Making Sense of an Unknown Terrain: How Parents Understand Self-harm in Young People

Nicholas D. Hughes[1], Louise Locock[1], Sue Simkin[1], Anne Stewart[2], Anne E. Ferrey[1], David Gunnell[3], Navneet Kapur[4], Keith Hawton[1]

[1] University of Oxford

[2] Oxford Health NHS Foundation Trust

[3] University of Bristol

[4] University of Manchester

Corresponding author:

Nicholas D. Hughes, School of Healthcare, Baines Wing, University of Leeds, Leeds LS2 9UT, United Kingdom. T: +44 (0)113 343 1289. E: n.d.hughes@leeds.ac.uk

Abstract

Self-harm is common in young people, and can have profound effects on parents and other family members. We conducted narrative interviews with 41 parents and other family members of 38 young people, aged up to 25, who had self-harmed. Most of the participants were parents, but included one sibling and one spouse. This article reports experiences of the parent participants. A cross-case thematic analysis showed that most participants were bewildered by self-harm. The disruption to their world-view brought about by self-harm prompted many to undergo a process of 'sense-making' – by ruminative introspection, looking for information and building a new way of seeing – in order to understand and come to terms with self-harm. Most participants appeared to have been successful in making sense of self-harm, though not without considerable effort and emotional struggle. Our findings provide grounds for a deeper socio-cultural understanding of the impact of self-harm on parents.

Self-harm is defined as intentional self-injury or self-poisoning regardless of motive (Hawton, Saunders & O'Connor, 2012; Oldershaw, Richards, Simic & Scmidt, 2008). It is common in young people, with some studies reporting up to 38% of young adults engaging in self-harm (Andover, Primack, Gibb & Pepper, 2010). Between 10-17% of adolescents are said to self-harm (Hawton, Rodham, Evans & Weatherall, 2002; Klonsky, 2009). While some research suggests that rates of self-harm are comparable in men and women (Andover et al. 2010), international studies with large community samples show that self-harm occurs three to four times more often in female adolescents than in males (Hawton et al., 2002; Madge et al., 2008; O'Connor, Rasmussen, Miles & Hawton, 2009., Mars et al., 2014; McMahon et al. 2014). While suicidal intent may or may not be involved, the most frequent motives for self-harm are intrapersonal – e.g. affect regulation, self-punishment (Klonsky, 2009) or interpersonal – e.g. appeal to others (Scoliers et al., 2009; Hjelmeland et al., 2002). Self-harm is frequently repeated (Hawton et al., 2002; Hawton, Bergen, Kapur, Cooper, Steeg et al., 2012) and often done in secret (Madge et al., 2008). While self-harm in young people often ceases by late adolescence or early adulthood (Moran et al., 2012) it can be a precursor of specific mental health problems (Mars et al., 2014). It also carries a significant risk of suicide (Hawton et al., 2012).

Previous qualitative research has explored the needs, perspectives and responses of parents to their children's self-harm (Byrne, Morgan, Fitzpatrick et al., 2008., Oldershaw et al., 2008; Raphael, Clarke & Kumar, 2006). These studies found that parents were deeply distressed by self-harm and that they struggled to understand and cope with it. They often felt helpless and worried about future incidents of self-harm. Their anxieties were increased by feeling that they lacked the parenting skills to respond appropriately, in some cases, and that they did not always receive the information and support they would like from health professionals. Each of these studies focused on parents of children who received hospital or

community health services in respect of their self-harming. As part of a large programme of research on suicide prevention, we conducted a qualitative study which explored the experiences of a wide range of parents, some of whose children had received health services care for self-harm and some who had not. The main purpose of this study was to create a web-based information resource at www.healthtalk.org for parents of young people who self-harm .

Parents describe feelings of confusion, rejection, hurt and shock when they realise that their child is self-harming (Raphael et al., 2006). Many feel that they cannot make sense of, or come to terms with, their child's self-harming behaviour (Oldershaw et al., 2008). In health research 'sense-making' has become a prominent theme in studies of chronic illnesses (Pakenham, 2012), including various cancers (Dunn et al., 2006; Fife, 1994; Gray, Fitch, Phillips, Labreque & Fergus, 2000; Öhlén, Gustaffson & Friberg, 2013), diabetes (Lang, 1989), dementia (Robinson, Clare & Evans, 2005), mental illness (Cardano, 2010) and multiple sclerosis (Pakenham, 2008). Whilst there is a broad literature on family and caregiver experiences (Baruch, 1981; Chamberlayne & King, 1997; Hinton & Levkoff, 1999; Pejlert, 2001; Harden, 2005), little research has focused specifically on sense-making in these groups, although Oldershaw et al. (2008) do report briefly on sense-making strategies of parents whose children self-harm. Owens, Lambert, Lloyd & Donovan (2008) examine sense-making in a group of parents in some detail, reporting and interpreting ways parents made sense of their sons' deaths by suicide.

Theoretical framework

Sense-making is a process whereby individuals attempt to understand adverse changes in their lives by trying to fit them in with their existing 'assumptive schemas' – taken for granted ways of seeing and experiencing the world – or by developing new ways of

interpreting their experiences (Pakenham, 2012). Early stages in this process involve private 'rumination' on experience, often seeking to answer the question 'Why?' something has happened (Pakenham, 2012). Later stages may include seeking information and testing out one's sense-making explanations by sharing them with significant others (Weick, 1995; 2001).

The role of others is central in the approach to sense-making proposed by Weick (1995; 2001) in the field of organisational studies, where sense-making is seen as a social process driven by action as much as it is an individual cognitive process fuelled by rumination and introspection. Weick's work on sense-making draws on Blumer's articulation of symbolic interactionism (which Weick describes as 'the unofficial theory of sense-making' (1995, p.41). Blumer proposed that: 1) people act towards things, including each other, on the basis of the meanings they have for them; 2) these meanings are arrived at through social interaction with others; 3) meanings are managed and transformed through an interpretive process that enables people to make sense of their social world.

Ancona (2012, p.3) summarises Weickian sense-making as 'how we structure the unknown so as to be able to act in it. Sense-making involves coming up with a plausible understanding – a map – of a shifting world; testing this map with others through data collection, action, and conversation; and then refining, or abandoning, the map depending on how credible it is.' Crucially, Weick argues that plausibility or 'reasonableness' is more important than accuracy in determining the validity of a particular way of making sense of a situation; sense-making is about 'invention rather than discovery' (2001, p.194). There is, he argues, no single factual truth waiting to be discovered, but rather a range of accounts which may be more or less useful in negotiating a way forward.

In developing his theory of sense-making Weick draws directly on Fay's (1990) articulation of critical realism. Fay argues that a 'critical' approach to 'realism' calls into question the idea of a pre-ordered reality that can be discovered through scientific enquiry. Rather, he suggests, we try 'to make our experience and our world comprehensible to ourselves in the best way we can,' and that 'the various kinds of order we come up with are a product of our imagination and our need, not dictated to us by Reality itself.' Considering science as analogous to cartography he argues that, 'there isn't any One True Map of the earth, of human existence, of the universe, or of Ultimate Reality….There are only maps we construct to make sense of the welter of our experience, and only us to judge whether these maps are worthwhile for us or not.' (Fay, 1990 p.38)

Fay uses this cartography analogy to explain how scientists approach their work of understanding the world—and in some cases trying to change it—but these ideas may have equally strong resonance for individuals facing a crisis and trying to find a way through. In his much cited book The Wounded Storyteller (Frank, 1995) sociologist Arthur Frank described serious illness in terms of losing the map that had previously guided the person's life towards desired destinations. Thus the 'mapmaker-scientist' can equally be the 'mapmaker-citizen' or the 'mapmaker-patient' or the 'mapmaker-parent.' In this article we offer a detailed examination of parents' reported experiences of young peoples' self-harming from the perspective of sense-making.

Methods

Sample and recruitment

We conducted narrative interviews with 41 parents or other family members of 38 young people aged up to 25 years who had self-harmed. Participants were recruited through mental health charities, support groups, clinicians, newspaper advertisements, social media, flyers in

clinic waiting rooms, personal contacts and snowballing through existing contacts. People who expressed interest were sent an introductory letter, a detailed Participant Information Sheet and a personal details form to be returned to the research office in a pre-paid envelope if they wished to take part. We excluded those who reported behaviour not generally regarded as deliberate self-harm – for example, repetitive head-banging in young people with learning disabilities. We contacted potential participants by telephone or email to answer any questions about the study and to arrange an interview, either in their own home or in a place of their choosing. All participants gave informed written consent before the interview started. The study was approved for national recruitment by Berkshire Research Ethics Committee (09/H0505/66).

We sought a maximum variation purposive sample (Coyne, 1997; Saunders, 2012) in order to capture a wide range of different experiences. We aimed for variation across a number of demographic characteristics including gender, ethnicity and geographical location (although with a planned focus on Oxfordshire and Buckinghamshire for recruitment via clinicians). We interviewed 34 mothers, five fathers , one female spouse and one female sibling. We included non-parents because the whole study was of parent's and carers' experiences. In this article we report the parents' experiences. We conducted separate interviews with two parent pairs. In one case both parents saw the study advert and both wanted to participate. In the other case, the mother was interviewed first and asked her husband if he would also like to take part, knowing that we wanted to recruit more fathers. The ethnic diversity of our sample was limited – with only two non-white participants – reflecting a recognised difficulty in recruiting people from ethnic minorities for research on mental health issues (Yancey, Ortega & Kumanyika, 2006). This inevitably restricted our ability to achieve a maximum variation sample. Interviewees came from a range of socio-economic groups and lived in various parts of England, Scotland and Wales. Thirty of the

young people who self-harmed were daughters, six were sons, one a husband and one a sister.

The age at which they had started self-harming ranged from nine to 21 years. Over two-thirds

were aged under16 years when they began to self-harm. The majority of self-harm incidents

involved cutting, but participants also described overdoses, burning, strangulation and other

methods. Several young people had used more than one method of self-harm. Three

participants – two parents and one sibling – withdrew from the study after the interview. In

this article we report analysis and findings based on interviews with 37 parents.

Data generation and analysis

We interviewed twenty-five participants in their own homes, eleven in a recording studio, two

at their place of work, one at a support group's premises, one in the interviewer's home and

one, at the participant's suggestion, in a coffee bar that was a mutually convenient location.

Interviews took place between August 2012 and October 2013. They lasted between 27

minutes and three hours, with an average length of one hour 24 minutes.

Interviews were video- or audio-recorded, according to the participant's

preference. Narrative interviewing was selected to enable participants to articulate their

perspectives and concerns rather than respond to questions framed by the issues professionals

think matter most. On the basis that 'if narrative experiences are desired, storytelling must be

allowed' (Riessman, 2008 p.23) we began interviews with an open question which

encouraged participants to 'tell us the story' of their child's self-harm in as much detail as

they wished. We listened without interruption until the participant finished speaking.

Following the elicitation of this unstructured narrative, with subsequent questioning we

sought further detail about the story – for example, asking them to clarify a sequence of

events and how they felt about particular aspects of their narrative – using active interviewing

techniques to collaborate in producing the narrative (Holstein & Gubrium, 1995). We also

sought the participant's evaluation of their experience; for example, inviting them to express the impacts of self-harm on their lives. Further questions were based on topic areas identified through the research team's familiarity with clinical and research literature and on suggestions from the project's Advisory Panel, which included people with personal experience of self-harm as well as researchers and clinicians.

The interviews were professionally transcribed verbatim from audio recordings and carefully checked by the researchers. We gave participants the opportunity to remove any part of the interview before giving their written consent for the content to be used in research and other publications. Final transcripts were uploaded to NVivo 9 for coding. A coding framework of both anticipated and emergent themes was developed using the technique of constant comparison. Coding reports were generated and used for thematic analysis, to theorise across cases by finding common elements in the stories told by research participants (Riessman, 2008; Ziebland & McPherson, 2006). The emphasis in our thematic analysis of narrative data is on the content of the interview rather than on its structure or form; that is, on the 'told' elements of the narrative, rather than the performative or interactional nature of the story 'telling' (Riessman, 2008). Two researchers (N Hughes & S Simkin) conducted the analysis independently and resolved any discrepancies, or differences of interpretation, through discussion. We pre-determined, on the recommendations of methodological literature (eg Morse, 2000), that around 40 interviews would give us the range and depth of data that we needed to produce a comprehensive analysis of how parents experience young peoples' self-harm. We felt that we had reached data saturation with 41 interviews, though we recognise that a more diverse sample may have presented different experiences. We shared summaries of all findings from the study, written in non-technical language, on our health experiences website (www.healthtalk.org). All participants were invited to a meeting at which findings were presented and discussed.

Results

Participants talked about episodes of self-harm which occurred from as recently as a few months ago, to as far in the past as seventeen years. In this section we report three themes which describe processes that underpinned parents' attempts to make sense of self-harm: 1) their initial reactions of bewilderment and confusion, followed by 2) the search for information and 3) their attempts to build a new way of seeing. All participant names are pseudonyms.

Bewilderment and confusion

Ancona (2012) states that 'sense-making is most often needed when our understanding of the world becomes unintelligible in some way' (p4). Discovering that a child or young person had been self-harming plunged many participants into just such a world of unintelligibility, experienced as deep confusion and bewilderment.

> I don't know what to feel because I'm at a loss as to why she's done it. I just cannot work out what's going on inside her head in order to make her do this. We'd spent an hour the night before talking about something that had happened at college that she was a bit upset about. We'd resolved it. So it [was] really total bewilderment as to why the hell she's done it because it didn't make any sense, really, to me.

Many participants spoke of feeling shocked, stunned, horrified, devastated—and underlying these strong emotions was a sense of confusion. S. went on to repeat, 'I am really, really confused as to what on earth is going on in her head.' A. echoed this: 'It's confusing. I felt angry. I felt sad. I didn't know what to do. Mums and dads are supposed to know everything aren't they, but we don't. We didn't have the answers and we didn't know why she was doing this to herself.' D. felt 'absolutely devastated' and 'just couldn't believe that

this could be happening, not to my daughter.' J. was 'horrified', 'shocked', 'stunned' and 'speechless'. N. said his first reaction was that it couldn't really be happening. He felt 'incredibly helpless' and 'absolutely clueless in terms of what you should do, what the next steps are'.

When they began to ruminate on the reasons for their child's self-harming, some parents felt as though they must be partly responsible for their child's behaviour and they experienced distressing feelings of guilt. Part of the sense-making process involved, for some parents, meticulous examination of their past actions or omissions in an effort to detect what they might have done to 'cause' their child's behaviour.

From the very beginning, when I was pregnant with her, what did I do wrong? Did I eat the wrong things? Did I get too stressed? When [she] was young, did I feed her properly? Did I interact with her? When she was older, did I praise her enough? Did I criticise her too much? […] I know that she's an adult now and she takes responsibility for her choices and I can be only supporting her but that was very, very difficult, the blame, the guilt.

Many parents came to terms with their feelings of guilt, over a period of time. T. learnt through receiving counselling that it was better to focus on what you can do rather than what you think you have done wrong. A. thought that guilt about the past was pointless as it did not help her be a good mother or a balanced person. N. said that Samaritan (voluntary mental health support) training enabled her to distance herself from feelings of guilt.

The disorientating impact of self-harm affected participants' mental health. Some had been mentally unwell in the past and were still having treatment, but others thought that their symptoms were a result of the stress surrounding their child's self-harm. Some were taking medication for depression. J.N. said that she 'couldn't stop crying. I was really upset, couldn't

sleep. I had three months off work and was put on antidepressants, which I take to this day and will never stop taking because they keep me sane.' J.T. 'went through the blackest time imaginable where I couldn't even get out of the chair or answer the phone'. J. T. refused medical treatment for her depression but accepted the offer of counselling which, despite her initial scepticism, she found helpful.

Looking for information

Many participants supplemented their rumination on the reasons why a young person was self-harming by looking for information, attempting to gain knowledge which might help them to understand. For most participants who wanted to look for information their first instinct was to search on the internet, though some said they hadn't thought of doing this. S. and D. said they would have searched online if internet access had been available when their child was self-harming.

> We live in a world with the Internet now. We can all go on to the Internet and Google. I guess if this was seventeen years ago I'd go straight on to the computer when she'd gone back to school and I'd be Googling "self-harm" and looking up anything I could find, any information at all. And then just looking also to see if there were any helplines or anywhere I could go.

Some participants did not want to look for information about self-harm, at first – they preferred to concentrate on trying to manage the immediate situation.

> I just wanted it to go away and I think I would have really scared myself at that point if I'd looked too deeply into the information on self-harming. I just got terrified about

what maybe was going to happen, and, at that point, I didn't need to know. I just needed to deal with what was happening.

A. R. did go on, at a later stage, to look for information about self-harm and about her daughter's diagnosis of borderline personality disorder.

Several participants stressed the importance of finding reliable information from trustworthy internet sources, such as NHS Direct or mental health charities. Some also wanted to find websites where people shared their experiences of self-harm. R. said 'It would be really helpful to have other people's experiences and have professional points of view, so that it's not such an alienating experience as it has been for me.' Others wanted more factual, research-based, information.

Participants reported other ways in which they had found information. I. had been helped by books, newspaper articles and TV documentaries. N. and S.E. had learnt about self-harm through a talk at their child's school by a psychiatrist. D. was working with a leading authority on self-harm who helped her to understand reasons for the behaviour. J.L. identified experts on eating disorders and self-harm through the internet and made personal contact with them through email or telephone.

A number of participants shared information with other parents they knew whose children self-harmed. These personal relationships were presented as mutually supportive in helping each other to understand and cope with their children's self-harming. They provided a platform for sense-making through the processes described by Ancona (cited above): 'testing the map with others through data collection, action and conversation' (Ancona, 2012, p3).

An almost instinctive reaction to try and make sense of why a young person had self-harmed was to ask them directly to explain why they had done it. The difficulty with this approach was that the emotional shock of discovering the self-harm meant that questioning the young person could turn into a kind of interrogation which the young person, understandably, resisted.

> So, I sat [her down] and, [said] "Oh, my God, explain." And she was really dismissive – "I don't want to discuss this" – completely gave me the cold shoulder.   And my thing was, "Right, do you know what? I'm going to leave the room, but we need to talk about this. I'm going to leave this till you get your head together and to let me get my thoughts together as well, to think about things before we sit and talk about this. We've both had a fright, a shock." So I left the room and I think it must have been about ten minutes later I thought, "Oh, my God, oh, God, I can't, I can't just, I can't leave it any longer." So I went upstairs and I sat with her. I said, "Right, okay, what have you been using? Right, where is it?"

Other parents, too, said their child 'refused' to talk about it, or 'clammed up' when first questioned.

Over a period of time, particularly where parent and child already had a relationship in which they did talk to each other, some parents found that they gained insight and understanding from their children's accounts of their experiences. J.N., in particular, said of her daughter: 'She has changed my mind set. She has educated me a lot. It's such an eye-opener. It's been amazing because I would have been completely different, completely shut off. She has taught me so much'.

Building a new way of seeing

Believing that they understood something of the reasons for self-harm was part of a sense-making process for most participants. They described a range of factors which they thought had contributed to self-harming – including the young person's difficulties in early childhood, experiences of abuse, the effects of puberty and teenage cultures, the young person's need to express painful feelings, difficulties in their own and their childrens' relationships and mental health problems in the young person. Some participants thought their own self-harming behaviour might have influenced their children. Over time, most participants constructed some kind of explanation which enabled them to build a new way of seeing things and to make sense of the young person's behaviour. Building a new way of seeing also included imagining what the future might look like.

Early childhood. Some parents looked back on the young person's early childhood behaviour, personality or experience and saw the roots of self-harming there – as J. said, 'I could see it in the cards'. J.Y. described her infant daughter's frequent emotional ' tantrums', on one occasion threatening to throw herself from a bedroom window. J.T. talked about her daughter having 'high anxiety' and 'obsessive compulsive disorder' from a very young age.   A.R. said that her daughter seemed to be unusually troubled emotionally from the age of about six years. S.Y. remembered that her daughter was 'demanding, impulsive and attention-seeking' when she was in primary school. S.Y. believed this was a result of her daughter's traumatic birth, subsequent facial deformity and multiple corrective operations. T. also believed that physical illness in early childhood affected her son's emotional and social development and contributed to his current problems.

Perceptions of abuse as a cause of self-harm. Sexual and psychological abuse – both within and outside the family – were reported as factors which contributed to self-harming and presented

ongoing challenges to sense-making. One woman spoke about her ex-husband sexually abusing his step-daughter (that is, her daughter) and his own sons. Two of those young people later self-harmed. Other participants highlighted the impact of abusive relationships outside the family. R's daughter began self-harming aged around 13 years after a long period of chronic pain, absence from school and depression. When she was sexually assaulted by a stranger her self-harming became much worse. It 'tipped her over the edge,' R. said, 'I didn't know what to do with her at all.' V. believed that an online sexual relationship had contributed to her daughter's self-harming. A. was still struggling to understand the nature and impact of a childhood relationship her daughter had with the child of family friends: 'I still don't know to this day [what] all the wrong doings were within that friendship, for want of a better word. All I know is the consequences that we're dealing with from it'.

Life as a teenager. A few participants thought that 'teenage hormones' played a part in self-harming behaviour. R. initially thought it 'was a teenage thing' but later was 'scared' to find out that some adults self-harm. Some people saw an element of manipulation in their child's behaviour. J.J. said that 'sometimes I can be very sympathetic and sometimes I can't because sometimes I think it is naughty behaviour'. C. wondered if his son might be using the threat of self-harm to get his own way. Some parents referred to their child's experiences of being bullied and several thought their child had been influenced by specific teenage subcultures.

[At] senior school, she started pushing some of her friends away but also taking up with boys. Her first boyfriend was quite a troubled character himself and I think they sort of egged each other on […] the music and the look was all very, very dark and very, very gloomy and their relationship was a bit like that. He was quite an unhappy boy and they seemed to encourage each other, in a way, to be unhappy. She was very keen on him and he wasn't very nice to her and, although I'd never blame him, I think that set of circumstances

probably is what put her in such a gloomy place, alongside the hormones and everything else that's kicking in at that age.

Expressing emotion. Several parents described self-harm as a reaction to intensely felt emotion, such as self-hatred or anger. L. said that her daughter 'thoroughly hated herself and the only way she could find of expressing that was to deface herself'. I. thought that her daughter's problems became too much for her and that taking an overdose was the only way she could think of to escape. J.T. described her daughter's cutting as a way of dealing with emotions she couldn't put into words, including feeling she had let herself or other people down.

> Whenever things just got on top of her and she just felt she couldn't cope or she felt angry, about herself, really, not the world. When she was beside herself with emotions that she couldn't really put into words or problems that she couldn't solve, feelings of failure in herself […] whenever she felt she'd let herself down or other people, that's what she would do to take it out on herself.

J.T. said she had come to understand – through thinking and reading, talking to experts and to her daughter – the reasons why cutting worked effectively to relieve her daughter's emotional pain. In keeping with our main line of argument, this combination of rumination and action helped J.T. to 'make some kind of sense' of it.

> I learned the reasons why it was effective. Even though I hated it and couldn't condone it, with my thinking and my understanding of it [I] made some kind of sense to it. And I found that when she realised that she was very poor at coping with her emotions at that

instant and she started to hold the emotions for a little bit longer and I supported her and helped her to do that, we were making some progress.

Difficult relationships. Several parents talked about the impact of the break-up of their marriage on the young person; but this was also seen by some as just one part of a complex set of changes and challenges in the young person's life which included difficulties at school and in their personal relationships with family members, friends, boyfriends or girlfriends, and both parents. S.H. thought that her separation from her partner had a big impact on her daughter, but a lot of other things had happened, too, which 'overwhelmed' her. I. talked about how she tried to make sense, 'looking back on it,' of the many different things that were causing problems in her daughter's life.

> I believe she was very upset at school, more upset than I'd realised. Her exams were looming. She was very worried about having missed some school […] and I think she'd never had a particularly happy time at that school, looking back on it. And when she went to senior school, it was a time of great change. We'd just moved house and I'd split up [from her father] so I don't think she was ever particularly happy there. It's a very big school, quite impersonal. She was having a few issues with her friends as well at that time and with her boyfriend and with myself and her dad in that we don't get on and it must be very difficult for her knowing that we don't like each other.

I. went on to talk about the conflict created for her daughter by the radically different parenting styles of herself and her former partner.

Mental health problems. Participants reported a range of mental health problems in the young person which they thought contributed to self-harming behaviour. Many of the young people were depressed**.** Some had been diagnosed with borderline personality disorder or post-traumatic stress disorder and some experienced upsetting visual or auditory hallucinations. Others had eating disorders, which some of the people we spoke to viewed as closely related to self-harm. A's daughter cut herself while having hallucinations. A .felt that health professionals didn't help her to understand this

> Apparently, she'd seen black shapes and things coming out the walls. I didn't know what to make of it and when I flagged it up with her psychiatrist, you just got the nod of the head and, you know, but nobody came back to us with anything.

Some people regarded self-harming not as a mental health problem but as a way of coping which, to some extent, 'worked' for the young person – though parents who saw it this way hoped their child would develop different coping strategies. J.A. was relieved to see on a self-harm support website that 'self-harm is not an illness'. M., admittedly expressing a minority view, had come to the view that self-harm was to some extent part of everyday life.

> I've come to the conclusion it's part of our culture, to some extent, in that we take for granted, at least in books, people biting their lip in frustration or anger or as a way of deferring pain from another part of the body. And I thought, maybe we should just learn to see it as something he does when he's upset. If it helps him, then perhaps it's not something to get too upset about and we just make a point of reminding him to keep the knife clean.

Parents' self-harming. Some parents talked about their own self-harming – including cutting and taking overdoses – and worried that they had influenced their children. S.H. said that her 'first fears' when she found out about her daughter's self-harm were, 'It's my fault. It's because I told her I did it, she started doing it, that's what happened'. J.Y. was relieved when she found out that her daughter had started self-harming before she did because, she thought, that meant her own self-harming had not influenced her daughter's behaviour. R.B's experience and reading had led her to believe that her daughter may have a 'genetic predisposition' to self-harm.

Looking ahead. For many participants self-harm was, or had been, a constant feature of their life and they were unable to see clearly ahead to a time when it might stop. Even when a young person had not self-harmed for some time, participants expressed uncertainty about whether it might recur in response to new crises. They were anxious about the future, but many were optimistic too. They saw the difficult time they had gone through as a learning experience for all, and hoped the young person had developed different coping strategies which they could use if they felt like self-harming again.

> I've got to the point where I accept that it works as a coping strategy for her but it still makes me uncomfortable. I still wish she wouldn't do it. I still want to wrap her up in cotton wool and fix it all for her. I don't think that will ever change either. I think life will continue as it does. It will continue to be a roller coaster because of her mental health issues, she'll have good times and bad times. I just hope that the good times are longer and bigger and better [and] that the periods between the self-harm continue to increase and that one day she can come to me and say, "It's been x years," rather than x months.

Discussion

Sense-making – comprising rumination, information-seeking (Pakenham, 2012) and social interaction (Weick, 1995; 2001) – can help people to develop a new understanding of the world when they find that their assumptions do not reflect reality. Parents who discovered that a young person had been self-harming were able to use these methods to make sense of a new world. They reached inside themselves to examine their own ways of thinking and behaving, and looked externally for information that would help them to understand the young person's behaviour. In some cases, sharing their experiences with others also helped to make sense of self-harm. Although the process of sense-making did not solve all of the participants' problems – for example, practical and emotional difficulties relating to self-harm often persisted for months or years – it gave them a new map or framework that allowed them to put self-harm into context, and to navigate the changes in their world-view.

Previous studies indicate that parents are deeply distressed by self-harm, struggle to understand it and to know how best to react when their child self-harms (Byrne et al. 2008; Oldershaw et al. 2008; Raphael et al.2006). Our work extends the insights provided by these studies by showing in detail some of the cognitive and social processes which helped to make sense of an experience which often unsettled them deeply. Participants' specific references to 'making sense' of their experience led us to consider the conceptual framework of sense-making – and associated metaphors of 'map-making', 'terrain' and 'landscape' – as a lens through which we believe it is illuminating to view what people told us about their lives.

Participants were often bewildered when they discovered their child was self-harming, not knowing why it happened or what to do about it.This discovery was so destabilising that they lost the 'map' which was guiding their lives (Frank, 1995) in tried and trusted ways – that is, their 'assumptive schemas' (Pakenham, 2012), or taken-for-granted ways of seeing

the world, came suddenly into view and had to be reconsidered. Challenges to assumptive schemas – generated by one's own illness or other traumatic experience –have been described variously as forms of biographical disruption (Bury, 1982), abruption (Locock, Ziebland & Dumelow, 2009) and disintegration (Owens et al. 2008). Processes analogous to sense-making may contribute to biographical repair (Locock et al. 2009) or reconstruction (Williams, 1984).

Participants in our study made sense of bewildering change by an automatic, or reflexive, cognitive process of ruminating – wondering, and asking themselves, 'why'? – followed by the volitional processes of information-seeking (Pakenham, 2012) and actively constructing a new 'map' (Frank, 1995). People supplemented their ruminating, their own internal attempts to understand and make sense, by looking for information from a variety of sources, including the internet, health and social care professionals, other parents – and from talking to the young person about the reasons for their self-harming. They built a new way of seeing which helped them to understand, to some extent, why the young person harmed themselves and which also allowed them to look forward to a future without self-harm.

These sense-making processes were difficult and time consuming but they were productive. Most participants reported that, over time, they had learned to make sense of self-harm and to understand why young people had self-harmed. Many of the reasons they identified are reported in the research literature as factors which are known to contribute to self-harm, including: psychiatric and personality disorders (Hawton, Saunders, Topiwala & Haw, 2013); psychological characteristics such as impulsivity and low self-esteem (Madge et al. 2011); stressful life events such as difficulties in relationships, knowing someone else who self-harms or who has attempted suicide, being sexually abused or being bullied (Madge et al. 2011; Werbart Törnblom, Werbart & Rydelius, 2015). A high level of impulsivity in early childhood has been implicated in later adolescent self-harming (Goldston, Daniel, Mathias &

Dougherty, 2008) and the effects of puberty are also thought to play a part in influencing self-harming behaviour (Patton, Hemphill, Byers et al., 2007). A genetic association with attempted suicide has recently been shown (Petersen , Sørensen, Andersen, Mortensen & Hawton, 2014).

The challenges presented to participants' world-view by young people's self-harming were not wholly diminished by feeling that they had reached some kind of understanding – for example, that self-harm might serve a logical function for the young person (Brossard, 2014; Chandler, 2012, 2013). Some continued to struggle with feelings of guilt and responsibility. Several participants became depressed themselves and needed treatment. Many of them remained fearful for their child's future welfare and anxious about the long-term consequences of self-harming. Participants always hoped that the young person would stop self-harming.

Implications for practice and research

Health and social care professionals can support parents and others to make sense of self-harm by showing understanding of their confused reactions, by listening to their perspectives and by making them aware of the broad range of factors which can cause young people to self-harm. Professionals should acknowledge the uncertainty and anxiety parents feel about their child's future, as well as their present suffering, and should also offer specific support to help parents understand their parental roles. This support should include helping parents to manage their sense of responsibility for the self-harm, and to reduce the guilt or shame they may feel. Professionals could also help parents to learn how to manage their emotions so that they can listen to the young person without becoming distressed, angry or judgemental. This may include learning how to express their emotions appropriately, so that the young person knows how their parent feels.

Researchers, policy makers and advocates for young people can help by making information about self-harm more widely available and more easily accessible, both online and in traditional formats such as leaflets and booklets. Most young people who self-harm do not look for professional help (Madge et al. 2011; Michelmore & Hindley, 2012) but seek a more general helping response from people close to them (Scoliers, 2009; Michelmore & Hindley, 2012). For this reason it may be productive to disseminate knowledge about self-harm as public health information across a wider population than just those who engage with health services. Our health experiences website (www.healthtalk.org) provides this kind of information source. Information providers need to be aware of the potential dangers of propagation – avoiding, for example, detailed reference to methods of self-harm. Further research should be conducted exploring young people's views of self-harm and the functions it serves for them.

The theories of sense-making we have applied to our study findings help to illuminate the experiences of parents trying to understand, come to terms with and respond to, their children's self-harming. The wider social contexts in which self-harming takes place in the developed world include heightened awareness of, and anxiety about, the vulnerabilities of childhood, altered expectations regarding how to make successful transitions from childhood through adolescence into adulthood, and changes in the perceived nature of mental health. Further research could investigate sense-making at one remove from the subjective experiences of individuals, to interrogate the phenomenon of self-harm in the historical context of transitions to adulthood in late modernity.

Strengths and limitations

This study benefited from a large sample of parents who were in different stages of coming to terms with their child's self-harm. It included both mothers and fathers who came from a

variety of geographical locations. However, most respondents were mothers, and because of the recruiting focus on Oxfordshire and Buckinghamshire, many came from this area. Two parent-pairs were interviewed, which provided different perspectives on a family's experiences. It may be that each parent might be more guarded or hesitant in discussing the others' reactions, knowing that parts of the interview may be seen by their partner –though the likelihood of this is diminished by the assurance that they would have the opportunity to edit the transcript. Ethnic diversity in our sample was limited. Our efforts to recruit participants from the South Asian community, for example, were not fruitful – possibly because of cultural prohibitions on acknowledging and talking about self-harm. Different perspectives on sense-making may have been apparent in a more diverse sample.

Conclusion

Self-harm is common in young people, particularly in adolescent girls. It is linked with a wide range of mental health problems and life stressors. We interviewed 41 family members, mostly parents, about their experiences of young people's self-harming. In this article we have focused on ways in which the parent participants tried to understand the reasons for self-harm so they could make sense of what seemed at first to be a bewildering and confusing experience. This 'sense-making' process involved three stages. First, participants responded to feelings of bewilderment by ruminating on what had happened, examining their past and present lives for explanatory signs. Secondly, they looked for authoritative information – from expert sources, from people who shared similar experience and from young people themselves – which would help them to understand the reasons for self-harm and, crucially, help them know how best to respond. Finally, over time, they constructed new ways of seeing self-harm.

Many of the reasons participants identified to explain self-harm reflected findings in the research and clinical literature. This is not surprising as many had sought information from expert sources. Most participants appeared to have been successful in making sense of self-harm, though not without considerable effort and emotional struggle. Painful emotional reactions often persisted alongside intellectual understanding. There is clearly a continuing role for individuals and organisations involved in mental health promotion to disseminate information about self-harm to the wider public. Health and social care practitioners should supplement information-giving with therapeutic support for parents and families.

Authors' Notes

1. Many participants in this study gave explicit written permission for their identities to be made public on the health experiences website www.healthtalk.org. Other participants chose to protect their identities with a pseudonym. In this article all participants are referred to by pseudonyms.

2. N.D.Hughes was a Senior Qualitative Researcher in the Health Experiences Research Group, University of Oxford, United Kingdom, when this study was conducted. He is now a Senior Research Fellow in Palliative Care and Lecturer in Nursing, University of Leeds, United Kingdom.

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Bios

Nicholas D. Hughes, PhD, RN, is senior research fellow in palliative care and lecturer in nursing at the School of Healthcare, University of Leeds, Leeds, United Kingdom.

Louise Locock, MA, MPhil, PhD, is director of applied research, Health Experiences Research Group, Nuffield Department of Primary Care Health Sciences, University of Oxford, and Health Experiences Fellow, Oxford NIHR Biomedical Research Centre, United Kingdom.

Sue Simkin, BA, was research associate (now retired) at the Centre for Suicide Research, University of Oxford Department of Psychiatry, Warneford Hospital, Oxford, United Kingdom.

Anne Stewart is consultant child psychiatrist at the Oxford Central Child and Adolescent Mental Health Service, Oxford Health NHS Foundation Trust, Oxford, United Kingdom.

Anne E. Ferrey, PhD, is research coordinator at the Centre for Suicide Research, University of Oxford Department of Psychiatry, Warneford Hospital, Oxford, United Kingdom.

David Gunnell, MBChB, DSc, FMedSci, is professor of epidemiology at the School of Social and Community Medicine, University of Bristol, Bristol, United Kingdom.

Navneet Kapur, FRCPsych, MD, is professor of psychiatry and population health at the Centre for Suicide Prevention, University of Manchester and honorary consultant psychiatrist, Manchester Mental Health and Social Care Trust, Manchester, United Kingdom.

Keith Hawton, FMedSci, DSc, FRCPsych, is professor of psychiatry and director of the Centre for Suicide Research, University of Oxford and consultant psychiatrist, Oxford Health NHS Foundation Trust, Oxford, United Kingdom.