supporting a friend in distress for many, but not for all participants. Two participants in particular valued the sense of purpose they achieved and the contribution they made to another's life, above the rewards of friendship or perhaps in the absence of opportunities for friendship.

b) Impact on the peer group.

A friend's disclosure of NSSI could also change the landscape of the wider peer group. Sometimes this happened in subtle ways and other times these changes were overt and sudden with negative consequences for the supporter. Often peer groups would extend group support to a member engaging in NSSI. Individually they may approach the person and offer support but group discussions concerning how the person was, their current level of distress, and what to do about this occurred almost daily. Some participants noticed a positive effect on their peer group stemming from these regular meetings and spoke of the group bonding as a result. However, there were disadvantages to this provision of support by the peer group.

> *"I feel it made my group more tight, like because we had that kind of bond of knowing that she was self-harming or that other person was self-harming or whatever, but other than that it was all just quite stressful I think"*
>
> (Sarah)

> *"…the people that were trying to help her became closer but… it caused conflict that we didn't want… it [peer group] would split into two. Me and her would be together and the other two would be together. That just made things a lot harder"*
>
> (Mikayla)

It would appear individuals within the peer group had varying levels of emotional stamina or resilience in terms of sustaining a prolonged support relationship with the person engaged in self-harm, but also different tolerance levels to group talk being so regularly permeated by this support topic.

> *"I think it made the friendships more stressful, like we had something to worry about. I think it made it like we always had to talk about if she was okay and we always talked about her and if she was alright and what was happening with her"*
>
> (Sarah)

Perhaps this stress also created peer relationships that were more purposeful and as such promoted a sense of role or identity for the peer group. Stress encountered may have been partially offset by a positive belief that the members were helping another, or meeting a need. However, stress within a peer group can have negative consequences for group members and also affect the structure and function of the group. The stress Sarah mentions led some in the group to pursue more self-focused tasks or conversations. Or some simply felt overwhelmed or burnt out by the ongoing nature of the support that was being provided, choosing to leave the group to avoid the intense level of group discussion and support efforts. These group members may have also judged the group member's self-harm as attention-seeking and/or manipulative and thus not worthy of their efforts or attention.

> *"…I got quite sick and then I came back and I noticed two of them are closer and the other girl [engaging in NSSI] was kind of left on her own… so I started to hang out with her because I felt left out as a friend too…it was hard…I was used to having two other people there to like talk to about what she was doing… but they didn't want to know, didn't want the drama in their life"*
>
> (Mikayla)

Mikayla relied on the help of her peer group to assist her support efforts as well as to meet her own companionship needs. However, when two group members saw an opportunity to discharge this responsibility, Mikayla decided to turn to her friend engaging in NSSI in an attempt to find companionship and continued to support her alone in this task.

The existence of a group member engaging in NSSI can also affect dynamics within the group in terms of strategic moves for connection, power, and status. In this way self-harm was used as a tool to socially manage the relationship between the person engaged in self-harm and a more powerful member of the group who was also self-harming. Thus NSSI can be used to manipulate members of the peer group for individual gain.

> *"I think I felt quite left out because we were all fighting for XXX's attention and so I felt like oh I haven't connected. Obviously I didn't cut myself or anything to be part of their weird group or anything, but I think I felt like they had something in common…"*
>
> (Sarah)

Sarah's comments demonstrate that self-harm adds another level of difficulty to the already challenging context of adolescent female relationships. NSSI has the power to isolate but conversely allow another to become socially mobile.

When a peer group becomes intently focused on group discussions about support provision, or experiences changing dynamics, the person engaging in NSSI can become isolated from their supportive peers.

> *"…being able to talk about it with other friends always like brought us closer together because we were able to talk about it. It also made us disconnected from the person who was self-harming as well…"*
>
> (Sarah)

The purpose of providing this support can take on a life of its own and become the glue that holds the group together or the reason for the group to continue to exist. Perhaps at these times the support goal of the group surpasses the friendship function. For the group to continue it is important for each member's needs to be met. Therefore a sole focus on supporting a peer engaged in NSSI is unrealistic and unsustainable as several of the excerpts above pay witness to.

Sometimes individuals providing support purposefully relinquish their ties to a peer group in order to channel their full attention and efforts to helping their friend engaging in NSSI. However, this

decision to leave a peer group may stem from feeling obliged to support a friend in distress. The support provider in this instance is acting out of a sense of duty and fear that her actions may contribute to the distress of her friend.

> *"I didn't like being around other people but her because I didn't want her to get upset or jealous"*
>
> (Lola)

> *"I felt like I couldn't partake in other things or be friends with other people because she was hurting herself and I felt like I owed my attention, like all my attention had to be on her always"*
>
> (Sarah)

Lola did not want to run the risk of her interactions with others in her peer group causing any negative emotion that may have led to her friend engaging in future incidents of self-harm. In some ways this appears a maladaptive choice as the helper is in effect isolating herself from sources of possible support. Sarah also withdraws herself from not only other people but the interests in her life, placing her full attention on her friend who was self-harming. Both participants' words are underscored by a sense of obligation. It is as if the supporters are mirroring their friends' withdrawal also by making choices that are unhealthy as they limit their options for support or time out from the demands of helping in this way.

c) Impact on wider relationships.

Wider relationships that the supporter participates in can also be affected by the perceived stigma of NSSI, the supporter's stress overflowing into these relationships, and position the supporter between their friend self-harming and the supporter's family.

> *"I think I became quite disconnected from my family I guess"*
>
> (Sarah)

> *"I'm not really a person who wants to tell my parents everything because I'm scared of what they'll think sort of. I'm just really scared to just talk to them even though they're still going to love me no matter what and stuff"*
>
> (Diara)

"…you'll be like oh can I have this person [over] and they'll be like, isn't she a bad influence or something"

(Samantha)

Families are also an important source of support for most adolescents. NSSI acting as a barrier to accessing this support can be problematic for young people requiring help to support a friend but also to locate support for themselves in this process. If obstacles prevent connecting with family members for support, or the young person engaged in self harm does not wish for outside support to be contacted, and peer group relations are unreliable or have been severed, the options for support become non-existent.

d) Summary.

NSSI is depicted as an unwelcome intruder into friendships from the perspective of the non-NSSI friend. Self-harm impacts on the individual friendship, the wider peer group and social network. The relationship changes as the person engaged in self-harm appears different, draws support from their friend but provides little in the way of respect, recognition or support in return. In a sense self-harm monopolises the relationship and can invite the non-NSSI friend into a game where they are perpetually playing the role of supporter, duty-bound to oblige. A lack of emotional stamina or perceiving the adolescent engaged in self-harm as lacking authenticity in their distress can lead to peer group members abdicating any sense of responsibility to assist with support actions. Emotional stamina was crucial for group members to sustain the helping process, sometimes resulting in members ending friendships with both the person engaged in self-harm and their supporters. Despite the level of resilience embodied by the individual supporter, each participant identified struggling with feelings of great responsibility for their friend's well-being and the associated burden this created for them. This perception and related emotions are expanded upon within the following theme.

Theme 2: Responsibility and Burden – "Carrying the Weight of a Thousand People"

All five participants spoke about feeling the weight of responsibility for a friend engaging in self-harm. This duty of care extended to the wider wellbeing of the friend, future episodes of self-harm and the level of distress exhibited by this friend as Sarah and Mikayla's comments show:

> *"…you kind of have to make sure everything is okay in their life or something. I feel I have to fix everything in their life because they're self-harming and I want to fix it and I don't want them to do that anymore"*
>
> (Sarah)

> *"…she said that if I wasn't there, she probably would have died because she didn't…because it would have been so much harder on her"*
>
> (Mikayla)

There are three main components to this theme – a) the role of loyalty and the dilemma this poses for accessing additional help, b) supporter goals and their impact on the helping process, and c) the disadvantages to being responsible in this context.

a) Loyalty and accessing further support – a dilemma.

The supporter's focus and attention is directed towards attempting to ensure the friend engaging in self-harm is safe. There are elements of obligation and uncertainty expressed by Sarah in this task noted in the following word choices: "I have to fix everything" (obligation) and "anything that might offend them" (uncertainty about predicting what this could be).

In some cases this responsibility was invited by the supporter as the following excerpts demonstrate:

> *"…you can tell me anything, I'll be here for you"*
>
> (Diara, in response to a disclosure of NSSI)

> *"I'll tell them I'm here if you want to talk about anything…"*
>
> (Sarah)

"Yeah, I was asking her if she was alright and stuff and if she needed any help we were there"

(Mikayla)

Participants offer support and a willingness to listen. These invitations for support are both general and passive, as the young person does not take any proactive steps to secure help for her friend. Promising that a friend can tell the supporter anything and that they will stand by this person not only implies an open-ended commitment but also loyalty. It is this loyalty, an important element of the adolescent friendship that can create conflict between the role of supporter and friend.

"…in reality you can't just tell someone about it because that's breaking your friend's trust for one, and you feel like it's just… you're put in the most difficult spot because you don't want to break that person's trust or you don't want to make them feel like they couldn't tell you things because at the end of the day you want to be trusted, you want people to be able to tell you things, well I do anyway"

(Sarah)

Sarah's reference to being "put in the most difficult spot" points to a perceived lack of control, powerlessness, and a dilemma experienced by those adolescents straddling the role of supporter and friend. The desire to help is surpassed by feelings of loyalty that epitomise close friendships, and may therefore prevent the employment of further support in the way of an adult or more specialised service. Some adolescents may believe that assuming the role of a loyal friend is more helpful than adopting the role of a useful supporter. Participants struggled with conceptualising these two roles, their parameters and aspects that overlap, which added yet another dimension to their predicament. This dilemma was grappled with by all participants especially when secrecy about NSSI was imposed by the friend engaging in NSSI.

Interviewer: *"Do you remember what it was like when your friend said 'don't tell anyone'?"*

Lola: *"Yes, it felt like I was carrying the weight of a thousand people on my back and I wasn't allowed to tell anyone because I didn't want to hurt her and I couldn't even tell my mum because she didn't want my mum to tell people and it just felt like I had a heavy weight, like I was carrying around something I wasn't meant to have"*

This imposition of secrecy created additional burden for this participant exhibited by the following comment:

> *"I felt like I could be sitting so far away from her but I still hear it ringing in my ears saying I had to tell someone, but I couldn't"*
>
> (Lola)

Whether this secrecy was promised by the supporter or demanded by the friend engaging in self-harm, this assurance added to the responsibility young people felt for their friends and the support burden, creating feelings of powerlessness and blame when NSSI continued.

b) Support goals.

Two other main factors that added to this sense of burden for participants was the goal several set for themselves as supporters, to stop their friend from self-harming, and a lack of support for the supporters (the latter being covered in more detail in theme five entitled *Supporter Needs*). Evaluating the effectiveness of an individual's support efforts by whether a friend discontinues NSSI is an unrealistic end goal. This is due to the multitude of factors that lead an individual to resort to self-harm to begin with and that this act in itself can quickly become a coping strategy for dealing with further distress. Therefore, expecting one's support efforts to eradicate the need for self-harm and for the young person to cease engaging in this behaviour is somewhat of a vast aspiration. Indeed whether the recipients of the support provided by participants aspired to end their engagement with NSSI does not seem to have been considered by participants as the following excerpts attest to:

> *"When people say oh yeah she cuts, I'm like who cuts and I'll message them or go find them and be like can you please stop cutting, I don't like that"*
>
> (Samantha)

> *"… just like knowing that I'm trying to like stop what's happening…knowing that they can try to do something to stop it"*
>
> (Diara)

"Oh I would be like why are you cutting are you okay or something or I'd be like don't do that you know…"

(Sarah)

Sarah's comment illustrates how the young supporter misses out a crucial step in their task of helping their friend to cease self-harm, that of assisting their friend to identify the contributing factors for their NSSI behaviour. Rather their support efforts are aimed at achieving the distal goal of ceasing self-harm, missing out the important proximal steps in between (identifying contributing factors and working to address these) that will render this goal achievable.

Despite all participants attesting to a veil of secrecy surrounding their support role, every participant also mentioned disclosing this in some form to another person with a purpose of accessing support for both their friend and themselves in a support role.

Interviewer: *"What were you hoping the counsellor would do, by you coming and telling the counsellor?"*

Diara: *"Well to keep XXX safe like if the mum knew, so that her mum like knows about what XXX is doing and try and keep her safe and that"*

And later on…

"… I think it's just letting it out, like letting someone know to see if they can help. That made me like feel a lot better"

(Diara)

"… I guess that's when I started worrying a lot so I said that I was going to take it to someone and she said 'please don't' and I had to. In the end I guess it didn't benefit her, but it did, because she was glad her mum found out. I guess that I helped her more than I would have helped the other person"

(Lola)

Sometimes the burden of worry became so much that it transcended the bond of loyalty. That is, the level of worry or anxiety was such that this unbalanced the tension between care and loyalty, and that between the role of supporter and friend, thus aiding a decision to seek additional help. In the eyes of the supporter this risked the friendship but they could no longer sustain such an independent helping role and the associated responsibility this required. The result of such a

disclosure often resulted in a short-term break in the friendship followed by positive reinforcement of the supporter's actions at a later date by the friend.

Interviewer: *"When you came and told the counsellor, and you walked away from that conversation, how did you feel?"*

Diara: *"I don't know, I was still quite upset with what had happened, like I was up all night… XXX had kind of like had a go at me because she found out that it would have been me because I came in with one of her other friends that had… she had also told, but then after a while she kind of thanked me"*

One participant spoke of accommodating both loyalty and the desire to involve extra support by warning friends that if their conversation became too intense ("they cut every single night or they reopen cuts" – Samantha, or mention imminent intent to suicide) they would tell someone.

> *"…if someone says hey can we talk I'll be like if… if it gets like if this talk gets really bad or something I'm going to have to tell someone… other than that I'll keep it too myself if it's not that bad"*
>
> (Samantha)

c) Disadvantages to being responsible.

One disadvantage to harbouring such a potent sense of responsibility for a friend engaged in NSSI is the blame and guilt felt when participants appraised their efforts as having not measured up to the task at hand.

> *"Sometimes I felt it was my fault and I couldn't stop them, because every time I tried they would just go back to it even if they had stopped for a period of time. So it made me feel like it was my fault, and that I couldn't stop them and I couldn't do anything to help them"*
>
> (Lola)

Lola clearly believes it should have been within her capabilities as a friend to help enough to stop her friend engaging in NSSI. Her comments indicate she takes a certain amount of personal responsibility for not being able to help in this way and perhaps as a result Lola evaluates herself negatively as a friend in this instance. Shortly after the comment above she distinguishes between the expectations she felt as not just a friend but a 'best friend' indicating it was her duty in this role to help more.

"..it made me feel like it was my job to make them happy and my job to cheer them up and my job to stop them"

(Lola)

Lola uses the word 'job' several times in the same sentence in reference to her commitment to attempting to support her friend who despite this, continued to self-harm. The term 'job' entails a regular commitment, and implies that one has a particular set of skills matching the tasks of this position. Lola's words demonstrate how the supporter can be placed in a position where the supporter's job description far outweighs the level of skill and ability. Lola thus felt confused, powerless and at the whim of her friend's turbulent emotions. Similar in fact to several other participants' experiences of being independent support providers within friendships with those engaging in self-harm.

"I didn't really know what to think but I was sad"

(Mikayla)

"…she's a lot happier now, which makes me happy"

(Mikayla)

The above comments from Mikayla depict how the supporting adolescent can begin to experience emotions almost vicariously through the distressed peer, their emotional well-being depending upon that of their friend. Perhaps as a result of Mikayla's experience of this task of responsibility and associated burden, she reflects on her encounter with hindsight stating her future intentions for providing support as:

"Let their whole family know so that they have support of everyone, not just a few people, not just their friends"

(Mikayla)

In this way Mikayla is advocating the sharing of this provision of support.

d) Summary.

The young adolescent supporter whilst grappling with the parameters of both friend and support roles accepts, sometimes unwittingly, a level of responsibility and its more covert companion that of

burden. The weight of this burden is accentuated by the secrecy that is attached to NSSI, a focus on achieving the distal goal of ceasing self-harming behaviours (rather than the more proximal goal of assisting a young person to understand the function NSSI serves and addressing these factors), and the lack of support adolescents experience in this helping role. Feeling responsible for the wellbeing of a friend engaging in NSSI lead to participants feeling powerless, and if the behaviour continued blaming themselves for the inadequacy of their efforts. If the weight of this burden became too onerous, the tension between care and loyalty, and likewise between friend and supporter, resulted in some engaging additional help. How adolescents transition to this supporting role to begin with and the nuances of the support transaction are offered in the following theme.

Theme 3: The Helping Response – Evolution of the Supporter

In order to provide effective support actions to a peer engaged in NSSI the adolescent needs to make a transition from the role of friend to that of supporter. How well they are able to help depends on how well they are able to evolve into this support role. As indicated in the previous theme it may be difficult for some young people to undertake both simultaneously. This shift is dependent upon a young person's motivation to help, their skills and abilities, their beliefs about if, when and how to help, experience helping others and receiving help themselves, and how they navigate the dual roles of friend and supporter. The receptiveness of the person engaging in NSSI to this help also influences how this support is provided, as does the wider context surrounding this support transaction which includes the stability and supportiveness of peer group relations, and the availability of assistance from family and other adults in the wider community. There seem to be five aspects of this theme – a) the young person's motivation to provide support, b) their beliefs and skill level, c) how they attempt to engage with additional support, d) how the helping process impacts on the support provider, and e) what kinds of assistance the supporter provides.

a) The support provider's motivation.

The inception of a support role is often not a conscious choice but is one which is thrust upon the adolescent. This is partially due to the existing friendship connection between themselves and the person engaged in self-harm, but sometimes also motivated by a sense of moral obligation to commit to helping a person in need where a prior friendship did not exist. Participant's stories also demonstrated that their awareness that a friend is self-harming occurred more gradually, that the supportive strings of friendship had been stretched to encompass this burgeoning distress as the friend role merged into one of supporter perhaps before the adolescent realised the full implications of this support role. At this point it may have been too late to withdraw such a commitment of support due to a sense of obligation or duty to the friend engaging in NSSI or from fear of the consequences such a withdrawal may create such as being identified by self or others as a 'bad friend', or this withdrawal adding to the distress of the friend engaged in self-harm. A realisation of the benefits this support role may afford could also encourage continuing this commitment of support such as finding this role exciting, supporting in this way creating a sense of purpose and value for the helper, and believing their contribution is making a real difference to the life of another.

Some participants mentioned their desire to help friends originated from experiences of observing someone take drastic and sometimes life-threatening actions to resolve their distress. Lola's doubts about her ability to help a friend who disclosed NSSI motivated her to divulge this information to a trusted adult:

> *"Before the end of school the [other person] attempted suicide and so it made me think, oh my gosh, what if I can't help her [another friend] and what if this is what I think it is and what if I can't help her and what if she wants to kill herself"*
>
> (Lola)

Lola's anxiety places her firmly in the role of a supporter as she takes affirmative action to prevent this friend from attempting suicide. Offering support necessitates a level of responsibility, which

unless shared is perceived to lie squarely on the shoulders of the helper. This time Lola absolved herself of this responsibility by passing this on to an adult, someone better placed to intervene and set up measures robust enough to accommodate concerns of safety.

Samantha's experience helping a friend who was engaging in self-harm who then ended her life stimulated her to provide support to others in the hope of steering others engaging in NSSI away from a similar fate. Her own experience of difficult times when Samantha herself entertained thoughts of suicide also provided motivation to help others.

> *"…well I actually don't want anyone else to go through what I went through so I want to help people"*
>
> (Samantha)

Prevention of a worst case scenario is the goal here, also motivated by the participant's ability to empathise with peers experiencing difficulties due to her own past troubles. The difficult past experiences that many participants described seem to have augmented their ability to perspective-take, a skill required for enhanced levels of empathy.

Helping others in order to help themselves is also evident through participants' stories as another source of motivation to provide support. Whether this is simply to secure companionship, to heal by healing others, or to avoid dealing with the helper's own issues, each participant was gaining something from this helping transaction.

> *"I've always been a fixer… I don't like people being uncomfortable around me and I think that is me running away from [my] own problems probably… like having to fix everyone else's"*
>
> (Sarah)

Diara:	*"Well I sort of just hugged her and told her that everything would be alright…"*
Interviewer:	*"How do you think that would have made her feel better?"*
Diara:	*"Knowing that I would be there for her and she can tell me anything…"*

b) Beliefs and skill level.

Beliefs about whether a peer requires assistance, or indeed deserves this, can promote or prevent help being offered at the outset. Each participant voiced beliefs about how they identified those who required or merited help and those who didn't depending on whether the person talked openly about their NSSI or not.

> *"…she didn't like showing people. She wasn't doing it for attention or anything"*
>
> (Mikayla)
>
> *"Some people do it for attention because they want to be you know, people feel sorry for them and then some people do it because they're genuinely like want attention, need help you know at that moment"*
>
> (Sarah)
>
> *"She kind of just told me. I don't know like she would just laugh about it, so I don't know if she's attention seeking or… but I don't know because she would just let everyone know"*
>
> (Diara)

> *"You can kind of tell. Attention they're showing it off I guess because when people are hurt and stuff they don't like showing it off that they do, they hide it. People that cut they're like no I'm going to hide these and they do it usually…"*
>
> (Samantha)

In effect participants were making judgements about who was genuine in their distress on a regular basis with significant consequences. Providing help to some but ignoring the plight of others. There is a belief evident in the excerpts above that if someone is self-harming and they communicate this openly then that person is craving attention but ironically no further thought is given to what lies behind such 'attention-seeking' and no help is provided in these instances. It appears there is a certain way that it is appropriate to ask for help. An honest call for help is one that is spoken quietly or not at all; communicated via the body; and denying that the injuries are self-inflicted appears to hook the helper more securely than an open admission of this distress.

Skill level is also an important factor regarding the effectiveness of help provided by the adolescent supporter. Some supporters had prior experience attaining support for themselves from either a member of the helping profession such as a counsellor, or another trusted adult. Skills and strategies appraised by the young supporter as valuable in this relationship were then applied to

help peers. One participant researched online strategies to help someone engaging in NSSI providing her friend with ideas and materials to draw when she felt distressed rather than self-harm.

> *"I talked to my counsellor and she actually gave me very good pointers and tips and stuff. I just learned from her…"*
>
> (Samantha)

> *"I kind of used what my teacher had said to the second person to give myself ideas like how to talk them out of it"*
>
> (Lola)

At other times participants feel a degree of uncertainty as to how to respond, exercising typical friendship skills and at times simply hoping for the best.

> *"I actually knew what I was talking about but I didn't. I kind of just blurted things out about it and I just kept going on"*
>
> (Lola)

Strategies to support a friend commonly used in adolescence such as distraction and offering companionship, do not seem to work as well for someone engaging in NSSI as they did for day-to-day worries. Asking a friend who is engaging in self-harm if they are okay, inviting a discussion of problems, or an offer to 'be there' does not feel effective enough to the supporter either. Even when more complex strategies are employed, as the above two excerpts demonstrate, the helper is often left uncertain about the effectiveness of their help. This led to feelings of confusion, uncertainty and worry for the supporter.

c) Connecting with additional support.

As outlined in the theme entitled *Responsibility and Burden* supporters assume a high level of responsibility for friends engaging in NSSI. What would reduce this level of responsibility and associated burden, but a decision all participants struggled with in some form, was telling a trusted adult: An adult in a position to advocate for the young person engaging in NSSI. This action would likely increase safety and result in the young person being connected with formal help, and thus reduce the responsibility of trying to "fix it" (Sarah) by the adolescent supporter.

All participants made reference to speaking to their parents about a friend self-harming with two broad purposes in mind – to ascertain support ideas for the friend and to access support for themselves. However, it appeared parents seemed to struggle with how best to advise their daughters just as much as their daughters did. There was often reluctance by parents to become involved in a direct way, such as contacting a parent of the young person self-harming or a pastoral staff member at school, but instead perhaps understandably focussed on providing support aimed at maintaining their daughter's wellbeing. A reflection of the fact that parents do not experience divided loyalties between caring for their daughter and caring for their daughter's friend. Parents' advice towards the person engaging in self-harm could be described as ineffective at best.

> *"Well I would talk to my mum and she told me how I should approach the situation, tell her that hurting herself isn't really helping her"*
>
> (Mikayla)

If an adolescent wanted to access support for their friend engaged in self-harm or for themselves, they had to consider stepping aside from the friendship bond in order to engage this next level of help – the employment of a formal help provider. The involvement of a formal help provider was difficult from within their role of friend as loyalty often prevented the involvement of outside adult assistance. This was a dilemma faced by each of the five interviewees.

> *"…you're put in the most difficult spot because you don't want to break that person's trust or you don't want to make them feel like they couldn't tell you things because at the end of the day you want to be trusted… telling someone is completely shattering that person's trust for telling you that they were hurting themselves. So when they just tell you to [tell] someone, you can't tell someone…"*
>
> (Sarah)

> *"…maybe I would lose her if I told…"*
>
> (Diara)

> *"Most of the time I keep it to myself"*
>
> (Samantha)

"…I could tell someone, I suppose, I mean I've done it before. It's not too hard to tell people, but I guess I feel like I'm betraying their trust when I do it so I think that I have to try and use what I already know, knew or know, at that point in time before I could say anything"

(Lola)

"…first we talked to each other, with our friends and then we talked to our parents and my mum said she would talk to her mum… but I don't think she did cos I don't know… she would say that she didn't want us to tell her parents"

(Mikayla)

Mikayla's comments demonstrate the strength of the friendship bond and how this can be used in an attempt to control supporters' helping responses. For those participants who managed to straddle the dual roles of friendship and support person and disclosed to a staff member at school or member of the helping profession, they were left feeling uncertain as to whether they had done the right thing and whether this was helpful for the person engaging in NSSI. This dilemma often resulted in supporters turning to their peers for assistance and advice instead.

"…it was really like scary and upsetting and it led to not sleeping and yeah… I had gone to my cousin and talked to her about it and asked her if she knew what to do"

(Diara)

"...she told my other friend so my other friend told me, look you know I think she's been cutting and that and it was all like oh what do we do"

(Sarah)

One participant provided the following caution about speaking out to an adult based on a prior experience where the information she shared was not maintained confidential.

"Be sure …if you trust them, like one hundred percent you trust them, then that's when you tell them, but if you don't trust them, don't tell them"

(Lola)

d) Impact on the support person.

Of course, the relationship the supporter may already have with the young person engaging in NSSI or how receptive this person is to receiving help, may also affect the process of support provision. If the supporter perceives the person engaging in self-harm to be receptive to their support or they partake in a friendship where mutual respect is exercised, the supporter is more confident in taking

on this role of support. However, if the supporter does not feel secure in their relationship with this person helping becomes more complicated and sometimes risky for the supporter.

> *"… oh no we didn't really bring it up as she was quite a scary person… so I didn't really want to talk to her about it because it was like she would probably just shoot us down or tell us to shut up or something"*
>
> (Sarah)

> *"… I didn't want to just go straight to her mum because I didn't want her to get angry at me…I get scared of her a lot…"*
>
> (Diara)

Diara found herself in a difficult bind between a friend she did not want to lose despite the abuse she suffered from this person, and a desperateness to help her. Diara's concerns about her friend becoming angry are perhaps twofold. On the one hand she does not want to experience any blame for disclosing to an adult, but on the other hand she also does not want to provoke her friend's anger which may then lead to further episodes of self-harm.

A supporter's assessment that a friend will be receptive to their help encourages them to approach the topic of self-harm with their friend and offer support of some sorts.

> *"…she's very easy to talk to and I know that she'll listen to me I guess, I would probably tell her that I'm here to talk…"*
>
> (Sarah)

Sarah's prediction that this offer will be received in kind gives her the confidence to broach what she refers to as a *"sensitive subject and it's always quite hard to approach the situation"*.

Sometimes young people did not want any kind of assistance from their friends. Some participants respected this response but were left feeling uncertain as how to then interact and worried especially when observing fresh injuries on their friend. Often the would-be supporter will make a general invitation to the adolescent engaged in NSSI to talk about their distress at any point in the

future. Others responded differently to such a rebuff displaying an enthusiastic and determined approach which at times resulted in help being forced onto their peer.

> *"I straight up said to her, they're not cat scratches are they and she said they are, and I was like, I know they're not and she goes, how can you tell?"*
>
> (Lola)

> *Interviewer:* *"Have you ever struck a situation where somebody didn't want help?"*
> *Samantha:* *"Not really. I had one person that said nah she was fine, she was fine and I was like show me your arms and she was like I'm fine, I'm fine, show me your arms and she showed me and I was like you're not fine so what's wrong and she sat down and told me"*

Those participants who embodied this more confident style of support providing were motivated by a significant personal narrative concerning the ineffectiveness of a prior helping response. Their active to vigilante-ish style of helping provides a salve for perceived past failings in this support role and acts to ensure others are prevented from a similar fate.

> *"…it's like everyone in my class they try and hide it but they can't like… they'll pull up their sleeve and they're like oh I can't do that and pull it down again, you're just like look at that and you're like oh well you need someone to talk to…"*
>
> (Samantha)

e) Support provided.

The types of help provided by participants are summarised below. This support has been divided into passive, active, and enforced forms of assistance to clearly distinguish between the array of different help strategies adolescents engage.

Passive types of support.

- Expressions of concern e.g. "are you okay?"
- Inviting discussion of troubles e.g. "you can talk to me if you need to"
- Discussing concerns for a friend engaging in self-harm with other friends (no active strategies employed as a result of this conversation)
- Suggesting talking to an adult or the school counsellor

- Discussing with own parent when this support remains between participant and parent e.g. does not elicit an active response from parent
- Providing physical comfort, reassurance, distraction, or allowing space when requested
- Using humour

Active types of support.

- Disclosure to an adult who has direct accountability to the person engaging in NSSI e.g. the person's parents, teacher, school counsellor, or year level dean
- Alerting an outside provider to the adolescent's distress in times of crisis e.g. the police

Enforced types of support.

- Seeking out those who may be self-harming by continual observation of body language and moods of those in supporter's social circle and/or wider peer group
- Confronting and forcing a disclosure of self-harm

Passive helping responses function to relieve distress and other negative emotions on a short-term basis only. They do not attend to the underlying issues that cause the level of distress that sees people resort to NSSI. Active strategies involve employing adult assistance to help and are more problem-focussed. An enforced approach is underscored by helping in any way possible and with conviction. Methods used are proactive, assertive but also at times demanding and forceful. These interventions allow little space for the person self-harming to maintain control or a sense of autonomy over their distress and NSSI behaviours.

f) Summary.

The transition from the role of friend to helper is essential to offer effective support to a peer engaging in NSSI as the strategies commonly used to support a friend in adolescence do not fulfil the more intense needs of someone engaged in NSSI. However, for some young people it is difficult to conceptualise and embody both roles at the same time. How well the adolescent evolves into a

support provider depends on the person's motivation to assist, their beliefs about who deserves this help, their skills, experience helping others and receiving help for themselves, and ultimately how the young person navigates the related roles of friend and supporter.

Sometimes the role of supporter is overtly accepted and appreciated due to the benefits that this responsibility may afford (a sense of purpose and value, and a sense of making a contribution and difference to another's life), but for some supporters this role is more insidious in its conception. Parents struggle to assist young people in a support role providing ineffective advice which sometimes prompted supporters to step further away from a friendship role in order to engage another level of assistance, that of a formal help provider. Supporters were well aware that this could risk their friendship or have other negative consequences for themselves and within the context of their peer group.

Three different types of support strategies were noted – passive, active and enforced. Which strategies were employed depended upon the points mentioned above but also on how the supporter assessed their friend engaging in self-harm would respond. This, in part, depended upon friendship and intrapersonal variables of the friend. Whichever strategies were utilised, there were definite costs associated with the assumption of a support role.

Theme 4: The Costs of Caring – Being "Intoxicated with Worry"

There are a multitude of difficulties that young female adolescents encounter when assisting a friend who is engaging in NSSI. Some costs have discrete effects limited to particular areas of the young person's life and other costs permeate the young person's sense of self in its entirety. Such disadvantages are perhaps offset to a degree by the benefits that this helping transaction provides, as it appears supporters do receive intangible and sometimes quite subtle but valuable rewards in return for their efforts. This theme contains three related aspects including a) disconnection,

isolation and loss, b) supporter distress, and c) the benefits that may be accrued from the provision of support.

a) Disconnection, isolation, and loss.

Participant accounts of their helping relationships provided strong evidence of associated feelings of isolation, disconnection and loss as a direct result of providing this assistance. A sense of isolation was experienced by all participants at times, as the following excerpt illustrates:

> *"… not being able to tell anyone, I guess is what made it the worst… Because I couldn't even tell my mum, who could have probably helped me and talk her out of it. Because I couldn't tell her, I didn't know how to fix it"*
>
> (Lola)

In Lola's case, not being able to tell someone and to access extra support in this way was dictated by the friend she was supporting. This isolation from further help was experienced as a barrier to improving her friend's wellbeing, but also prevented the lessening of Lola's burden of responsibility for her friend.

This separation occurred between the young person and her peer group, family members, support structures at school, and among the young person and the adolescent engaging in NSSI. At times this perception of isolation prohibited the engagement of further support for both young people involved in the helping relationship. At other times it left the participant feeling bereft and with a sense of loss.

> *"… she wasn't herself at home… like she was sad and changed a lot. She wasn't like her happy self, she was real sad… it's hard to reach her like talk to her because we didn't know what to do"*
>
> (Mikayla)

Isolation from a peer group cuts off any threads of support that were being provided to both the person engaged in NSSI and also the young support provider. The effect this has on the support

provider is to increase the sense of responsibility they feel to help and care for their friend, in the absence of other peer support.

> *"…she said that if I wasn't there, she probably would have died because she didn't… because it would have just been so much harder on her"*
>
> (Mikayla)

A perception of closeness and bonding within the supporter's peer group could be created from the unique and at times almost all-consuming purpose to help the group member who was engaging in NSSI. However, conflict occurred if the group's assessment of their helping effort outweighed that of the distressed person's. This could result in frustration amongst members and loss at a peer group level if the young people respond by moving out of this friendship clique as happened to Mikayla.

> *"Maybe she'd [person engaged in self-harm] like try and reach out to us rather than us doing all the work"*
>
> (Mikayla)

> *"It caused conflict… it [peer group] would split into two… me and her would be together and the other two would be together. That just made things a lot harder"*
>
> (Mikayla)

Feelings of loss were also experienced by young people when the relationship ended between the support person and student engaged in NSSI. This end of a friendship occurred for several participants and marked the turbulent nature of the friendship, the severity of distress of the person engaged in NSSI, or an act of betrayal perceived by either person. Diara almost fell into a support role with her friend whose behaviour towards Diara could at times be erratic as well as verbally, emotionally and physically abusive. Diara describes realising "that if I keep my distance from her I don't have to put up with it anymore". As a result of this decision Diara described the following consequence:

> *"…she sent me a big paragraph saying I hate you, I'll never love you, you're half the reason why I did what I did [attempted suicide]"*
>
> (Diara)

This severing of their friendship caused Diara significant distress, feelings of blame, and sleepless nights thereafter.

The ultimate loss of a friendship occurs when one person dies. The suddenness of a death such as that by suicide can leave the support person with intense feelings of guilt, shame, grief and other negative emotions, but also a renewed sense of determination to prevent others in distress from taking such permanent action.

> *"…she'll have a shower and I knew exactly where she put all of her um razors and stuff and I used to take them home with me and throw them out. And then like one day I went over there and I was like come on it's your birthday let's go, and her mum was like oh she's not actually here and I was like where is she and she had killed herself. She was one of my best friends. That's another reason I like helping people because I don't want anyone else to do that"*
>
> (Samantha)

The loss of a friend (and the receiver of help) leads Samantha to strive for increased efficacy as a support provider. Successful helping and early intervention then become her aims within her wider peer group. In essence, 'getting it right' next time as a supporter and preventing further NSSI and attempted or completed suicides become increasingly important to this participant. Or perhaps for Samantha this goal also provides a way to fend off the negative feelings these past traumatic experiences have left her with.

There are also risks associated with connecting to others for support for either the person engaged in NSSI or the supporter. If the young person is determined that this information is to be confidential any breech of this, even in good faith, could have negative consequences for the supporter. These may include being ostracised from the friendship or peer group, or having their own personal information shared in confidence, revealed. On discussing the reasons for not telling an adult about a friend's engagement in self-harm Diara stated "so just like the fact that maybe I

would lose her if I told". The often unspoken threat of this occurring seems enough to provoke caution for some participants as shown below.

> *"…they could spread your secrets and everything you told them could mean nothing to them after that [disclosure] because they told you something important and then you blew it so maybe because you told them something important maybe they'll blow it"*
>
> (Lola)

b) Supporter distress.

Many other emotional costs of supporting a friend engaged in NSSI were revealed by participants. These costs affected their physical being and day-to-day psychological functioning. Worry, difficulties sleeping, panic attacks, and anxiety are listed as typical symptoms of participants' concern for their friends engaging in NSSI. Other feelings such as sadness, desperation, confusion, uncertainty, abandonment, betrayal, protective, angry, overwhelmed, relief, happiness, suspicion, curiosity, helpless, defensive, sympathetic, helpful, exhaustion, guilt, lonely, responsibility, disgust, disappointment and feelings of responsibility were also mentioned.

> *"…I found out that XXX was self-harming and stuff and she would always come to me and tell me like all the stuff that would be going on in her life, then I would have like… I would sort of have like panic attacks"*
>
> (Diara)

> *"I kind of forgot about what was going on in my life and made them [friends self-harming] more important because I felt like that my problems were slim to nil to what their big problems were"*
>
> (Lola)

> *"I feel like the stress made me quite… I had to talk about it a lot to let it out I guess and it made my whole life just kind of intoxicated with this kind of worry about this person"*
>
> (Sarah)

Overwhelmed and consumed by stress and worry were common reactions to supporting a friend. Being "intoxicated" as Sarah describes provokes the notion of alcohol or substance inebriation. Applying this metaphor to Sarah's words prompts an interpretation of the participant rendered incapable of functioning perhaps in line with her own life goals or ambitions, but being consumed with concern for her friend engaging in NSSI. 'My whole life' points to the consistency of these

worrying thoughts and how they pervade constraints of time and place. Worrying is not limited to interacting with the person engaging in self-harm, indeed this worrying has no limits at all.

Behaviours such as internalising one's own difficulties and engaging in self-harm were also expressed as attempts at coping with this secondary distress. In response to a question about self-care, Lola stated the following:

> *"Normally I just kept it bottled in because I didn't know if I could tell anyone else and she was the only one I wanted to tell so I just didn't tell anyone, I just kept it bottled up. Because I just felt if I told anyone else that I couldn't trust them"*
>
> (Lola)

Lola highlights the dilemma of the person who is engaging in NSSI and the recipient of a friend's support also being the one person whom the supporter feels safe revealing their innermost worries and concerns. In this case the participant felt she had to withhold this distress and feared overburdening her friend if she were to disclose. 'Bottled in' is a commonly used phrase to relate the experience of containing emotions within oneself due to lacking the required skill or opportunity to express these. Used in the above excerpt this phrase also signals choosing to whom and perhaps how and when emotions are expressed given feelings of safety, trust, and space required to do so.

c) Benefits accrued from support provision.

Despite the negative emotional and social impact on an individual supporting a friend engaging in NSSI, there appear to be some benefits incurred in this helping relationship also. Supporting someone in distress provided some with a social connection that perhaps they would otherwise have not had. Others derived a sense of satisfaction from successful helping, a sense of relief tempered with gratification or pleasure at what their efforts had achieved. Lola had been supporting a friend and described how she "kind of talked her out of it [self-harm]". The following is Lola's response to this friend telling her she had stopped self-harming.

"Imagine carrying a 10kg sack of potatoes on your back. It felt that the whole sack had ripped open and fallen off my back… She couldn't see that I was actually crying that I was so happy that she had stopped, I had been so worried about her and I guess when she said that she had stopped, the whole sack of potatoes fell off"

(Lola)

"It was hard but we did it somehow and then we became closer when she got really bad and then got better"

(Mikayla)

Perhaps accompanying someone to such depths of despair and empathising to such a degree evident within these young participants' stories provides an upside of experiencing more positive emotions with a similar intensity such as joy, relief, and a sense of achievement. Lola certainly responds with high emotion to her friend's disclosure of no longer engaging in NSSI and both excerpts reveal the satisfaction each participant feels with being part of their friend's journey through self-harm and out the other side.

Closeness and bonding between individuals and between supporter and peer group are also noteworthy benefits. Samantha attributes the support she gave her friend who was self-harming to developing the close relationship they now enjoy and the advantages that this provides.

"… like she knows when I'm upset, like I'll walk into school and she'll be like you're upset, come here, what's wrong and yeah she just knows. I'll be texting her and she's like what's wrong. Just by something I've said"

(Samantha)

The connection that has occurred between Samantha and her friend, instigated by Samantha when her friend was self-harming, has now become a symbiotic relationship functioning to provide both with the usual benefits expected of friendship at this age and stage.

"…like being able to talk about it with other friends was always like brought us closer together because we were able to talk about it"

(Sarah)

"Well we became closer, the three that… like the people that were trying to help her became closer but we were getting closer to her but not as close as we could have been at the time"

(Mikayla)

An additional benefit to supporting a friend for participants was further building a sense of identity, satisfaction with current place in life, and/or social status within their wider peer group. Using comparisons between self and other to learn more about the self. For the supporter gaining perspective on their troubles compared to their friend's was also beneficial.

> *"It made me think I'm a lot like her… I was grateful for what I had and how I felt about things"*
>
> (Mikayla)

> *"I'm not a girly girl, I don't like wearing dresses or skirts or anything and when we [friend who was self-harming] went to the social she went and bought me a dress, she said you're wearing this to the social, you're not wearing shorts, you have to wear a dress. I was like oh fine. Ever since then I started wearing dresses and skirts and stuff and turned into kind of a girl"*
>
> (Samantha)

The characteristics of the friend who is self-harming impact on the supporting friend's identity as one would expect particularly within a friendship during adolescence when identity formation is an important task of this stage. Also it is clear that particular aspects of the helping process reinforce the identity of the helper that some participants have included within their persona.

d) Theme summary.

Supporting a friend engaging in NSSI resulted in participants experiencing costs and benefits attributed to this helping transaction. Some costs gave rise to discrete effects and others permeated the adolescent's sense of self. Most felt a sense of isolation, resulting from disconnection with their friend who could appear different once knowledge of NSSI was shared or gained, and detachment from their peer group and parents in a support role. Stress and a host of other negative emotions such as guilt, shame, grief, and sadness were experienced. For some, negative evaluations of their helping effort intensified feelings of worry, incompetence, self-blame, and vulnerability. In many ways the young supporter's mental health and wellbeing was compromised by the helping effort.

Despite these concerns, it appears that by supporting a friend the adolescent may also gain some positive benefits. These advantages included a connection within what was a sparse social landscape for some participants, a sense of satisfaction derived from the act of helping, feelings of gratitude for their own current position in life, and positive influences on the supporter's sense of identity. Therefore, it appears experiencing the lows of being emotionally connected to a friend engaging in self-harm was at times balanced by the benefits this process afforded. Navigating this helping process and the associated costs and benefits for the supporter requires resiliency and support from key members of the young supporter's environment. What adolescents' supporters need to maintain their well-being and to continue to provide this help is expanded upon in the next theme.

Theme 5: Supporter Needs – "…Our friends hurting themselves is hurting us"

The supportive relationship between a peer and their friend engaged in NSSI can be described as intense for this group of participants. Complex emotions including confusion, uncertainty, worry and fear are triggered within the usual bounds of friendship attachment and from the addition of a helping role. Young supporters are concerned as to whether their helping actions have been beneficial (enough to avoid further episodes of self-harm or more risky behaviours such as a suicide attempt), whether it was detrimental, or if they could have been doing more. Worries about the changes in their friend's behaviour, resulting changes within the adolescent's peer group, and negative consequences of helping also provide the young supporter with many dilemmas to consider. In response to these worries and the associated burden of responsibility felt by many supporters, some attempted to secure the aid of a mutual friend of the person engaged in NSSI or a family member of the supporter. Occasionally an adult positioned to directly intervene with the young person at risk was approached to assist. Whilst this decision sometimes provided the supporter with a form of support it did not affect any reduction of risk for the person engaged in

self-harm or ease the supporter's concern. Thus the level of responsibility an adolescent supporter typically assumes for their friend in this position was not alleviated in any way.

The challenging task of helping a peer incurs many possible costs for the supporter, as well as some benefits as described in the preceding theme. Supporters describe being "intoxicated with worry" (Sarah) but in some ways paradoxically determined to "help them in any way that you can" (Samantha). Given the resolve of these young helpers it is important to consider what their support needs might be, and what can be done to support the supporters.

Supporters' needs can be divided into a) those related to the current developmental stage of the adolescent (developmental needs), b) those that require meeting by the environment surrounding the adolescent supporter (environmental needs), and c) needs essential to the support act itself (support-specific needs).

a) Developmental needs.

All participants mentioned interpersonal difficulties they experienced such as difficulties making friends, their only friend being the person engaged in NSSI, and/or a history of being bullied. Friendship provided an open gateway to accelerating the offer of help amongst peers. The flipside of engaging in this helping transaction is that participants in return often searched for their friendship needs to be met by the person engaged in self-harm, desiring the friendship to be on more equal terms where this person would be available to partake in the tasks of adolescent-stage friendship. Essentially participants wished for a reduction in their friend's level of distress both for their friend's wellbeing but just as importantly for more self-interested reasons, that is, in order for the person to be available and able to participate in a mutually beneficial relationship.

Interviewer: *"Is there anything else that you'd like to say about what girls in this situation, what you needed?"*

Mikayla: *"No, I just needed my friend to be happy and not hurting herself anymore"*

Within Mikayla's words is the notion that what she really craves is to have her friend back, functioning as a friend, fulfilling the expectations that such a relationship usually provides. When Mikayla's self-harming friend receives additional support and her own distress levels dissipate, Mikayla describes their relationship in favourable terms indicating those things that she is now deriving from the friendship which were missing when NSSI and support provision were focal points.

> *"Well we hang out practically every weekend now…we have fun and that together which I think matters… when she is upset she does tell me now and we're a lot closer"*
>
> (Mikayla)

Lola describes the concessions she made within her friendship with a peer engaging in NSSI, prioritising her friend's needs beyond her own in every area of her life, and feeling unable to table her own issues creating a relationship that was decidedly one-sided.

> "*…I chose to forget about myself and think about them until their problems were sorted and then I could think about myself again… they would get grumpy because they wanted it to be about them and they wanted their situation fixed before mine could even be thought of"*
>
> (Lola)

There is an expectation and acceptance inherent in Lola's words that friendship tasks such as both parties having space to air their worries would not be mutually offered for a length of time. The desire for connection and to belong motivates adolescents to form friendships. However, a need for recognition and perhaps it could also be argued a sense of agency, provides some motivation to assist those engaging in self-harm. This need for recognition and agency once gained, albeit from best attempts at helping, can be the factor that impedes the relationship between supporter and friend.

This highlights the importance for the supporting peer to be able to connect with another trusted person with whom they can air their own worries and concerns. It was important for some participants to be able to discuss the difficulties of providing support and receive encouragement for the help they are providing to peers.

"…just being able to let someone else know will help me so that I'm less panicked and that"
(Diara)

"I think we also need support and someone to talk to, because I wish I had support when I was supporting other people because I felt like I was giving it all away and I had nothing that was keeping me going…"
(Lola)

The absence and yet importance of self-care strategies was also present within participants' stories. Few participants were able to articulate how they cared for themselves when suffering extreme stress as a result of the support they were providing or other sources of stress in their lives. Indeed the supporter's attention was narrowly focussed on their friend's needs. A belief about self-care in order to better care for another was largely an invisible concept amongst participants. Few exhibited any attempts at establishing boundaries with friends to ensure their own wellbeing as well as the safety of distressed friends. The application of boundaries was most commonly for the purpose of safety of the person engaged in self-harm. Perhaps this lack of restriction to the help provided is a result of a knowledge gap for young adolescents. One participant who was most effective at creating boundaries applied her experience from a prior counselling relationship.

"…if someone says hey can we talk I'll be like if it gets really bad or something I'm going to have to tell someone. But they're like yeah that's okay"
(Samantha)

In terms of other self-care strategies, only one participant overtly commented on this topic listing the following tactics to reduce the stress that helping a peer exposed her to: exercise, talking to a parent, accessing counselling, and art. Learning how to look after oneself, how to manage emotions, and problem-solve are skills that are typically learnt and developed at this stage of life. However, for peers supporting friends in distress these are essential skills to maintain the helpers' wellbeing and to sustain the helping effort.

b) Environmental needs.

For young people securing support from their day-to-day environment was fraught with difficulties and pitfalls. Accessing parental support was hard for some. Diara talked about needing to "be brave" in order to do this due to an inability to predict how her parents would respond and uncertainty about whether her parents would be upset with her. Another supporter was concerned about the impact disclosing her distress would have for her parents not wanting to pass this burden on.

> *"I sort of had to think about it for a couple of days and then be able to be brave and tell my mum what had happened because I didn't know what to expect like what she would say"*
>
> (Diara)

> *"I'd talk to my mum about stuff like that but then obviously she wouldn't know what to do about it. Like she couldn't go and tell her mum that you know her daughter was self-harming or anything because she felt like that wasn't her place to say anything… I was like kind of just handing that stress on to her…"*
>
> (Sarah)

Supporters need people to confide in who they trust to discuss their worries with and the difficulties inherent in the support process. They need reliable and knowledgeable forms of support from the adults within the environment they provide this helping response in. Thus the young adolescent supporter's surrounding environment could be further harnessed to help fulfil their support needs.

When Lola disclosed to a teacher that her friend was engaging in NSSI, the following took place:

> *"And she said what do you want me to do about it… what do you want to come out of it and I said I want her to stop hurting herself and I wanted her to be happy…"*
>
> (Lola)

At no point in this initial discussion as relayed by Lola, did either participant in the conversation appear to consider what Lola needed in the support role she had assumed. Subsequent to this Lola is charged with the task of informing her friend's mother of her daughter's self-harm in a meeting also including the teacher and her friend. Again from Lola's transcript there is no evidence that

anyone involved in this process displayed insight as to how Lola may have been affected by helping her friend prior to disclosing to the teacher, during the meeting, or after this concerning how the friendship may have changed. Adults in positions of support for young people need to be aware of the disadvantages adolescents encounter whilst providing this support, the emotional strain this can cause, and the support needs that arise as a consequence from this helping process.

c) Support-specific needs.

With regard to the support-specific needs of adolescent supporters, all participants described feeling inadequately prepared to meet their peer's support needs. For some the process of consulting with mutual friends or on the rare occasion a teacher or counsellor, increased their helping resources somewhat leading to an incremental increase in confidence. It is important to note that this increase in confidence did not necessarily correlate to an increase in skill level. This knowledge and skill gap is understandable given the age and stage that young supporters are at and highlights the need for advice to be able to provide effective support.

> *"I don't know, sometimes I just come out with weird stuff and I guess that that was one of those weird things that I came up with… I actually knew what I was talking about but I didn't. I kind of just blurted things out about it and I just kept on going"*
>
> (Lola)

As Lola describes, her experience of helping friends engaged in self-harm was a process of developing or refining her helping efforts in an attempt to come up with a plan that she could implement again when required in the future. Participants, who had not had prior experience with accessing formal help services from which to draw support strategies from, floundered with this lack of direction sometimes resorting to creating their own helping advice in the absence of any direction.

Mikayla: *"Well get people to talk to her friends and tell them how they should react and what they should say and things like that"*

Interviewer: *"Where do you think that kind of help, those ideas that you're talking about, where would they best come from?"*

Mikayla: *"From their parents or people like you [school counsellor]"*

Supporters are yearning for direction and a plan that they can implement with confidence knowing that this will be helpful for their friend. The provision of helping strategies would afford supporters reassurance and the confusion, indecision and worry felt as supporters require more than to be simply told to tell an adult as Sarah notes:

> *"…there is no way that they've actually told us to deal with it and it's really hard… I think having some actual steps to know how to deal with it would be very helpful… I want to know what to do"*
>
> (Sarah)

Sarah's comment expresses feelings of frustration at this lack of direction and is accusatory towards a group of people, most likely school staff and the wider group of adults in her life. She at least partly attributes her struggle to help with the lack of assistance she has received. A dilemma Sarah exposes in a plea for help. Sarah's comments stem from her commitment to solve the issue at hand, self-harm and the effects of this on her friend, their relationship, and herself. Sarah is not yet able to conceive her own limitations and of crucial importance, to therefore know when to share this role with an adult. Staff and parents becoming better informed about NSSI including antecedents, signs, risk, how to respond to the person engaging in self-harm and an awareness of how peer supporters are affected by this process and attending to their wellbeing are all pertinent. Adolescents are looking to adult figures in their lives to provide this information and assistance. Albeit still wanting to be the ones who are providing support at the coalface. Perhaps this has been a function of the dilemma for young people supporting a friend engaging in NSSI: How to provide this help with limited resources and skills or knowledge alongside an urge to be the one, instigated in part through the loyalty of a friendship, who fulfils this helping need.

> *"I think emotionally it would help people and just like let them know what to say like about that, trying… that staying living is the best option for them"*
>
> (Mikayla)

Mikayla recognises the emotional assistance supporters require as well as the need for direction in terms of managing risk. An acknowledgement of the difficulty inherent in straddling the dual roles

of friend and supporter is required to help the young adolescent navigate these roles effectively and safely. Support and encouragement in order to continue to manage these positions is also important.

Increasing the circle of support for the person engaging in NSSI will have a trickle-down effect to the supporter. The engagement of a young person self-harming with a formal support service where evidence-based best practice is utilised will relieve a portion of the responsibility and burden of care felt by the adolescent supporter in and of itself.

> *"Let their whole family know so that they have support of everyone, not just a few people, not just their friends and maybe let their teachers know…"*
>
> (Mikayla)

The developmental, environmental, and support-specific needs of the adolescent supporter are identified by those engaged in the support provision process. These needs are entwined together such that the fulfilment of one requires awareness of and direct action amongst the other areas, creating a synergy of support for the young helpers. For example, in order to have school staff who are informed about NSSI support issues and are approachable to students (environmental need), staff need to receive professional development concerning the age-related needs (developmental needs) of adolescents related to a support provision role, particularly the dilemma between assuming a friend or support role that adolescents face. If young people are to learn specific skills to assist a peer in distress (support-specific needs), self-care strategies also require attention to compliment and ensure balance between caring for oneself and caring for another (developmental needs).

d) Summary.

Young supporters are faced with several complex dilemmas associated with helping a friend engaged in NSSI. Some of this complexity originates from the dual roles of helper and friend, which can be

difficult for adolescents to conceptualise let alone navigate to provide effective support whilst maintaining their own health and wellbeing. While loyalty provides a foundation for friendship, it also creates a sense of responsibility and sometimes the additional belief that a friend should be able to fix the problem of self-harm. Perhaps this is why solving the 'self-harm problem' is so attractive to young friends. The bond to their friend is such that there is a covert expectation that this help is not only expected, but is a reasonable role to fulfil and one that adolescents eagerly take up to demonstrate the level of their dedication, care and concern. As Lola declared:

> *"…it was my job to make them happy and my job to cheer them up and my job to stop them"*
>
> (Lola)

Summary

The main findings from the application of an IPA methodology (J. Smith et al., 2009)concerned the impact that being a supporter had on the individual adolescent within the context of their peer group and wider social network. The transition from friend to supporter was essential to offer effective support to a peer engaging in NSSI as the strategies commonly used to support a friend in adolescence do not fulfil the more intense needs of someone engaged in NSSI. However, for some young people it was difficult to conceptualise and embody both roles at the same time. The burden of responsibility perceived by supporters in this study highlights this dilemma. As such, NSSI was somewhat of an unwelcome intruder into relationships changing the social landscape and nature of social interactions.

How well the adolescent evolved into a support provider depended upon the person's motivation to assist, their beliefs about who deserves this help, their skills, experience helping others and receiving help for themselves, and ultimately how the young person navigates the related roles of friend and supporter.

Performing this role of support afforded many costs but sometimes also provided benefits. Whether the supporter could access help for their friend engaging in self-harm and for themselves in this role, mitigated the degree to which the supporter experienced this role as difficult or fulfilling and affirming.

Each of the themes explored are closely connected and entwined together. The concept of straddling support and friendship roles impacts the level of responsibility and burden that is felt by the supporter. This in turn impacts established relationships not only with the individual who support is directed towards, but within the wider peer group and beyond. If these relationships then become disconnected, support options for the supporter are reduced. The introduction of an adult supporter can moderate the negative effects of helping, but to connect with this person or service the young helper needs to understand the dilemma of friend and helper.

The following chapter places these findings within the wider context of existing literature in the area of NSSI and adolescence. Recommendations for the improvement of support for the supporters are offered. Limitations of this study and implications for further research are discussed.

Discussion

NSSI is a maladaptive behaviour used to manage distressing emotions and in response to life stressors for approximately 18-55% (James, 2013; M. Wilson et al., 2015) of the New Zealand adolescent population in the community. The literature shows that peers are often aware of those who are engaging in self-harm among their peer group (James, 2013), and that adolescents provide a support system within and beyond these friendships, with friends frequently being the 'resource of choice during times of emotional distress' (Barton et al., 2013). However, existing research provides little insight as to how the supporting adolescent engages in this process and what affect this form of helping has on the individual supporter.

The aims of this study were to uncover and explore how young female adolescents support friends who engage in NSSI, including how the supporting adolescent is affected by this process, how a disclosure of NSSI impacts the relationship between supporter and friend, and what the supporter requires to continue to fulfil this helping effort. Several key findings emerged from the application of an IPA methodology (J. Smith, 2004). These points included how young people determine whether a peer engaging in self-harm requires support, the distress supporting adolescents' can experience whilst performing a support role, the level of confidence exhibited to intervene in a supportive manner compared to associated levels of skill and ability, and the role of identity as a motivating factor for assuming and/or continuing in a support role.

Beliefs Regarding Support Provision

Responding to a disclosure of NSSI with openness, warmth and empathy (Walsh, 2006) is imperative to assist the young person to engage in a supporting relationship with their peer. This is important beyond a purpose of receiving peer support, as research shows those who access informal support for a range of distress symptoms (including NSSI) are more likely to engage with a formal helping

service (Idenfors et al., 2015; Nada-Raja et al., 2003; Pinto-Foltz et al., 2010). The young people in this study possessed some unhelpful beliefs that guided their perception of who was genuine in their communication of NSSI and therefore, who required support as opposed to who was "attention-seeking".

All participants made reference to making a judgement about whether communications regarding NSSI were attention-seeking or genuine expressions of help from young people engaged in self-harm. If they considered a peer's communication about self-harm was disingenuous this resulted in responses that undermined the request for help. If they believed a peer's communication of NSSI was to achieve a social goal, for example to influence their social standing with a group, this communication was largely ignored. It appeared that a direct and repetitive communication of NSSI was left unmet by peer support, whereas a more covert and often unspoken message of self-harm was attended to. This is significant given that Armiento et al. (2014) found in their study including 268 undergraduate females, that individuals reporting prior engagement in NSSI resulting in severe tissue damage (labelled 'severe NSSI' by the researchers) were more likely to disclose this behaviour than those engaging in 'less severe NSSI' (NSSI that resulted in mild tissue damage only). Paradoxically, it appears young people may be more likely to attend to peers who reveal less severe forms of NSSI and deliberately not engage with those exhibiting higher levels of NSSI. Perhaps the communication of severe or chronic NSSI is left unattended as potential supporters realise they are ill-equipped to meet the needs of these young people.

Distress and the Act of Supporting

Young people assuming a support role experience various levels of distress when assisting a friend engaging in NSSI. Feelings of stress, worry, fear, and sadness, as well as sleepless nights, panic attacks, and a lack of support options contribute to this distress. Often supporters are so closely entwined with their friend in distress that they begin to vicariously experience their friend's

emotional lows in addition to their own life stress (Kessler & McLeod, 1984). That is, they can experience empathetic distress (Swenson & Rose, 2009). Empathetic distress is a potentially maladaptive type of empathy that occurs when individuals are unable to distance themselves emotionally from a relationship partner's distress, and instead take on this distress as their own (R. Smith & Rose, 2011). This level of distress is further compounded by the supporter's sparse self-care strategies and limited NSSI-specific support-tools to meet the needs of the person engaging in NSSI, and thus reduce both individuals stress levels. All participants displayed at least some reluctance to involve an adult who could provide, or connect the friend engaging in self-harm, to more specialised help. This was due to the tension between secrecy, trust and non-disclosure, and the need to share this burden and responsibility with someone more experienced and adult-like.

Confidence versus Ability

The findings from this study provide an explanation as to why this decision, to not involve an adult, was made. Attitudinal barriers were evident as the young person aspired to be the one to provide the helping effort, with some participants referring to this as their responsibility given their friendship connection, or as their "job" to fulfil. Existing research regarding mental health literacy and first aid actions, demonstrated that young people (aged 12-17) had "less sophisticated first aid knowledge and beliefs than young adults (aged 18-25) but were paradoxically more confident about providing help to a peer" (Jorm et al., 2007, p 61). The life stage of adolescence in itself works against peers actively involving an adult as during adolescence young people are forming tighter bonds with their peers, weaker connections with adults, and are more likely to take part in risky behaviour. These factors encourage young people to embrace the role of supporter with independence. This study has made a valuable contribution in this area, discovering that the friendship bond between peer supporter and the young person engaging in self-harm is such that it may preclude the involvement of an outside source of adult help. The involvement of an adult may, for this group of young people, demonstrate their failure as a friend.

The Support Role and Identity

Some participants are more confident in their helping abilities than others. For some the support role formed an important component of their identity. Young people who value and commit to this role embrace the tasks of the helper with intensity and determination. Their efforts are not restricted to one or two friends engaged in self-harm, but anyone within their wider social circle may receive this support. For such a young person the support role morphs into a supporter identity such as the 'hero' or even 'vigilante'.

Erikson (1968) described identity as an interpersonal development which sees a young person exploring their culture searching for 'sources of identification', for 'identity types' that appear significant and applicable to that person and which they can commit to assuming. The maintenance of a supporter identity requires exhibiting regular helping efforts which further contribute to and accentuate a positive perception of the young person's identity.

A supporting role may also provide 'identity capital' for the adolescent. Identity capital is composed of tangible and intangible assets that can be traded to gain entrance into coveted social groups or institutional domains (Côté, 1996). Capital can be exchanged symbolically, emotionally or pragmatically. Within the peer group an adolescent can employ a supporting role strategically to gain entrance or maintain membership to a particular social group. Their ability to perspective-take, to attend to distressed members, and to engage readily in difficult situations, may afford them status and the ability to better understand and negotiate various social obstacles. In this way the young adolescent supporter has become socially visible and influential as a result of her supporting role and its integration with her 'theory of self' (Harter, 1990).

There is also the question of why do some young people decide to help their peers engaging in NSSI, whilst others do not? Curiosity may partially fuel an offer of support to a friend engaging in NSSI, for

the supporter to then realise that withdrawing this support is too difficult. For participants in this study motivation to disclose a friend's NSSI to an adult was partially inspired by a need to share responsibility for the friend's support needs. This sharing of the support burden may also provide a way for the supporter to at least partially extricate themselves from this role if required.

Despite this, the majority of participants put aside their own concerns and commitments to attend to another person in distress. Sometimes the people in distress were not friends, but young people the participant did not have a prior friendship or connection with. Perhaps this altruistic style of helping is a reflection of an adolescent's more cultivated sense of identity, or within their family system they may have been exposed to more difficulties and learnt coping skills from these experiences, or they may simply display a higher level of emotional literacy and regulation skills.

People who choose to help a peer in distress when others choose to abdicate responsibility for intervening are referred to by Zimbardo (2009) as 'heroes'. Zimbardo defines the construct of 'hero imagination' as a focus on one's duty to help and protect others, which forms the basis for a hero's actions in difficult circumstances. One participant in this study spoke of it being her 'job' to intervene to help her friend engaging in self-harm based on having best friend status. One other described searching out those who were in distress and assertively providing assistance, whilst another expressed her desire to 'fix' peer's troubles. In these instances, acting heroically, beyond what other peers were providing in terms of assistance, was cultivated within the perceived role of best friend and a strong concept of identity as a supporter. According to Zimbardo (2009), surviving a trauma makes a person three times more likely to be a hero. Similarly, several of the participants referred to above had endured significant traumas in their lives and referenced applying the skills and learnings they had accumulated from these times to helping others.

However, in order to provide our adolescent heroes with the best opportunity to be effective in this role, they need to be part of a network. To have "the resources to bring their 'heroic impulses' to life" (Zimbardo, 2009). The school setting can play a significant role in ensuring these adolescents are well-resourced to provide effective support to students in distress throughout the campus.

Application of Findings

This is a small-scale exploratory study and therefore caution needs to be exercised when offering practical applications based on the findings. Young people in this study indicated several factors that would be helpful to assist support providers to continue to help peers in distress. Adolescents desired information about effective ways to support a friend engaging in NSSI and assist their friend to manage distress. It is also apparent that having an understanding of the functions NSSI fulfils, focussing on helping the peer to understand the factors that underlie this behaviour and addressing these, as well as ensuring adolescents at risk of harm are referred on to an adult, is important. Adolescents also required emotional support from adults and to be providing support within a network that functioned to resource and support the supporters.

The school environment can provide this supportive network by developing (or further expanding) a student-led mentor programme focussed on enhancing student well-being where student mentors act as gatekeepers to further sources of assistance. Student mentors would provide an approachable source of assistance within the day-to-day environment of young people and promote the sharing and disclosure of problems. The connection between student mentor and adult helping services advocates and allows the involvement of an adult, reducing stigma regarding speaking out about friends' troubles and obtaining help. Once a connection with a mentor is made, sole responsibility for supporting a friend engaging in NSSI is taken away from the supporter. The burden of providing this support is shared.

To resource this effectively a selection of students and staff who have a 'heroic imagination' (Zimbardo, 2009) need to be identified across the student population (that is, students from different year levels, ethnicities, genders, and with different strengths and interests). Those selected, staff and students, require education concerning identifying and responding to a peer in distress, accessing further assistance for this person, and how to be a 'hero' rather than a 'bystander' (Zimbardo, 2009). Students would be empowered to gain further support for the distressed person and themselves in this supporting role through their connection to a well-resourced mentoring network. Imperatively, this student-led mentor programme must have strong connections with community helping services for youth to ensure referrals are responded to in a timely fashion and the programme is adequately supported by those with specialist knowledge concerning youth issues.

There is a need for professional learning and development concerning NSSI and how to respond to a disclosure for the wider staffing body. Staff need to be aware of the signs of NSSI (and general distress), how to respond to a disclosure of NSSI from a young person engaging in this behaviour or their friend's disclosure on their behalf, but also understand how the process of supporting a friend engaging in NSSI affects the supporter. In particular, it is important that staff respect the privacy of a young person and their friend when a disclosure is made. Although confidentiality cannot be guaranteed in a situation where harm may imminently occur, students do not appreciate their disclosure being repeated unnecessarily to staff who are not involved in the provision of help. Encouraging staff to validate, care, and offer support to both parties at the time of an initial disclosure of NSSI and beyond, is important. Taking action to relieve the person engaging in NSSI's distress and keep in contact with the supporter is valued by supporters, as is encouragement and an offer of emotional support to the supporter. Supporters also value staff that have an understanding of NSSI and do not act to stigmatise or undermine the support person or young person engaged in self-harm.

Staff development modules must be nestled within robust policies and procedures that clearly outline other school processes that assist the supporter in this role, the student engaged in NSSI, staff members and families to access support and improve student well-being (such as the peer mentoring programme, student education regarding self-care and instigating further help, and the process for engaging specialist helping services).

It is vital that education is provided in the school setting for all young people regarding robust self-care strategies, alongside a clear message that if a friend indicates that they are at risk of harming themselves (or someone else) this message is passed on to a student mentor or trusted adult. Within the community provision of youth-specific services, the school setting, and the family system young people need to be provided with a clear message that asking for help in times of trouble can be difficult but commendable and a sign of strength. Asking for help when difficulties are at a low level is preferable to when the young person is experiencing great distress. Therefore being proactive in the approach to seeking help for oneself or another is also to be encouraged.

Consultation and education for the wider school community including parents must be provided. This would include the principle that young people are more likely to approach their peers for support for NSSI as well as general distress, thus it is important that adolescents are well-supported for this task in their home and school environments. Education offered to parents concerning how to support their children to support others, when to be concerned, what action to take at this point, and how to access further help, would be extremely beneficial. This study has shown that parents and caregivers are at a loss as to how to assist young people manage their friend's distress. Imperatively parents require a plan they can instigate if alerted to a young person at risk of harm. Whether this is their own child, or someone else's.

It is recommended that public health information circulated to young people that recommends 'treating your friend as usual' needs to be adapted. The findings from this study have shown that interactions between a friend and person engaged in NSSI do change substantially. Promoting a treat your friend 'as usual' message can add to further frustration for friends trying to negotiate the new ground rules of this relationship. Perhaps reference instead could be made to the friendship feeling different for a time and that the non-NSSI friend may need to have their own friendship needs temporarily met by other peers.

For individual clinicians in the helping profession, being aware of the effect helping another peer can have on an adolescent is crucial. Offering support and guidance to help sustain both the helping effort, within appropriate boundaries, and assisting the supporter to navigate the changing landscape of the friendship is important. Ensuring practice includes monitoring the supporter's well-being and advocating the use of self-care strategies will also be of benefit.

Lastly, high schools are challenged to engage young people in the design and structure of student health and well-being services in their school. It is known that peers are often the first to notice a young person's distress and can be a valuable source of support with the potential to connect young people to helping services. Young people need to have their voice heard in the development of school services and policies that encourage and reduce barriers to fulfilling this support function.

Limitations of this Study

There were difficulties inherent in carrying out research with an adolescent population. Factors such as negotiating consent to carry out the study within a school context where adults are sensitive to the subject of NSSI, recruiting participants who were prepared to speak about an experience that not only involved reflecting on their distress but that of their friend's, made this a complex process. The five-month period that recruitment for this study required is testament to these difficulties.

As a result of obstacles during the recruitment phase, and after gaining two amendments to the ethical profile for this study, a School Guidance Counsellor reviewed her files to create a sample for this research. It is acknowledged that the sample is somewhat biased as a result, as the recruitment process was not open or accessible to the wider school population within age range and other inclusion criteria of the study. However, it is believed that within the parameters of the qualitative methodology applied, the findings are relevant and offer important insights to the experiences of young adolescents supporting their friends engaged in NSSI.

Another limitation is that participants were of European or New Zealand/European ethnicity only. Therefore the views of other ethnicities such as those young people from Māori**,** Pasifika or Asian descent were not captured in the data collected. Given that some research shows prevalence rates of NSSI for Māori are higher than those of NZ/European youth (Coggan et al., 2003; Fortune et al., 2010; Garisch, 2010; Nada-Raja et al., 2003), this is an important omission. However, when referenced with regard to the barriers encountered in the recruitment process for this study as noted above, perhaps somewhat understandable.

Recommendations for Future Research

Further research with a larger sample of young people, a wider age range, and including males to understand gender differences in the peer support process, would be useful. As would exploring whether there is disparity between supporters who have a history of self-harm and those who do not within the support process. Additional investigation of the supporter identity could uncover 'heroic' attributes which could be used to identify and recruit adolescents for a peer-support mentoring programme.

The concept of empathetic distress could be advanced further with this population. Exploring the construct across cultures would be useful to predict which populations are more vulnerable to experiencing this distress. It has been suggested that those cultures that are individuated, where people are viewed as unique and independent, may reveal different levels of empathetic distress compared to cultures where interdependence and connectedness among individuals are valued (R. Smith & Rose, 2011). It may be that Māori rangatahi experience greater levels of empathetic distress because the division between self and other is blurred, making it more likely that Māori rangatahi will take on the distress of others as their own.

Conclusion

This study has demonstrated four key points: the intrusive effect that NSSI has within relationships, the enmeshment between roles of friend and supporter, the burden of responsibility afforded in a supporting role, and the assistance required to perform this role effectively.

NSSI interferes with existing support relationships, creating a hurdle that some are unwilling to overcome in order to continue the relationship. Existing friendships can falter, peer group relationships become strained, and accessing support from family members becomes complicated. To maintain a friendship with someone engaged in NSSI presents many difficulties such as navigating the different presentations of this person across private and public forums, continual attendance to their changing needs, and managing the distress that the supporter feels in response to this role.

However, to provide effective assistance to a friend engaging in NSSI requires the young person to conceptualise, adopt and maintain a support role. To move beyond the duties of a friendship and provide something more to meet the needs that NSSI creates. As the usual tasks of friendship such as the mutual discussion of problems, showing empathy, and companionship, fail to meet the requirements of the peer engaging in self-harm. In this way NSSI changes the interaction between

the young person and the person engaging in self-harm, as well as wider relationships amongst the peer group and beyond.

Taking on the role of a supporter in conjunction to a friendship role required careful negotiation to maintain these two functions simultaneously. The loyalty that underpins and is one of the hallmarks of a quality friendship interfered with a key process of providing support to someone engaging in NSSI – that of accessing further support sourced from an adult when the young person's safety was at risk. The loyalty that the friendship created, alongside the secrecy the person engaging in self-harm often demanded, and the young supporter's desire to be the one helping from the 'front line', created a context where further help was often not secured. The resulting responsibility for the friend's behaviour and safety created feelings of burden, accentuated by other negative emotions experienced by the supporter such as distress, worry, and fear. This was a heavy load for supporters at this stage of adolescence to carry.

This burden would be alleviated by putting in place several key strategies such as educating young people, parents and school staff, about NSSI and how this behaviour impacts friendships and the supporting peers' well-being. Young people understanding what behaviours constitute a safety risk and how to respond appropriately is important as well as age-appropriate and effective ways that they can provide support. Encouraging young people to access support and to view this as a strength and helpful for both their friend and their own self-care would be worthwhile. As Lola insisted:

> *"… we may not be hurting ourselves, but our friends hurting themselves is hurting us".*
>
> *(Lola)*

References

Aisbett, D. (2006). Interpretive phenomenological approaches to rural mental health research. *Rural Social Work and Community Practice, 11*, 52-58.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Andover, M., Morris, B., Wren, A., & Bruzzese, M. (2012). The co-occurence of non-suicidal self-injury and attempted suicide among adolescents: Distinguishing risk factors and psychosocial correlates. *Child and Adolescent Psychiatry and Mental Health, 6*(11), 1-7.

Armiento, J., Hamza, C., & Willoughby, T. (2014). An examination of disclosure of nonsuicidal self-injury among university students. *Journal of Community & Applied Social Psychology, 24*, 518-533.

Barker, G. (2007). Adolescents, social support and help-seeking behaviour. *Geneva: World Health Organization*.

Barton, A., Hirsch, J., & Lovejoy, M. (2013). Peer response to messages of distress. *Crisis, 34*(3), 183-191.

Biddle, L., Cooper, J., Owen-Smith, A., Klineberg, E., Bennewith, O., Hawton, K., . . . Gunnell, D. (2013). Qualitative interviewing with vulnerable populations: Individuals' experiences of participating in suicide and self-harm based research. *Journal of Affective Disorders, 145*(3), 356-362.

Breen, A., Lewis, S., & Sutherland, O. (2013). Brief report: Non-suicidal self-injury in the context of self and identity development. *Journal of Adult Development, 20*(1), 57-62.

Bresin, K., Sand, E., & Gordon, K. (2013). Non-suicidal self-injury from the observer's perspective: A vignette study. *Achives of Suicide Research, 17*, 185-195.

Brocki, J., & Wearden, A. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health, 21*(1), 87-108.

Brown, E.-J. (2015). *What is the nature of the relationship between bullying and non-suicidal self-injury in New Zealand adolescents?* (Unpublished doctoral dissertation), Victoria University of Wellington, Wellington, New Zealand.

Buskirk-Cohen, A. (2012). Intimate disclosure among best friends of youth: An opportunity for prevention of internalizing disorders. *Forum on Public Policy, 2012*(1).

Clark, R., MacGeorge, E., & Robinson, L. (2008). Evaluation of peer comforting strategies by children and adolescents. *Human Communication Research, 34*(2), 319-345.

Coggan, C., Bennett, S., Hooper, R., & Dickinson, P. (2003). Association between bullying and mental health status in New Zealand adolescents. *International Journal of Mental Health Promotion, 5*(1), 16-22.

Coggan, C., Patterson, P., & Fill, J. (1997). Suicide: Qualitative data from focus group interviews with youth. *Social science & medicine, 45*(10), 1563-1570.

Côté, J. (1996). Sociological perspectives on identity formation: The culture–identity link and identity capital. *Journal of Adolescence, 19*(5), 417-428.

De Leo, D., & Heller, T. (2004). Who are the kids who self-harm? An Australian self-report school survey. *Medical Journal of Australia, 181*(3), 140-144.

del Valle, J., Bravo, A., & Lopez, M. (2010). Parents and peers as providers of support in adolescents' social network: A developmental perspective. *Journal of Community Psychology, 38*(1), 16-27.

Dent, C., Galaif, J., Sussman, S., Stacy, A., Burtun, D., & Flay, B. (1993). Demographic, psychosocial and behavioral differences in samples of actively and passively consented adolescents. *Addictive Behaviors, 18*(1), 51-56.

Denton, K., & Zarbatany, L. (1996). Age differences in support processes in conversations between friends. *Child Development, 67*, 1360-1373.

Derlega, V., & Grzelak, J. (1979). Appropriateness of self-disclosure in social relationships. *Journal of Social Issues, 33*, 102-115.

Erikson, E. (1968). Youth: Identity and crisis. *New York, NY: WW*.

Evans, E., Hawton, K., & Rodham, K. (2005). In what ways are adolescents who engage in self-harm or experinence thoughts of self-harm different in terms of help-seeking, communication and coping strategies? *Journal of Adolescence, 28*, 573-587.

Favazza, A., DeRosear, L., & Conterio, K. (1989). Self-mutilation and eating disorders. *Suicide and Life-Threatening Behavior, 19*(4), 352-361.

Fortune, S., Seymour, F., & Lambie, I. (2005). Suicide behaviour in a clinical sample of children and adolescents in New Zealand. *New Zealand Journal of Psychology, 34*, 165-170.

Fortune, S., Sinclair, J., & Hawton, K. (2008a). Adolescents' views on preventing self-harm: A large community study. *Social Psychiatry and Psychiatric Epidemiology, 43*(2), 96-104.

Fortune, S., Sinclair, J., & Hawton, K. (2008b). Help-seeking before and after episodes of self-harm: A descriptive study in school pupils in England. *BMC Public Health, 8*(369).

Fortune, S., Watson, P., Robinson, E., Fleming, T., Merry, S., & Denny, S. (2010). *Youth'07: The health and wellbeing of secondary school students in New Zealand: Suicide behaviours and mental health in 2001 and 2007.* Auckland, New Zealand: The University of Auckland.

Furman, W., & Buhrmester, D. (1992). Age and sex differences in perceptions of networks of personal relationships. *Child Development, 63*(1), 103-115.

Garisch, J. (2010). *Youth deliberate self-harm: Interpersonal and intrapersonal vulnerability factors, and constructions and attitudes within the social environment* (Doctor of Philosophy in Psychology, Victoria University of Wellington, Wellington, New Zealand). Retrieved from http://hdl.handle.net/10063/1500

Goodwin, R., Mocarski, M., Marusic, A., & Beautrais, A. (2013). Thoughts of self-harm and help-seeking behavior among youth in the community. *Suicde and Life-Threatening Behavior, 43*(3).

Harter, S. (1990). Self and identity development. In S. Feldman & G. Elliott (Eds.), *At the threshold. The developing adolescent.* London: Harvard University Press.

Hartup, W. (1992). Friendships and their developmental significance. *Childhood social development: Contemporary perspectives*, 175-205.

Hawton, K., Rodham, K., & Evans, E. (2006). *By their own young hand: Deliberate self-harm and suicidal ideas in adolescents*. London: Jessica Kingsley Publishers.

Heath, N., Ross, S., Toste, J., Charlebois, A., & Nedecheva, T. (2009). Retrospective analysis of social factors and nonsuicidal self-injury among young adults. *Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement, 41*(3), 180-186.

Hefferon, K., & Gil-Rodriguez, E. (2011). Interpretative phenomenological analysis. *Psychologist, 24*(10), 756-759.

Helsen, M., Vollebergh, W., & Meeus, W. (2000). Social support from parents and friends and emotional problems in adolescence. *Journal of Youth and Adolescence, 29*(3), 319-335.

Hill, E., & Swenson, L. (2014). Perceptions of friendship among youth with distressed friends. *Child Psychiatry & Human Development, 45*(1), 99-109.

Horwood, L. J., & Fergusson, D. M. (1998). *Psychiatric disorder and treatment seeking in a birth cohort of young adults* (Report No. 0478228465). Retrieved from Wellington, New Zealand: www.moh.govt.nz

Idenfors, H., Kullgren, G., & Renberg, E. (2015). Professional care as an option prior to self-harm. A qualitative study exploring young people's experiences. *Crisis, 36*(3), 179-186.

Isaac, M., Elias, B., Katz, L., Belik, S.-L., Deane, F., Enns, M., & Sareen, J. (2009). Gatekeeper training as a preventative intervention for suicide: A systematic review. *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie, 54*(4), 260-268.

Jacobson, C., & Gould, M. (2007). The epidemiology and phenomenology of non-suicidal self-injurous behavior among adolescents: A critical review of the literature. *Achives of Suicide Research, 11*, 129-147.

James, S. (2013). *Has cutting become cool?: Normalising, social influence and socially-motivated deliberate self-harm in adolescent girls* (Doctor of Clinical Psychology, Massey University, Albany, New Zealand). Retrieved from www.bbc.com

Jorm, A., Wright, A., & Morgan, A. (2007). Beliefs about appropriate first aid for young people with mental disorders: Findings from an Australian national survey of youth and parents. *Early Intervention in Psychiatry, 1*(1), 61-70.

Jose, P., Ryan, N., & Pryor, J. (2012). Does social connectedness promote a greater sense of well-being in adolescence over time? *Journal of Research on Adolescence, 22*(2), 235-251.

Jose, P., Wilkins, H., & Spendelow, J. (2012). Does social anxiety predict rumination and co-rumination among adolescents? *Journal of Clinical Child & Adolescent Psychology, 41*(1), 86-91.

Kelly, C., Jorm, A., & Rodgers, B. (2006). Adolescents' responses to peers with depression or conduct disorder. *Australian and New Zealand Journal of Psychiatry, 40*(1), 63-66.

Kenny, R., Dooley, B., & Fitzgerald, A. (2013). Interpersonal relationships and emotional distress in adolescence. *Journal of Adolescence, 36*(2), 351-360.

Kessler, R., & McLeod, J. (1984). Sex differences in vulnerability to undesirable life events. *American sociological review*, 620-631.

Klineberg, E., Kelly, M., Stansfeld, S., & Bhui, K. (2013). How do adolescents talk about self-harm: A qualitative study of disclosure in an ethnically diverse urban population in England. *BMC Public Health, 13*(1), 572.

Klingman, A., & Hochdorf, Z. (1993). Coping with distress and self harm: The impact of a primary prevention program among adolescents. *Journal of Adolescence, 16*, 121-140.

Klonsky, E. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27*, 226-239.

Klonsky, E., May, A., & Glenn, C. (2013). The relationship between nonsuicidal self-injury and attempted suicide: Converging evidence from four samples. *Journal of Abnormal Psychology, 122*(1), 231.

Klonsky, E., & Muehlenkamp, J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology, 63*(11), 1045-1056.

Klonsky, E., Victor, S., & Saffer, B. (2014). Non-suicidal self-injury: What we know, and what we need to know. *The Canadian Journal of Psychiatry, 59*(11), 565-568.

Lakeman, R., & FitzGerald, M. (2009). The ethics of suicide research: The views of ethics committee members. *Crisis, 30*(1), 13-19.

Lawrence, D., Johnson, S., Hafekost, J., Boterhoven de Haan, K., Sawyer, M., Ainley, J., & Zubrick, S. (2015). *The mental health of children and adolescents: Report on the second Australian child and adolescent survey of mental health and wellbeing.* Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/9DA8CA21306FE6EDCA257E2700016945/$File/child2.pdf

Layte, R., & Jenkinson, C. (1997). Social surveys. In C. Jenkinson (Ed.), *The assessment and evaluation of health and medical care*. Buckingham: Open University Press.

MacGeorge, E. (2001). Support providers' interaction goals: The influence of attributions and emotions. *Communication Monographs, 68*(1), 72-97.

Mason, R., Hart, L., Rossetto, A., & Jorm, A. (2015). Quality and predictors of adolescents' first aid intentions and actions towards a peer with a mental health problem. *Psychiatry Research, 228*, 31-38.

McAndrew, S., & Warne, T. (2014). Hearing the voices of young people who self-harm: Implications for service providers. *International Journal of Mental Health Nursing, 23*, 570-579.

McGrath, B., Brennan, M., Dolan, P., & Barnett, R. (2014). Adolescents and their networks of social support: Real connection in real lives? *Child and Family Social Work, 19*, 237-248.

Michelmore, L., & Hindley, P. (2012). Help-seeking for suicidal thoughts and self-harm in young people: A systematic review. *Suicide and Life-Threatening Behavior, 42*(5), 507-523.

Muehlenkamp, J., Brausch, A., Quigley, K., & Whitlock, J. (2013). Interpersonal features and functions of nonsuicidal self-injury. *Suicde and Life-Threatening Behavior, 43*(1), 67-80.

Muehlenkamp, J., Claes, L., Havertape, L., & Plener, P. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(10).

Nada-Raja, S., Morrison, D., & Skegg, K. (2003). A population-based study of help-seeking for self-harm in young adults. *Australian and New Zealand Journal of Psychiatry, 37*, 600-605.

Nock, M. (2009). Why do people hurt themselves? New insights into the nature and functions of self-injury. *Current directions in psychological science, 18*(2), 78-83.

Nock, M., Joiner, T., Gordon, K., Lloyd-Richardson, E., & Prinstein, M. (2006). Non-suicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. *Psychiatry Research, 144*(1), 65-72.

Nock, M., & Prinstein, M. (2005). Contextual features and behavioral functions of self-mutilation among adolescents. *Journal of Abnormal Psychology, 114*(1), 140-146.

Osborn, M., & Smith, J. (1998). The personal experience of chronic benign lower back pain: An interpretative phenomenological analysis. *British Journal of Health Psychology, 3*, 65-83.

Pearson, J., Stanley, B., King, C., & Fisher, C. (2001). Intervention research with persons at high risk for suicidality: Safety and ethical considerations. *Journal of Clinical Psychiatry, 62*(25), 17-26.

Pietkiewiez, I., & Smith, J. (2012). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne, 18*(2), 361-369.

Pinto-Foltz, M., Hines-Martin, V., & Logsdon, M. (2010). How adolescent girls understand and manage depression within their peer group: A grounded theory investigation. *School mental health, 2*(1), 36-43.

Reid, K., Flowers, P., & Larkin, M. (2005, January). Exploring lived experience. *The Psychologist, 18,* 20-23.

Rissanen, M., Kylmä, J., & Laukkanen, E. (2009). Descriptions of help by Finnish adolescents who self-mutilate. *Journal of Child and Adolescent Psychiatric Nursing, 22*(1), 7-15.

Roberts, T. (2013). Understanding the research methodology of interpretative phenomenological analysis. *British Journal of Midwifery, 21*(3), 215-218.

Rose, A. (2002). Co-rumination in the firendships of girls and boys. *Child Development, 73*, 1830-1843.

Ross, S., & Heath, N. (2002). A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence, 31*(1), 67-77.

Rowe, S., French, R., Henderson, C., Ougrin, D., Slade, M., & Moran, P. (2014). Help-seeking behaviour and adoelscent self-harm: A systematic revivew. *Australian and New Zealand Journal of Psychiatry, 48*(12), 1083-1095.

Ryan, K., Heath, M., Fischer, L., & Young, E. (2008). Superficial self-harm: Perceptions of young women who hurt themselves. *Journal of Mental Health Counseling, 30*(3), 237-254.

Sharkin, B., Plageman, P., & Mangold, S. (2003). College student response to peers in distress: An exploratory study. *Journal of College Student Development, 44*(5), 691-698.

Shaw, R. (2011). The future's bright: Celebrating its achievements and preparing for the challenges ahead in IPA research. *Health Psychology Review, 5*(1), 28-33.

Sierksma, J., Thijs, J., Verkuyten, M., & Komter, A. (2014). Children's reasoning about the refusal to help: The role of need, costs, and social perspective taking. *Child Development, 85*(3), 1134-1149.

Smith, J. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative research in psychology, 1*(1), 39-54.

Smith, J. (2005). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harre, & L. Van Langenhove (Eds.), *Rethinking methods in psychology*. London: SAGE Publications.

Smith, J. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9-27.

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis. Theory, method and research*. London: Sage Publications Ltd.

Smith, J., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds.), *Qualitative health psychology*. London: Sage Publications Ltd.

Smith, R., & Rose, A. (2011). The "cost of caring" in youths' friendships: Considering associations among social perspective taking, co-rumination, and empathetic distress. *Developmental Psychology, 47*(6), 1792-1803.

Storey, L. (2007). Doing Interpretative Phenomenological Analysis. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology*. London: SAGE Publications Ltd.

Sullivan, K., Marshall, S., & Schonert-Reichl, K. (2002). Do expectancies influence choice of help-giver? Adolescents' criteria for selecting an informal helper. *Journal of Adolescent Research, 17*(5), 509-531.

Swannell, S., Martin, G., Page, A., Hasking, P., & St John, N. (2014). Prevalence of nonsuicidal self-injury in nonclinical samples: Systematic review, meta-analysis and meta-regression. *Suicide and Life-Threatening Behavior, 44*(3), 273-303.

Swenson, L., & Rose, A. (2009). Friends' knowledge of youth internalizing and externalizing adjustment: Accuracy, bias, and the influences of gender, grade, positive friendship quality, and self-disclosure. *Journal of abnormal child psychology, 37*(6), 887-901.

von Salisch, M., Zeman, J., Luepschen, N., & Kanevski, R. (2014). Prospective relations between adolescents' social-emotional competencies and their friendships. *Social Development, 23*(4), 684-701.

Walsh, B. (2006). *Treating self-injury: A practical guide* (2nd ed.). New York: Guildford Press.

Weiner, B. (1995). *Judgments of responsibility: A foundation for a theory of social conduct*. New York: Guilford Press.

Whitlock, J., Pietrusza, C., & Purington, A. (2013). Young adult respondent experiences of disclosing self-injury, suicide-related behavior, and psychological distress in a web-based survey. *Achives of Suicide Research, 17*, 20-32.

Wichstrom, L. (2009). Predictors of non-suicidal self-injury versus attempted suicide: Similar or different? *Archives of Suicide Research, 13*(2), 105-122.

Wilson, C., & Deane, F. (2001). Adolescent opinions about reducing help-seeking barriers and increasing appropriate help engagement. *Journal of Educational and Psychological Consultation, 12*(4), 345-364.

Wilson, M., Judge, M., Garisch, J., Russell, L., Robinson, K., Brown, E.-J., . . . Brocklesby, M. (2015). Adolescent non-suicidal self-injury in Aotearoa New Zealand. *Psychology Aotearoa, 7*(2), 130-133.

Yap, M., Wright, A., & Jorm, A. (2011). First aid actions taken by young people for mental health problems in a close friend or family member: Findings from an Australian national survey of youth. *Psychiatry Research, 188*(1), 123-128.

Zeman, J., & Garber, J. (1996). Display rules for anger, sadness, and pain: It depends on who is watching. *Child Development, 67*(3), 957-973.

Zimbardo, P. (2009). *The Lucifer effect : how good people turn evil*: London : Rider, 2009, c2007.

Appendix A – Letter to Schools

5th February 2015

Principal
High School

Dear _____

RE: Research Project – "Supporting the Supporters. A Study about Young Adolescent Females Supporting Girls in Distress"

My name is Kelly Fisher and I am a local Guidance Counsellor currently completing a Master of Arts (Psychology) at Massey University. As part of the requirements to fulfil this degree I have designed a research project to explore how young people respond to a friend disclosing they have self-harmed (non-suicidal self-injury or NSSI).

Interestingly, adolescents who do disclose NSSI are far more likely to tell their peers rather than family or mental health services. The aim of this study is to understand the young adolescents' experience of providing support to a peer engaging in NSSI. I am hoping to recruit three to six female students who are 13-15 years of age to take part in a 40-60 minute individual interview.

I would like to invite your school to take part in this research project. Attached is a comprehensive information sheet detailing the research procedure, information management, and contact details for the project.

Expectations of the school's involvement include the following:

1. That the school would arrange for information about the study to be included in the usual communication channels to parents of female students aged 13-15 years including email.
2. That parents who are known to not access school information via email will have this information communicated via post.
3. That a private space is provided for a maximum of six interviews (approximately 40 to 60 minutes each).

I would welcome the opportunity to talk with you further about your proposed involvement and to answer any questions you may have in person. Please make contact by either phoning 0276 122 371 or emailing Kelly.fisher@woodford.school.nz.

Kind regards,

Kelly Fisher

Appendix B – School Information Sheet

"Supporting the Supporters"

Young Adolescent Females Supporting Girls in Distress

INFORMATION SHEET FOR SCHOOLS

My name is Kelly Fisher. I am a local School Guidance Counsellor and am currently completing a Master of Arts (Psychology) at Massey University, which requires conducting a research project. I have devised a study exploring adolescent experiences of providing support to peers engaging in Non-Suicidal Self-Injury.

Introduction

Non-suicidal self-injury (NSSI) is the intentional destruction of body tissue that occurs outside of cultural acceptance and *without* suicidal intent. Past research has shown that NSSI has increased over the last decade with lifetime prevalence rates estimated between 12-21%. Interestingly, young people are far more likely to disclose this behaviour to their peers, before family or mental health services (including their GP). However, little is known about how young people respond to a peer disclosure of NSSI and how they are affected by the process of providing support.

The aim of this study is to understand the young adolescent's experience of providing support to a peer engaging in NSSI.

I would like to invite your school to take part in this research project. A summary of what this would involve, including participant recruitment, is outlined below.

Procedure

I am looking to recruit a small sample of four to six 13-15 year old female students to participate in a 40-60 minute informal interview to discuss their experience of supporting a friend who is engaging in NSSI. Interviews will be audio-recorded (with the consent of participants) to enable a thorough analysis of the data collected. Students will be able to be accompanied by a support person of their choice for the interview.

Due to the age of prospective participants and the research topic, all parents will be emailed or posted a Parent/Caregiver Information Sheet. This will provide details about the study and outline student participation in this. The information sheet will also include an option for parents to withdraw a student from the study if they wish to do so.

Students that the Guidance Counsellor is aware fit the study's criteria will be approached by this staff member, inviting their participation. Interested students will be provided with an information sheet about the study to read. This includes details about what participation will involve, statements about privacy and limits of confidentiality, rights as a research participant, and what the information collected will be used for. If the student agrees to take part a time to meet convenient

to both student and researcher will be made. Any further questions will be answered before the student is invited to give their informed consent to taking part in the interview. Interviews will also take place around school commitments in a private room supplied by the school.

The interview process will be relaxed and informal. The researcher will introduce herself and explain why she is interested in how young people support each other. Then she will ask the participant approximately five questions to find out what they think about things like helping a friend who is distressed, what the friendship is like with this person, and how supporting a friend who self-harms has affected them.

At completion of the interview a resource sheet detailing a range of local support services specifically for youth will be provided to each participant. This sheet will also include self-care strategies and ideas for peer-to-peer support when facing different life challenges. Participants will be encouraged to talk to the school guidance counsellor for face-to-face support as required.

Students participating in an interview will be reimbursed for their time by either a $20 phone top-up voucher or an ITunes card.

If the researcher has concerns about the imminent safety of a student (whether they are a participant in the study, or someone spoken about by the participant) this information will be passed on to the School Guidance Counsellor expediently. This point is clearly made in the information sheets for both parents and students, and will be explained as part of the consent process with each student.

Information Management

Results will be used for the purpose of completing the above-mentioned thesis and for publication in a psychological journal. All data will be kept in a secure environment and will be disposed of by the researcher's supervisor after the requisite period. Upon completion of this study, your school will receive a summary of the findings. *At no time will your school or individual students be identified in any research reports*.

Project Contacts

If you have any queries about this study or would like to discuss any aspects in further detail, you may contact myself, or my research supervisor.

Researcher:	**Kelly Fisher**	**Supervisor:**	**John Fitzgerald**
	0276 122 371		(04) 801 5799 extn: 63620
	Kelly.fisher@woodford.school.nz		j.m.fitzgerald1@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 15/57. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63487, email humanethicsoutha@massey.ac.nz.

Appendix C – Participant Information Sheet

"Supporting the Supporters"

Young Adolescent Females Supporting Girls in Distress

INFORMATION SHEET FOR PARTICIPANTS

My name is Kelly Fisher. I am a local School Guidance Counsellor and am currently completing a Master of Arts (Psychology) at Massey University, which involves planning and completing a research project. I have designed a study to find out about young people supporting their friends who harm themselves.

Have you been helping a female friend or classmate to cope with self-harm recently? For this study I am looking for 13-15 year old female students to take part in a 40-60 minute interview. Participants will be interviewed individually and asked about their experience being friends with and supporting a female peer who self-harms. This interview will be audio-recorded to allow me to be thorough in analysing information provided during the interview.

All identifying details about you, your school, and the person you know who is self-harming, will be kept confidential, which means this information will not be included in my report about this research.

Information collected from the interview will be securely stored and used to write my Masters thesis and to write a report which will be published in a psychological journal. Some of participants' words will be used to describe their individual experience in these reports. However, participant names or any identifying features will *not* be attached to these quotations. Participants will be provided with a summary of the research findings.

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Have a support person of your choice present to be with you and look after you while you are being interviewed. They will not take part in the interview themselves.
- Decline to answer any particular question
- To withdraw from the study up until 2 weeks after the date of the interview
- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used in the final report
- Ask for the audio recorder to be turned off at any time during the interview
- To be given access to a summary of the project findings when it is concluded.

The interview process will be relaxed and informal. The researcher will introduce herself and explain why she is interested in how young people support each other. Then she will ask you a bit about yourself and five questions to find out what you think about things like caring for a friend who is harming themselves, what your friendship is like with this person, and how supporting a friend who self-harms has affected you.

At the completion of the interview a resource sheet detailing a range of local support services for young people will be provided to each participant. This will include some ideas for coping with difficult times in life that other young people have found helpful, as well as some ways of helping friends "when life sucks". It is important to understand that if a participant tells me they are thinking about ending their life or that another student is having these thoughts, I will need to tell the School Counsellor to ensure that person's safety.

All students who participate in an interview will be reimbursed for their time with either a $20 mobile phone top-up or an ITunes voucher to the same amount at their choice.

If you would like to take part in this study, please let your Guidance Counsellor know or contact Kelly (researcher) by text or email using the contact details at the bottom of this information sheet. We can then arrange a time for us to meet that suits us both, answer any questions you may have, and carry out the interview.

Unfortunately students who self-harm cannot take part in this study. You will only be able to participate if your parent/caregiver reads the attached information sheet and signs the consent form. You will not be able to take part in the research project if you do not have a signed copy of this consent form on the day of the interview.

Project Contacts

Please feel free to contact myself or my supervisor if you have any questions about this study.

Researcher:	**Kelly Fisher**	**Supervisor:**	**John Fitzgerald**
	0220 80 69 50		(04) 801 5799 extn: 63620
	Kellyfisher800@gmail.com		j.m.fitzgerald1@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 15/57. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63487, email humanethicsoutha@massey.ac.nz.

Appendix D – Parent/Caregiver Information Sheet

"Supporting the Supporters"

Young Adolescent Females Supporting Girls in Distress

INFORMATION SHEET FOR PARENTS/CAREGIVERS

My name is Kelly Fisher. I am a local Guidance Counsellor and am currently completing a Master of Arts (Psychology) at Massey University, which requires organising a research project. I have designed a study to look at how young females support and look after female friends who harm themselves. This kind of self-harm is called Non-Suicidal Self-Injury (or NSSI) because the person is trying to cope with their distress, rather than wanting to end their life.

I am looking to recruit a small sample of 13-15 year old female students to participate in an individual interview to discuss their thoughts and feelings about supporting a female friend who has been engaging in NSSI.

Participation is voluntary and involves taking part in an individual 40-60 minute informal interview that will be audio recorded and take place on school grounds. Students can withdraw from the study at any point up until two weeks after their interview, in which case their audio recording and signed consent form will be destroyed.

Participants will also have the right to:

- Have a support person of their choice present during the interview
- Decline to answer any particular question
- Ask any questions about the study at any time during participation
- Provide information on the understanding that their name or any identifying information about them (e.g. the name of the school) will not be used in any reporting of the project
- To be given access to a summary of the project findings when it is concluded.

The interview process will be relaxed and informal. The researcher will introduce herself and explain why she is interested in how young people support each other. Then she will ask the participant approximately five questions to find out what they think about things like helping a friend who is distressed, what the friendship is like with this person, and how supporting a friend who self-harms has affected them.

At completion of the interview a resource sheet detailing a range of local support services specifically for youth will be provided to each participant. This sheet will also include self-care strategies and ideas for peer-to-peer support when facing different life challenges. Participants will be encouraged to talk to the School Guidance Counsellor for face-to-face support as required. If the researcher has concerns about the imminent safety of a student (whether they are a participant in the study, or someone spoken about by the participant) this information will be passed on to the School Guidance Counsellor expediently. Unfortunately students who self-harm will not be able to take part in this study.

Information collected from the interview will be securely stored and used to write my Masters thesis and to write a report which will be published in a psychological journal. Some of participants' words will be used to describe their individual experience in these reports. However, participant names or any identifying features will *not* be attached to these quotations. All identifying details about students and the school will be kept confidential, which means this information will not be included in my report about this research. Participants will be provided with a summary of the research findings.

All students who participate in an interview will be reimbursed for their time with either a $20 mobile phone top-up or an ITunes voucher to the same amount at their choice.

For your daughter to participate in this study I require your consent as her parent or caregiver. If you agree to her taking part in an interview, please complete the attached page titled "Parent/Caregiver Consent Form". No student will be interviewed for this project without first providing a signed consent form from their parent or caregiver to the researcher.

Project Contacts

If you have any queries about this study or would like to discuss any aspects in further detail, you may contact myself, or my research supervisor.

Researcher:	**Kelly Fisher**	**Supervisor:**	**John Fitzgerald**
	0220 80 69 50		((04) 801 5799 extn: 63620
	Kellyfisher800@gmail.com		j.m.fitzgerald1@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 15/57. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63487, email humanethicsoutha@massey.ac.nz.

Appendix E – Parent/Caregiver Consent Form

"Supporting the Supporters"

Young Adolescent Females Supporting Girls in Distress

PARENT/CAREGIVER CONSENT FORM

I have read the attached Information Sheet for Parents/Caregivers (E. C. identification no. 15/57).

I AGREE/DO NOT AGREE (please circle which applies) to _____ participating in this study under the conditions set out in the information sheet.

Signature: _____ **Date:** _____

Full Name (printed): _____

Relationship to student: _____

Appendix F – Participant Consent Form

"Supporting the Supporters"

Young Adolescent Females Supporting Girls in Distress

STUDENT PARTICIPANT CONSENT FORM

I have read the Information Sheet (E. C. identification no. 15/57) and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I AGREE/DO NOT AGREE to the interview being sound recorded.

☐ I would like to read through and have the opportunity to edit the transcript of this sound recording.

☐ I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ **Date:** _____

Full Name (printed): _____

Appendix G – Interview Schedule

"Supporting the Supporters"

Young Adolescent Females Supporting Girls in Distress

1. **Can you tell me about the time you first found out your friend was harming themselves?**
   Prompts: What happened? What were you thinking? How did you feel? What did you do?

2. **How did you respond to your friend at the time? How do you respond now?**
   Prompts: what did you do? How helpful do you think this was? Did you involve anyone else in providing help? How did you know what she needed?

3. **Has your friendship been affected in any way by your friend's self-harming behaviour? In what way?**
   Prompts: Can you tell me about your friendship before you found out your friend was harming herself? What is your friendship like now that you have been supporting her? What do you enjoy about your friendship?

4. **Have you been affected in any way by your friend's self-harming behaviour? In what way?**
   Prompts: What has this meant for you? Stress/distress (physically, emotionally, mentally), other relationships (peer/school staff/family), image of self, sense of responsibility, school work, other activities in your life.

5. **How do you think you will respond in the future? What would help you respond in this way?**
   Prompts: To continue supporting your friend? To maintain your own health & wellness? What resources, skills, or extra support do you need to keep doing this? Something else?

GENERAL PROMPTS…	**"Can you tell me more about that?"** **"Why?" "How?"** **"How did you feel?"** **"Can you tell me what you were thinking?**

Appendix H – Resource Sheet

"Supporting the Supporters"

Resource Sheet

If you are worried about a friend, or are struggling to cope with something in your life, please talk to a trusted adult. This could be a family member, teacher, the School Guidance Counsellor or your family doctor (GP - can help us with how we think and feel as well as our physical health).

Strategies to cope with difficult thoughts/feelings that other young people have found helpful:

1. Talk to a friend or trusted adult about what's going on
2. Spend time with friends
3. Get some exercise – go for a run or walk
4. Read a book
5. Listen to some music you enjoy and makes you feel good
6. Write down your thoughts and feelings, or do some creative writing
7. Draw
8. Watch tv or a movie
9. Phone a helpline to talk to someone anonymously

LOCAL SUPPORT SERVICES…

Directions Youth Health Centre provides confidential medical, counselling and youth support to people aged 10-24 years old. They are based in Hastings and have Napier clinics, can provide transport, and are FREE. Phone: 871 5307, or check them out on Facebook.

Be Unique local support group for LBGTIQ youth at Directions Youth Health Centre

Awhina Whanau Services Maori counselling service for family violence and sexual abuse, phone 878 4827, Hastings

Central Health drug and alcohol service for rangatahi, phone 876 5120, www.centralhealth.co.nz

Te Taiwhenua o Heretaunga education, employment and life skills programmes for rangatahi, phone 871 5350, www.ttoh.iwi.nz

Church or religious group you are connected to will offer a range of support services and sometimes will have a youth group you can join. If you are looking for a church or religious group to link in with, you can speak to your School Guidance Counsellor for further help to find one that is the best fit for you.

FREE PHONE/TEXT/ONLINE SUPPORT OPTIONS…

Youthline counselling service free phone 0800 37 66 33 (24/7 support), free TXT 234 (8am – midnight), email talk@youthline.co.nz, and webchat service.

Outline LBGT confidential telephone support, 0800 OUTLINE (6885463), 9am-9pm Mon-Fri, 6-9pm Sat, Sun & Holidays, or check them out on Facebook OUTLine NZ.

Netsafe for text/cyber bullying, phone 0508 638 723, email queries@netsafe.org.nz, www.netsafe.org.nz.

The Lowdown confidential counselling service 24/7, free text 5626 www.thelowdown.co.nz.

WHAT FRIENDS CAN DO TO HELP A MATE WHO'S SELF-HARMING…

1. Find out more about self-harm and/or talk to people like your School Counsellor or another professional who can help you support your friend.
2. Listen, help out with problem-solving, and do fun stuff together.
3. Treat your friend as usual – they are still the same person and self-harm does not make them abnormal or a freak. See the person rather than the injuries.
4. Don't tell them to stop. Self-harm is a coping strategy and before someone can move on from this behaviour, healthier ways of coping need to be learnt and practiced first.
5. Look after yourself. It is difficult to see someone you care about distressed and to hear them share about their self-harm. Get help for yourself so you can continue to be an awesome supporter. See you school counsellor, or try one of the support services listed above.

IF YOUR FRIEND EVER TALKS ABOUT ENDING THEIR LIFE, TAKE THEM SERIOUSLY AND TELL A TEACHER OR PARENT, EVEN IF YOUR FRIEND ASKS YOU NOT TOO. SUGGEST THAT YOU CAN TELL SOMEONE TOGETHER.