Young Adults' Accounts of Recovery from Youth Non-Suicidal Self-Injury: An Interpretive Phenomenological Analysis

by

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Abstract

Non-suicidal Self-Injury (NSSI), defined as an intentional act of self-harm or injury, without the intent to die, is a mental health issue with concerningly high prevalence rates and associated negative clinical outcomes for youth, internationally and in Canada. Several theoretical explanations and treatment protocols for NSSI exist and have been the subject of research over the past few decades. According to recent meta-analyses, current available specialized NSSI treatment approaches have only modest success in reliably and consistently facilitating recovery for youth who engage in NSSI. There is currently a need for a more nuanced and workable understanding of the mechanisms and factors that facilitate recovery from adolescent NSSI. This study intended to add to the growing body of phenomenological inquiry into recovery from NSSI, and examined, through in-depth personal accounts, the effective mechanism of change involved in recovery from youth NSSI. Interpretive Phenomenological Analysis, a qualitative method, with established precedence studying personal meaning making of accounts of lived illness experiences, was employed to study the question, "What do youth, who self-identify as having recovered from youth NSSI, understand to have facilitated or made their recovery possible?" Implications for mental health professionals working with self-harming youth are discussed based on analysis of the interview data obtained.

Key Words: Non-Suicidal Self-Injury; Self-harm; Counselling Psychology; Interpretive Phenomenological Analysis; Shame Resilience; Trauma Informed Practice

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Lastly I would like to acknowledge the good work that is being done in regards to research and therapeutic applications on the Power of Empathy and Compassion by Neff & Germer, Shame Resilience by Brene Brown and Trauma Informed Therapeutic Practice. I believe there are many concurrent efforts and insights being generated in the NSSI and related research fields that will add to the body of recovery literature in regards to facilitating healing from youth self-harm. I think we are getting somewhere. There is good reason to be hopeful.

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Chapter 1: Literature Review

1.1 Introduction:

The aim of this literature review is to offer an up to date theoretical and clinical conceptualization of Non-Suicidal Self-Injury (NSSI) from several viewpoints. This is presented in order to lay a foundational understanding for how NSSI is currently understood and researched, as well as to point to some important unanswered questions about intentional self-injury. First, NSSI will be presented as a phenomenon, based on how it is currently defined and understood, especially in the context of this study. Next, an overview of the mechanisms that are thought to perpetuate and sustain youth NSSI, as well as the available clinical treatments for NSSI and their evidence reviews will be presented as a way to explicate the current state of NSSI treatment. This explication will point to necessary future considerations for NSSI recovery research, several of which informed the approach of this study. This study will also be situated amongst the recent growing body of phenomenological research on NSSI and recovery, with an aim to describe features of this study that will allow it to make an important contribution to this topic as well as to this type of participant driven research.

This study proposes that there is substantial value in turning to youths' personal accounts of recovery from NSSI, examined through Interpretive Phenomenological Analysis, to better understand the mechanisms of change involved in NSSI recovery. The aim of this study is to enhance, from an in-depth, client centered (or participant driven) perspective, our understanding as mental health researchers and practitioners, the mechanisms of change that underlie, perpetuate and sustain, youth recovery from intentional non-suicidal self-harm. As this thesis unfolds, the case will be made that this in depth, phenomenologically derived understanding can inform and offer key insights into recommendations for future therapeutic approaches and support for youth recovery from NSSI.

1.2 Defining NSSI (Non-Suicidal Self-Injury):

It is necessary to first define intentional self-injury or self-harm for the purposes of this study and literature review. For the extant body of literature on intentional self-harm demonstrates variability in terms of how intentional self-harm or injury is named and defined as a construct. Ougrin et al. (2015), in the outset of their meta-analysis of Therapeutic Interventions for Adolescent Suicide Attempts and Self-harm, explained that self-harm is often defined differently by region, and that definitions may vary depending on whether or not self-harm is being studied in conjunction with suicide attempts. According to Muehlenkamp et al.'s (2012) study on prevalence rates of intentional self-harm, Deliberate Self-Harm (DSH) is the preferred term in the UK, most European countries, and Australia. Studies originating in these countries tend to employ DSH as an all-encompassing term for self-injurious behaviours both with and without suicidal intent, that do not result in completed suicide (Muehlenkamp et al., 2012).

Muehlenkamp et al. (2012) explain that in Canadian and American studies, a consensus exists to exclude behaviours motivated by suicidal intention when studying and defining non-suicidal self-injury. This is due to there being potentially different underlying mechanisms at work in the context of suicidal self-injury or harm, and self-injury which does not reflect intent to die (Muehlenkamp et al., 2012). Suicidal self-injury has been further demonstrated to be a separate construct (related to but not coming from the same motivation as non-suicidal self-harm) requiring its own, separate set of theoretical constructs and intervention protocols in other research (Csorba et al., 2009). Non-Suicidal Self-Injury (NSSI) is thus the preferred term in North America for intentional self-harm without the intent to die, and does not include in its construct any behaviours which are suicidal in intent. While this literature review will not restrict itself to research based out of North America, it should be noted that any international studies that have been included for the purposes of contextualizing this study, focus on self-injurious behaviour that is consistent with the North American definition of NSSI.

This study will employ, and is focused on understanding recovery experiences related to, the North American/Canadian conceptualization of intentional, non-suicidal self-harm or injury - NSSI. NSSI is defined for the purposes of this study as self-directed, physically harmful or injurious behaviour (e.g., self-directed cutting, burning, banging, hitting, lashing, pinching, etc.), that is not a suicide attempt, and whose intent is explicitly harm and not death (Brent et al., 2013).

It was important to make this definition explicit at the outset of this project, in response to some of the lack of construct clarity in the self-harm research field - as lack of clarity at the construct level could pose problems when it comes to finding a homogenous participant basis and when discussing meaning related to data obtained. It was also important to have a clear definition of NSSI moving forwards as this definition informed the participant inclusion and exclusion criteria that this study employed.

It should be noted that throughout this thesis, at the semantic level, the written terms NSSI and self-harm or self-injury will be used interchangeably, hereafter. Where the terms self-harm or self-injury are used, they are intended to covey the same meaning as NSSI – intentional self-harm that is non-suicidal in intent. The abbreviation for Non-Suicidal Self-Injury, NSSI, is employed predominantly in contexts related to academic literature or clinical findings, to reflect the language used in that domain. The more colloquial term self-harm or self-injury is employed more often in contexts related to participant accounts and meaning making, as this matched the language used by participants and myself during the research interviews, and seemed to be a more accessible, participant driven term.

As second layer of consideration in defining NSSI, it is important to note, so as to properly frame the type of self-harm that this study investigated, that in NSSI literature there is an awareness that a relationship with self-harm can vary in terms of severity and chronicity. It is important to briefly explore this in order to further clarify the kind of NSSI that this study is

investigating. It has been found that that some individuals who self-harm engage in self-harming acts only once or twice and then spontaneously recover (Whitlock, Eckenrode & Silverman, 2006). Whitlock, Eckenrode & Silverman (2006) estimate that this type of experimental or brief self-harmer comprises 25% of those willing to disclose engagement in NSSI. Alternately, the majority of those who report engaging in NSSI report a recurrent, persistent relationship with NSSI (Whitlock, Eckenrode & Silverman, 2006). Barrocas et al. (2014), further discussed this idea in their study of NSSI development and duration, when they named three trajectories of NSSI engagement - low, moderate and chronic.

It is the latter two types, those individuals for whom self-harm is a persistent, chronic issue as Barrocas et al. (2014) described, or whom according to Whitlock et al. (2015) would identify as a 'self harmer,' that this study sought to increase an understanding of, in regards to their experience of recovery. The rationale for this choice was to increase understanding of the factors of recovery of NSSI for individuals who may require increased levels of support and who may be at increased long term risk for NSSI perpetuation, as opposed to those who may recovery spontaneously, naturalistically or without intervention.

1.3 Theoretical and Clinical Conceptualizations of Non-Suicidal Self-Injury:

This section explores the etiology and function of persistent NSSI as it is understood clinically and theoretically, and in youth specific populations where the data is available. The available explications on NSSI etiology are derived primarily from the theoretical underpinnings of Dialectical Behavioural Therapy DBT-A and Mentalization Based Therapy MBT-A, two evidence based treatment protocols for youth NSSI cessation, as well as from models on the biological and social substrates of NSSI. Theories on the function of NSSI will be presented from the perspective of clinical research and conceptual models to give an overview of why NSSI can become a persistent behavioural coping tool. This overview of the factors underlying and

explicating potential origins and functions of NSSI, is presented to offer a holistic understanding of the mechanisms that perpetuate NSSI. These perspectives highlight both intrinsic factors (emotional, cognitive, biological and psychological) as well as extrinsic or interactive factors such as familial, attachment, developmental, and socio-contextual influence related to NSSI initiation and maintenance. An awareness of these explanations will offer context to the subsequent data analysis. There is not presently a single unified theoretical model to explain the etiology and function of NSSI, although different models often rely on shared explanations.

1.3.1 Stress-Diathesis Models Of NSSI:

Cognitive vulnerability and life stressors have been identified by longitudinal research from Guerry &Prinstein (2009) as playing a part in the emergence of NSSI in effected populations. Their research provides evidence for a stress-diathesis model of NSSI, and posits that cognitive vulnerability (characterized by negative attributional styles, higher scores on depression and NSSI) interact with life-stressors to reliably predict incidence of NSSI (Guerry & Prinstein, 2009). Those life stressors or experiences which are commonly correlated with NSSI incidence are low socio-economic status, being female, coming from a family in which abuse or neglect is experienced, early life trauma, and associated mental health disorders (Guerry & Prinstein, 2009; Spears et al., 2013). However, it is more commonly the interaction of these factors with other intra-psychic, learned coping means or response sets that relates to the etiology and incidence of NSSI, as opposed to these pre-dispositional factors alone (Spears et al., 2013). Thus they are mentioned, as potential risk factors, but not explored in further detail as part of the etiology of NSSI, as their predictive value alone in contributing to NSSI is not clear.

Research on NSSI, in the context of Dialectical Behavioural Therapy – a third wave cognitive behavioural modality often employed in the treatment of self-harm and emotional regulation difficulties - offers a stress-diathesis explanation of NSSI that is attachment-based and

focuses on the interaction of emotional/cognitive vulnerability and environment/stress in the emergence and maintenance of NSSI behaviour. Drawing from Linehan's formulation of the Bio-social Model of Vulnerability originally formulated in 1993, Chapman et al., (2006, p.462) reiterated the model's foundational notion, "that the transaction between a biological tendency toward emotional vulnerability and an invalidating rearing environment produces a dysregulation of the patient's emotional system" in ways that can lead to disordered or harmful coping strategies, such as the use of self-harm. Without access to other effective coping strategies, individuals pre-disposed to emotional reactivity, especially in the context of threatening, invalidating or stressful situations, often turn to impulsive or self-destructive behaviours (NSSI) in an attempt to alter their emotional experiences, regulate emotional responding and communicate their pain to others (Linehan, 1993). In this way NSSI is understood to be the product of interacting external and internal disruptions and stresses that an individual moderates or modulates through self-harm. This explanation offers both an etiological and functional frame of reference for NSSI and posits the origins of NSSI as being situated in attachment dynamics between primary caregivers and the self-harmer, as well as in the self-harmers dispositional or emotional response tendencies.

1.3.2 Biological Considerations on NSSI:

An exploration of Groschwitz & Plener's (2012) review, which meta-analyzed studies investigating the biological substrates of NSSI, offers further explanation for the potential mechanisms of emotional vulnerability or dysregulation that are thought to contribute to the etiology of NSSI. Like the aforementioned models, their review also speaks to a stress-diathesis conceptualization of NSSI. They concluded from their review that, "NSSI behaviour functions as a method of regulation of both affective experience and social situations in the occurrence of a stressful event," for individuals who may have an altered or vulnerable stress response system due to irregular neuro-physiological mechanisms (Groschwitz & Plener, 2012, p.26). While Groshcwitz & Plener (2012, p. 28) discuss that the precise biological mechanisms underlying

emotional dysregulation/vulnerability are inconclusive, they state that their review "supports a neurobiological model of NSSI as described by Sher & Stanley [which] suggests that abnormalities in the serotonergic, the dopaminergic and the opioid system as well as the hypothalamic-pituitary-adrenal (HPA) axis (cortisol) may lead to an increased level of stress vulnerability."

While a neurobiological explanation can be appealing from a positivistic standpoint – as it points to a measureable locus or origin of a phenomenon - if one takes into consideration, Glenn et al.'s (2011) research, it becomes inconclusive whether or not this dysregulated or vulnerable stress response, that is thought to explicate NSSI, is due to dysregulated neuro-biological factors alone, or for the ways in which the experience of higher emotionality is evaluated or experienced intrapsychically. Glenn et al. (2011) summarized evidence on the etiology and functions of NSSI to purport that, "intense negative states appear to precede engagement in NSSI and decreases in negative affect following NSSI predict lifetime frequency of the behaviour" (p.167). They went on to present a study on NSSI and emotional reactivity, which focused on assessing the impact of discrepancies between self-report of emotional reactivity and emotional reactivity as measured by psycho-physiological controls as it related to incidence of NSSI. They found that individuals who engaged in NSSI had higher ratings of self-perception of emotional reactivity, but that this was not necessarily matched by a corresponding higher level of physiological measured recordings of emotional reactivity compared to non-self injuring controls (Glenn et al., 2011). Thus while higher levels of emotional reactivity were found to correlate with a higher tendency towards NSSI, self-perception of emotionality as intense and unbearable had greater influence in predicting NSSI behaviour than one's actual, documented state of physiological arousal (Glenn et al., 2011).

An important consideration emerges from this research especially when juxtaposed with the findings of Groschwitz & Plener (2012). While there seems to be a correlation between a

tendency towards emotional reactivity or dysregulation and engagement with NSSI, with NSSI serving the role of functional mediator between states of dysregulation and the ability to self-regulate, one's evaluation or meaning made of such states of dysregulation may also be an important mediator in terms of presence of emotional reactivity/dysregulation and NSSI engagement. Glenn et al.'s (2011) study leaves a layer of nuance to consider when making sense of the role of neuro-physiological mechanisms, stress responses and NSSI. This nuance being that, a dysregulated emotional response system may not be determined purely by the physical presence of altered neuro-chemistry, but also by how one experiences their emotions, and evaluates their stress responses, particularly if that evaluation is that one's emotions are unacceptable or unbearable.

1.3.3 Attachment and NSSI:

As introduced above, in the context of Linehan's Biosocial Model of Vulnerability and NSSI, *attachment* is another important construct to explore in order to frame and understand NSSI etiology. Child-Caregiver attachment or bonding and its impact on childhood development, was first described by Bowlby (1973), where-after Attachment Theory developed and has been integrated into many counselling models and theories of human development (Linehan & Wilks, 2015). Bowlby's work, as reiterated in Linehan & Wilks (2015), posits that based on the presence or lack thereof of consistent, available and properly nurturing support from their primary caregiver, a child will develop either a secure, or insecure (anxious or avoidant) attachment bond with their caregiver, based on whether or not they believe their needs will be reliably met – a lack of reliability, consistency and effective mirroring resulting in the latter two insecure attachment styles.

Child-parent attachment ruptures and these ruptures subsequent impact on childrens' development of non-adaptive stress responses and difficulty learning effective coping strategies

are posited by several theoretical models, most notably DBT-A and MBT-A, to be shortly elaborated on, as contributing to the incidence of persistent NSSI. A substantial proportion of youth with NSSI tendencies describe experiences of persistent invalidation, usually by primary caregivers, in their formative years, which is said to result in attachment failures, a fractured sense of self and a resultant difficulty with emotional stability and regulation (Mehlum et al., 2014). NSSI is conceptualized, from this standpoint as an attempt to mitigate or actualize feelings of worthlessness and self-hatred that may develop a result of insecure attachments with primary caregivers (Linehan & Wilks, 2015).

The idea that attachment failures and parental invalidation, underlie or play an important role in the etiology and incidence of NSSI behaviour, has been replicated in several empirical studies. A UK study by Palmer, Welsh and Tiffin (2016, p. 259) found that, "adolescents hospitalized for self-harm reported that their families were more dysfunctional than healthy controls on the family perceptions scale." Interestingly, in this study, while NSSI adolescents consistently rated their family/parents lower on qualities like support, cohesion, and nurturance, and higher on parental rejection, over-protectiveness and family conflict, their parents did not have the same perceptions of dysfunction and their ratings did not match those of their children (Palmer, Welsh & Tiffin, 2016). Whether this discrepancy points to a tendency towards heightened sensitivity in youth with NSSI, or invalidation/lack of acknowledgment of dysfunction present in the family by the parents of said youth, was not discussed by the researchers. However, that feelings of invalidation and lack of family cohesion could play a role in the conceptualization of distress that gives rise to self-harm, may be an important consideration.

The connection between parental invalidation/family conflict, attachment ruptures and incidence of self-harm has been replicated in other studies of youth NSSI. Swahn et al.'s (2012) study found that parental conflict, more so than peer conflict, was found to be a predictor of NSSI

in teens. Rossouw (2012) discussed her clinical experience working with youth who self-injured and detailed that parent-teen conflicts were often youth's reported triggers for NSSI episodes. Roussow (2012) also discussed that relational (particularly romantic) stressors or difficulties that elicit feelings of abandonment and rejection, were perceived as particularly threatening by individuals with anxious or avoidant attachment constructs, and were significant NSSI triggers for said youth (Rossouw, 2012).

Overall it is concluded that individuals with secure attachment are able to develop a more cohesive sense of self and more reliably use this stable basis of self through which to regulate distress (Linehan & Wilks, 2015). Individuals who have not been afforded the opportunity in parental attachment relationships to experience effective mirroring and have their needs be reliably met are alternately more prone to affect regulation difficulties (Chapman et al., 2006). Anxious or avoidant coping styles and attachment ruptures, as they impact affect regulation development for which NSSI becomes an affect regulation tool, may then for some inform part of the etiological basis of their NSSI.

1.3.4 Mentalization Failures, Self-Concept and the Etiology of NSSI:

The following section reflects on a construct called Mentalization, and the ways in which it is related to the etiology and emergence of NSSI. *Mentalization* is considered, "the ability to reflect upon and understand one's state of mind, and to have insight into what one is feeling and why" (Hoermann, Zupanick & Dombeck, 2013). This is deemed a critical skill for emotional regulation and prerequisite to the ability to accurately experience and interact and understand the emotional states and behaviour of others (Rossouw, 2012). Mentalization, is one of the key constructs upon which Mentalization Based Therapy (MBT-A), an empirically validated protocol for NSSI treatment, is based. An exploration of the theoretical basis of MBT-A offers a further nuanced conceptualization into the attachment-based understanding of youth NSSI.

MBT- A theory speaks to how attachment relates to mentalization – a construct which is considered an important mediating factor in the use of NSSI as a coping tool for distress. Trudie Rossouw is the primary research/advocate for this form of therapy and bases her MBT-A/MBT-F approach on the theoretical work of Fonagy and Bateman and their emphasis on attachment constructs, family dynamic constructs and the concept of mentalization (Fonagy & Bateman, 2006; Roussow, 2012). Rossouw (2012) explains that an ability to successfully mentalize develops as part of a secure attachment relationship in early childhood. Bateman and Fonagy (2006) theorize that when children interact with their parents, a caregiver's accurate and consistent response to their child's moment to moment emotional expressions allows a child to become self-sufficient in regulating their own emotions. It is thought that accurately mirroring and responding to a child's emotional expression, allows the infant to form a mental label for their emotions and perceive them, as they develop, as understandable and controllable (Bateman & Fonagy, 2006). Hoermann, Zupanick & Dombeck (2013) further explain that a progression from assisted to independent understanding and observation of self depends on a healthy consistent child-caregiver relationship. In an insecure attachment relationship, a child receives either mixed, inaccurate or absent messages about their emotional world, which is thought to result in difficulties developing successful mentalization capacities (self-soothing, understanding and responding) in childhood and later in life (unless a reparative experience occurs or skills are learned) (Bateman & Fonagy, 2006).

An inability to accurately understand and process emotions and self-soothe, otherwise considered a low mentalization capacity, can make it difficult for individuals to deal with intense emotions, especially any impulsive urges that come along with those emotions. The insecure attachment experiences that lead to poor mentalization abilities, also make it difficult for children to perceive the world as meaningful and predictable. In turn they will lack the ability to respond to complex social interactions with resilience (Rossouw, 2012). In this way, with mentalization

being the mediator between attachment and intentional self-harm, NSSI can be conceptualized as a developmental, cognitive and social/relational issue.

Rossouw (2012) goes on to explain how an inability to mentalize, is intimately connected to the development of a negative self-concept. This link helps to make sense of why self-injury is result of mentalization failures in teens with NSSI. Fonagy and Bateman (2006) proposed, that when children have repeated invalidating and inconsistent emotional interactions with caregivers, they are more likely to internalize inaccurate or negative representations of themselves. Fonagy (2000) developed a construct based on this idea, which he termed the 'alien self.' He purported that the 'alien self' contains the mixed or inaccurate 'mirrorings' from a child's attachment relationship (Fonagy, 2000). The 'alien self' is considered an internalized self-concept that is often 'alien' or in contradiction with the child's authentic mental state and intentionality (Fonagy, 2000). Children who have internalized an, 'alien self,' will experience that self as in constant conflict with an authentic or healthy self-concept, as if in constant battle with an inner tormentor. This results in a regular experience of inner criticism, self-hatred, lack of internal validation and expectation of failure (Rossouw, 2012).

Whether the 'alien-self' develops first, and interferes with the development of mentalization capacities, or whether it is a product of not properly learning to mentalize in the first place is admittedly inconclusive according to Roussow (2012). However, what is proposed is that NSSI is often the product of a mentalization failure. Roussow (2012) reports as such that the impulsivity, intense emotionality and difficulty with self-regulation (all considered experiences related to low mentalization) can result in NSSI as a way to organize and make sense of one's experience. NSSI can serve a self-punishment function, allowing one to experience organization and congruence with the 'alien self,' or NSSI may be in other instances an attempt to liberate oneself from the 'alien self'- to destroy it (Fonagy, 2000). NSSI is thus conceptualized as a

concrete, physical way of managing emotions that one may not able to regulate internally or cognitively.

1.3.5 NSSI and Affect Regulation:

As has been touched on in the preceding discussion, many theoretical and clinical models suggest that NSSI, when employed by youth and non-youth populations, serves an important affect regulation function, especially for the regulation of negative affect. A formal analysis of NSSI and the affect regulation purpose that it serves was conducted by Klonsky (2007) who reviewed 18 studies of NSSI, (not youth specific) including self-reports of reasons for self-injuring, descriptions of NSSI phenomenology, as well as lab-based NSSI studies, to conclude consistent convergent evidence exists that NSSI has an affect-regulation function. His review concluded that, "acute negative affect precedes self-injury, decreased negative affect and relief are present after self-injury, and self-injury is most often performed with intent to alleviate negative affect" (Klonsky, 2007, p. 227). Klonsky (2007) also reported that negative affect and arousal are reduced by the performance of self-injury proxies in laboratory settings. Klonsky's (2007) review concluded there is also strong support for NSSI having a self-punishment function, and modest evidence for it being used for anti-dissociation purposes. His review offers both an etiological explanation for NSSI engagement – that being that it is triggered by the experience of intense negative affect – as well as describes it as a functional behaviour. NSSI can be understood from the conclusions of this review as a functional means of attenuating distress, and for dealing with urges to self-punish, especially in the absence of other effective means of achieving regulation and relief.

1.3.6 Summary of the Etiological and Functional Considerations on NSSI:

Overall, there are slightly divergent explanations in regards to the etiology of NSSI, however most models rely on an interactionist conceptualization of NSSI which sees the

emergence of intentional self-harm as influenced by both intrinsic and extrinsic factors. There is evidence that those who engage in NSSI do so because of an innate stress response that is driven by biological, physiological or cognitive-evaluative dispositions, interacting with life stressors and challenging developmental events. There also seems to be consensus among researchers from different disciplines (counselling and neuropsychology) that a biological vulnerability for emotional reactivity, (neurotransmitter dysregulation or overactive HPA system or a tendency to self-evaluate reactions to stress as intense and unbearable) paired with environmental stressors and rearing factors (family dysfunction, childhood physical, sexual or emotional abuse, and insecure child-caregiver attachment patterns) may interact to predict NSSI in affected youth.

In synthesis of the current conceptualizations of the function of Non-Suicidal Self-Injury, in sum NSSI is best conceptualized as the behavioural byproduct of an intra-psychic experience - usually the experience of overwhelming and unmanageable distress. While different theoretical models posit various explanations as to the nature and type of distress that gives rise to NSSI, whether it be intra-psychic, (cognitive, emotional, psychological), socio-environmental or attachment based, the overall consensus seems to be that in the absence of an effective means of dealing with said distress, NSSI can be an effective coping tool, that may be repeatedly turned to for relief.

1.3.7 Summary of the Function of NSSI in Youth Specific Research:

In youth specific research, acts of self-mutilation and injury are said to be used to express self-directed anger, shame or blame (as a means of self-punishment), as means of attracting the attention and support of others by signaling distress (usually when other communication has failed), as a means of distracting oneself from painful emotions (diverting transient/difficult to pin down emotional pain into a concrete physical form), or to bring oneself 'back into their body'

during dissociative episodes (when individuals lose touch with reality/their sense of physical presence) (Rossouw, 2012, Swahn et al., 2012).

1.4 The Importance of Researching NSSI Recovery with Youth Specifically:

Youth Non-suicidal Self-Injury is a major public health concern in many countries, and in Canada, that urgently demands improved clinical understanding and treatment. NSSI has a reported global annual prevalence rate of 5-10% for adolescents, proportionately more of which are female (~75-85% according to most studies) (Melhum et al., 2014). One study estimated, based on a meta-analysis of 52 international studies, that the annual prevalence of NSSI in Canada for teens (median age 15.9) was between 13.9 % and 16.1% in their age range (Muehlenkamp et al., 2011). It has been established, that NSSI is a negative clinical treatment outcome predictor, is common in individuals with treatment resistant depression, and that 30% of self-harming teens continue to self-harm as adults (Bateman & Fonagy, 2004; Bleiberg, Rossouw, Fonagy, 2012). Furthermore, individuals who use NSSI as a coping tool and means of emotional regulation are at a clinically significant higher risk for future suicide attempts and suicide completion, more so than those who attempt suicide with no prior history of NSSI (Mehlum et al., 2014; Rossouw & Fonagy, 2012).

In light of all the aforementioned data, specifically the high prevalence rates and the potentially predictive long-term, negative impact of NSSI, it seems clear that finding an effective, and reliable treatment approach for youth NSSI is of critical social and therapeutic value. Given that youth NSSI is a predictor of suicide attempts and completion, and that chronic or persistent adult NSSI and can co-occur with treatment resistant depression, targeting NSSI in youth, through continued research and intervention, can be conceptualized as a preventative mental health endeavor (Bateman & Fonagy, 2004; Bleiberg, Rossouw & Fonagy, 2012). If effective strategies are in place to assist youth to better cope with the roots of their self harming urges early

on, to help them deal with the distress that gives rise to NSSI, and learn alternative coping tactics, we may as a mental health community be able to effectively support effected youth before NSSI becomes an embedded coping strategy that is more difficult to recover from. Given that NSSI can be a predictor of and is correlated with higher risk for completed suicide, it could also be suggested that improving treatment for youth NSSI, could potentially reduce rates of completed suicide (Mehlum et al., 2014; Rossouw & Fonagy, 2012).

1.5 The Current State of Youth NSSI Treatment Efficacy:

The follow section will explore what is currently available by way of specialized NSSI treatment, research on these treatments' efficacy, as well as explore unanswered questions in regards to bridging the gap between a functional and etiological conceptualization of NSSI behaviour and effective treatment and recovery support.

Of the evidence based specialized treatment protocols for youth NSSI treatment that exist, MBT-A and DBT-A - described previously in regards to the functional and etiological mechanisms of NSSI - hold a tentative place in regards to superior clinical efficacy over treatment as usual (TAU) for assisting youth with recovery from NSSI. MBT-A, Mentalization Based Therapy for Adolescents, was identified by Hawton et al. (2015) in a Cochrane review published meta-analysis, as having the largest effect size for assisting youth with recovery from NSSI compared to treatment as usual. DBT-A was deemed worthy of further investigation as an effective treatment for youth NSSI although it did not produce the same rates of recovery, as MBT-A. However therapeutic protocols from both of these modalities resulted in significant reduction in the frequency and severity of NSSI behaviours, at follow up intervals following treatment, as compared to baseline, - reduction of NSSI behaviours and not total cessation being the marker for successful treatment (Hawton et al., 2015, Ougrin et al., 2014).

That MBT-A is the most effective available treatment protocol for youth NSSI, was not confirmed or supported by a meta-analysis of NSSI treatment and cessation done the previous year by Ougrin et. al (2014). This may be due to differences in the inclusion criteria for studies investigated in these two meta-analysis, and difference in effective sizes and basis of comparison between studies' efficacy, however the overall consensus from these two meta-analyses is that the superior clinical efficacy of any available treatment for youth NSSI, compared to another non-specialized therapy, is inconclusive at this point. Before the implications of these meta-analysis are discussed, in regards to directions to be taken in this study and mechanisms of change in the NSSI recovery process that are at present not well understood, it should be noted that these meta-analysis complicated any conclusions that can be drawn about NSSI treatment due to their inclusion of studies in their review which do not adhere to consistent definition of NSSI – that being NSSI as defined as self-harm which is specifically non-suicidal in intent. For both Ougrin et al. (2014) and Hawton et al. (2015) included studies in their meta-analyses which examined treatment and recovery protocols for self-injury and harm, intent non-specified. Ougrin et al.'s (2014) meta-analysis reviewed treatments for self-harm cessation and suicide attempts together, without making the distinction between self-harm behaviour that was non-suicidal and suicidal in intent. While Hawton et al. (2015) did exclude studies of treatment for suicide attempts in their meta-analysis, and examined treatments for 'self-harm' exclusively, they relied on a definition of 'self-harm' that does not capture an explicitly non-suicidal understanding as conceived of by the term NSSI that this study intends to investigate.

In Hawton et al.'s (2003) analysis, "the term 'self-harm' [was] used to describe all intentional acts of self-poisoning (such as overdoses) or self-injury (such as self-cutting), irrespective of degree of suicidal intent or other types of motivation." This definition included acts intended to result in death, 'attempted suicide,' those without suicidal intent, for example, to communicate distress or to temporarily reduce unpleasant feelings, and those with mixed

motivation (Hjelmeland, 2002; Scoliers, 2009). This lack of construct clarity and consistency in regards to the type of NSSI being studied or included in the aforementioned meta-analyses, makes it difficult to draw conclusions about which interventions could best be matched to or improved upon in order to support the treatment specifically of 'youth *NSSI*.' The lack of construct clarity essential muddies our ability to draw conclusions about treatment that is NSSI specific or defined as exclusively non-suicidal - despite acknowledgement that self-harm that is suicidal vs. non-suicidal in intent is likely motivated by different underlying mechanisms and may require different treatment protocols (Csorba et al., 2009).

Hawton et al (2015) and Ougrin et al. (2014) purported as part of their assessment of the current state of youth NSSI treatment, that it was also at present difficult to determine what aspects of the therapeutic interventions reviewed were effective in promoting NSSI cessation and why. For few of the studies reviewed included a built in assessment of change mechanisms or processes involved in recovery (the study on MBT-A did) (Hawton et al., 2015; Ougrin et al., 2014). A lack of built in processes analysis in a study can make it difficult to know how a treatment protocol is interacting with participants to produce effects, and thus how it could be best modified to maximize on the effective change processes.

Despite the limitations of some of the available studies on self-harm treatment, as described and revealed by the preceding analysis, these studies and meta-analyses did provide a seminal overview in regards to the types of specialized self-harm treatment currently available, their methods, some sense of their efficacy, as well as the kind of questions and populations currently being studied in regards to self-harm and recovery. More importantly, in terms of contextualizing the need for this present study, the limitations of the previous studies provide evidence that further investigation and clarification into the mechanisms of change and processes involved in NSSI recovery is needed, especially in the context of self-harm recovery that is youth and NSSI construct specific.

1.6 In Shifting to a Qualitative Inquiry into Youth Recovery from NSSI:

In making sense of the preceding information contained in this literature review, including explications on the etiology, function, and current state of available NSSI recovery treatment, it can be concluded that there presently exists a gap between our clinical and theoretical understanding of NSSI, and our practical ability to reliably and effectively support youth NSSI recovery, therapeutically. Despite the availability of many studies and theories on the functions, risk factors, impacts, and origins of self-harm behaviour as well as several peer-reviewed meta-analyses on present treatments for youth self-harm - pointing implicitly to the fact that many NSSI treatment protocols have been developed in response to the issue of NSSI – a consensus on what best supports recovery from NSSI, especially youth NSSI, has been conclusively deemed inconclusive at this point in time.

In sum, this inconclusivity can be seen as due to several factors including: a) the multitude of intersecting factors contributing to self-harm incidence which can make it difficult to formulate a treatment that addresses all precipitating factors and change mechanisms, b) a lack of construct clarity in regards to self-harm in previous RCTs and meta-analyses of self-harm and its treatment, as well as c) a lack of understanding in regards to the process factors and change mechanisms involved in NSSI recovery, an understanding of which could be used to increase the efficacy of treatment. Hawton et al. (2015) and Ougrin et al. (2014), in the conclusion of their meta-analyses, made several recommendations for future directions in self-harm treatment research and ways to begin to fill some of these gaps in understanding. These recommendations, as well as a reflection on the limitations of previous studies and the resulting gaps in understanding about the change mechanisms involved in NSSI recovery, were integrated to inform this study's research questions, methodology, and design.

Ougrin et al.'s (2014, p.105) recommendation for future NSSI treatment research was that, "additional research and replication studies are critically needed to identify…the mechanisms through which interventions reduce self-harm risk, and those variables most important for matching specific youths and families to the interventions with greatest likelihood of benefits." While they did not specify means or type of study through which to access and uncover these change mechanisms, they did highlight that it is the mechanisms at play in recovery, that if better understood, could help generate treatment approaches with the greatest likelihood of benefits for effected youth. The present study will propose that a qualitative, participant driven line of inquiry, which asks participants to reflect on key aspects of their change or recovery experience, will afford the most direct access to an understanding of the mechanisms involved in recovery youth NSSI and begin to fill some of these gaps in understanding about change mechanisms and NSSI treatment.

Hawton et al. (2015, p. 2), concluded their meta-analysis with a similar recommendation and stated that, "despite the scale of the problem of SH (self harm) in children and adolescents, there is a paucity of evidence of effective interventions." Their recommendations were that in regards to an, "investigation of therapeutic mechanisms underpinning these interventions…it is increasingly apparent that development of new interventions should be done in collaboration with patients to ensure that these are likely to meet their needs" (Hawton et al., 2015, p. 2). They too pointed to in an increased understanding of mechanisms underpinning recovery as needed to improve the current state of NSSI treatment as well as the idea that IPs or those struggling with NSSI may have important insight into what these are. What this present thesis research will suggest, is that such mechanisms of recovery may be best uncovered by working with a small homogenous sample of individuals, through which rich in-depth, meaning making can be extracted. This type of research would correspond to the collaborative type of treatment and inquiry that Hawton et al. (2015) alluded to.

While Hawton et al. (2015) did not name the need for a qualitative line of inquiry into the mechanisms of recovery of NSSI explicitly, they did suggest that research in which participants have 'collaborative' say in their treatment and opportunity to speak to their needs could offer valuable new information needed to improve upon the present standard of NSSI cessation treatment. There is presently a growing body of qualitative inquiry into the mechanisms involved in NSSI cessation and recovery – research which essentially matches the recommendations for future NSSI research put forth by the above reviews. This line of inquiry is in many ways a response to the post-positivistic tradition of clinical NSSI treatment research and represents an attempt to understand human processes and change mechanisms directly, especially from the perspective of those experiencing the phenomenon in question (Creswell, 2007; Smith, 2011).

Since understanding and clarification of such change mechanisms is acknowledged to be, at present, of critical importance in furthering the field of self-harm recovery treatment and research, research which is able to isolate such mechanisms, especially in a way that matches client's lived experience and understanding as qualitative approaches often are, can be seen as of unique value. It is upon these bases that this study turned to a qualitative and phenomenological line of inquiry in order to better understanding mechanisms involved in recovery from youth NSSI.

1.7 Current, Qualitative Considerations on NSSI and Recovery:

An overview of what is presently understood, based on recent qualitative and phenomenological lines of inquiry, about self-harm recovery, as well as some key gaps in understanding that emerge from this body of research, is now presented in order to situate this study amongst the compendium of emergent participant driven self-harm research that this study intends to build upon and add to. There presently exists a growing qualitative body of research on NSSI cessation and recovery, some of which is youth/young adult specific, notably reviewed by Mumme et al. (2016).

Mumme et al.'s (2016) review was chosen as starting point for a summary of current qualitative understanding of NSSI recovery, as it focuses critically on studies that investigated mechanisms of recovery or cessation, as the present study seeks to, in light of it being clear that such a focus is an important avenue of further investigation and clarification at this point in the state of self-harm recovery research and understanding. Mumme et al.'s (2016) review found 9 studies out of 454 on self-injury cessation and recovery that sought to answer the question, "How do people stop non-suicidal self-injury." Their review complied a list of common or shared factors that commonly influence the self-injury cessation process. This review revealed that reasons for NSSI cessation can be reliably categorized in terms of intra and inter-personal factors and identified 4 key areas whereby cessation support came from – family support, self-esteem, emotional regulation and professional help (Mumme et al., 2016).

Notable studies included in this review - those that related to my population, research question, and methodology - and what can be learned from them will now be discussed. Mumme et al. (2016) reviewed a study, with some overlapping research intent and demographics to this present study– a qualitative study of cessation of deliberate self-harm in a university sample by Gelinas & Wright (2013). Gelinas & Wright (2013) identified 6 core themes of strategies used to reduce self-harm behaviours. These 6 themes, or reasons why individuals ceased to stop self-harming, or chose to recover from self harm were determined to be 1) realization of the stupidity futility of self-harm, 2) distress regarding scarring or negative attention as motivation to stop, 3) wanting to change for interpersonal reasons (ie. to avoid parental/partner disappointment or hurt, as a response to requests or threats from parents or significant others), 4) increased reception of help/support, 5) desire for wellness, and 6) development of effective alternate coping strategies (Gelinas & Wright, 2013). This study revealed several key aspects of psychological and interpersonal growth factors that facilitate recovery from NSSI, which authors of this study state can inform treatment strategies in terms of which strategies to capitalize on in treatment and

which to avoid (Gelinas & Wright, 2013). This study emphasized, as did Mumme et. al's (2016) review, that interacting intra-psychic and interpersonal factors play a part in most NSSI cessation or recovery experiences. This study also provides a clear starting point in terms of examples of the types of factors that may motivate youth to recover from self-harm.

Limitations of this study included that it was restricted to an investigation of self-harm recovery with an exclusively university based sample, and that it defined recovery on behalf of the participants, recovery as being the current absence of self-harming behaviour (Gelinas & Wright, 2013; Mumme et al., 2016). A matter which becomes apparent when thinking about the approach and content of this present thesis study, in juxtaposition with the following study by Kool et al. (2009), is that there may be a difference in terms of the functional or lived experience of what is meant by 'cessation' vs. 'recovery' in regards to NSSI. This distinction was not elaborated upon by Mumme et al. (2016). However, in considering the approach and criteria of Kool et al.'s (2009) study, as well as the way recovery was assessed by Hawton et al. (2015) and Ougrin et al. (2014), it should be noted, that for some, recovery from self-injury does not always reflect complete cessation of NSSI behaviour, as was an inclusion criteria for Gelinas & Wright's (2013) study. In this way cessation or absence of NSSI behaviour may not be the same thing or mean the same thing as being 'recovered' or in recovery from 'self-harm' – this is a question that nonetheless bear further investigation.

Kool et al. (2009) conducted a study on the process of self-injury cessation, using semi-structured interviews with adult long-term self-harmers who identified as having stopped self-harming or who at present only self-harmed minimally. This was the only study in Mumme et al.'s (2016) review to make the distinction that self-harm recovery is not always defined by a total absence or cessation self-harming behaviour, and that recovery may follow more of a stage or process model. Kool et al.'s (2009) study resulted in the development of a 6-step phase for self-injury cessation, that was translated into a treatment protocol for psychiatric nurses working with

inpatients, and identified positive connection in close personal relationships as being the key change facilitator at play at all stages of cessation. Kool et al.'s (2009) study employed the same research methodology as the present study and thus supports the notion that a qualitative, phenomenological research endeavour can generate data that can be reliably used to inform mental health treatment protocols. Their study differs in important ways that this present study intends to respond to, in that Kool et al.'s study was exclusively of inpatient IPs, many of whom were diagnosed with mood and personality disorders, and their NSSI cessation process and recovery recommendations were tailored to nurses working in an inpatient setting. This may restrict the applicability of their findings to non-inpatient settings, as well as to younger, undiagnosed populations, like the population this study seeks to understand.

The qualitative, phenomenological study from Mumme et al's (2016) review that most closely matches the line of inquiry pursued by this thesis research, in terms of demographic, methodology and research question, was conducted by Wadman et al. (2016). Wadman et al. (2016) conducted an IPA study with youth aged 19-21, from a university sample, who were still active self-harmers, in an attempt to determine what maintained their self-harming behaviour and what they thought might help them recover. The questions these youth were asked were, " 'Why do you keep on self harming?', 'What might help you to stop self harming?', and 'What supports/services have been (un)helpful?' " (Wadman et al., 2016, p.3). While Wadman et al.'s (2016) study did probe the issue of self-harm 'recovery' with youth self-harmers, in the same idiographic, client centered way that this study did, their study asked participants to predictively answer questions about a recovery they had not yet made. This could be considered a limitation of Wadman et al.'s (2016) research, in that an in-depth inquiry into a known or lived experience of recovery, as opposed to an imagined one, might more directly uncover critical insight into NSSI recovery experiences. However, important insight was offered by this study into re-current

experiences and common perceptions of those who want to recover from NSSI and their relationship with support seeking or formal NSSI treatment.

Wadman et al. (2016) found, as was echoed by similar phenomenological, youth-based NSSI recovery research by McAndrew and Warne (2014), that many individual's considering recovery or cessation did not want to or believed they could not stop self-harming completely, although were interested in reducing the frequency and incidence of their self-harm behaviour. It was noted that the perception that formal treatment would try to eradicate NSSI behaviour completely was associated with reduced outreach to those services (McAndrew & Warne, 2014; Wadman et al., 2016). Hume and Platt (2007) found, in line with this, that in adults seeking NSSI cessation support, there was a preference for approaches geared towards self-harm management or reduction, as opposed to complete eradication or cessation.

In line with the findings that individuals struggling with NSSI often see formal support as inaccessible or undesirable based on wanting to maintain the functional aspects of their relationship with NSSI, exists research by Buser, Pitchko & Buser (2014). These researchers explored key factors involved in naturalistic recovery from self-injury, also using a phenomenological basis of inquiry, to described key features of NSSI recovery experiences not involving formal help seeking. Buser, Pitchko & Buser (2014) reported on both intra-psychic processes, such as recognition of serious physical damage and related consequences, and interpersonal factors, such as corrective interpersonal influences, as reliably underscoring and facilitating NSSI recovery.

Interestingly, these change factors are similar to those reported by the aforementioned studies with individuals that did receive formal support, either inpatient or outpatient, in the course of recovery from NSSI. That similar mechanisms of recovery – interpersonal support, and changes in perspective in regards to the benefits of NSSI - were noted across multiple, varied

qualitative and phenomenological inquiries into self-harm cessation and recovery, regardless of individuals' relationship with formal mental health services, may speak to critical processes that consistently support self-harm cessation and recovery and that bear further investigation and understanding for the purposes of improving NSSI treatment (Mumme et al., 2016).

1.7.1 Reflections and Implications for the Present Study:

In reflecting, in summary, on the common themes and proposed mechanisms of NSSI recovery and cessation generated by the aforementioned qualitative studies, as well as the strengths, limitations and unanswered questions from these studies, the following considerations on the present, well-indicated directions in NSSI recovery research emerged. The present thesis research intended to respond to some of these considerations through its design and research questions.

It is clear from the body of qualitative inquiry into self-harm recovery, that such inquiry has elicited shared understanding of factors involved in NSSI recovery and cessation. While nuanced in some ways in each study, depending on population and study question, the consensus from this body of qualitative inquiry is that recovery from NSSI tends to revolve around common themes of increased social support, increased self-esteem, and changes in cognitive and emotional appraisals of one's relationship with self-harm. These themes bear further investigation, especially into the ways they translate into mechanism of change for recovery that is youth and NSSI construct specific. While the type of research methodology this present study will employ requires the bracketing of previous assumptions or theories, and as such will not ask about these mechanisms specifically, further inquiry into these constructs where initiated by participants may be useful.

Given that the aforementioned qualitative research has often been restricted to either exclusively academic or inpatient samples, or mixed adult samples, another consideration that

emerges from this review, that will be incorporated into the present study, is that there may be value in conducting phenomenological research into the mechanisms of youth NSSI recovery with a mixed community youth sample. An in-depth inquiry into mechanisms of recovery with a sample that is homogenous in terms of experience with persistent NSSI, but varied in terms of life backgrounds, could add necessary breadth to the basis of inquiry into NSSI recovery mechanisms, while maintaining the ability to generalize findings to other young adults who share the common experience of having a dealt with and recovered from persistent NSSI (Smith, Flowers & Larkin, 2009; Wadman et al., 2016).

Given the body of research pointing to the barriers between NSSI and help seeking, concluding that formal help seeking is not always experienced as reliable, available or supportive by those pursuing self-harm cessation, an increased understanding of the barriers to help seeking, effective aspects of informal social support as well as what effective support is and is not, especially from the perspective of the 'recoverer,' may be useful avenues of future phenomenological inquiry as well.

What can also be concluded from an overview of the available qualitative NSSI recovery research is that the distinction between cessation and recovery from NSSI is not always clear (Gelinas & Wright, 2013; Kool et al., 2009; Mumme et al., 2016). There presently exists ambiguity in regards to whether NSSI recovery reflects a complete absence of NSSI behaviour or rather a cognitive and emotional state of recovery, and whether or not recovery may include variable lapses into self-harm acts (Buser, Pitcko & Buser, 2014; Mumme et al., 2016). This variance in terms of how recovery vs. cessation is understood, experienced and defined in extant qualitative research, as well as who it is defined by (participant or researcher) points to an important consideration for continued NSSI recovery research that the present study hopes to address.

A recommendation that Mumme et al. (2016) put forth at the conclusion of their review may be useful in clarifying the questions and gaps in understanding that have emerged throughout this literature review. They recommended that future NSSI recovery research incorporate in design and question, "the notion of the self-injurer being the expert in understanding their behavior, and possessing the ability to fully describe the phenomenon and its meaning" (Mumme et al., 2016, p.16). This study intends to respond to this and the above considerations. As such this present research works towards a participant-driven definition of NSSI recovery or cessation, and an exploration of the mechanisms involved in recovery from youth NSSI, from an in-depth, phenomenological perspective with a mixed community sample.

1.8 Literature Review Conclusions:

In conclusion, this study, its design and methodology, as well as and the content of its research questions, were informed by reflecting on and building off of the culmination of the understanding, strengths and limitations of the studies, reviews and meta-analyses, both qualitative and quantitative included in this literature review. This study attempts to access meaning and increase understanding of what is presently not well understood about the mechanisms involved in self-harm recovery, specifically in regards to what facilitates recovery from self-harm that is youth, and NSSI construct specific. The recent growing body of phenomenological inquiry into NSSI recovery mechanisms, which this research intends to build upon and add to, has demonstrated strength in terms of accessing, in-depth participant generated insight and increasing clinical understanding of recurrent themes involved in NSSI recovery. (Kool et al., 2009; Mumme et al., 2016). I am hopeful that this study will further enrich our understanding, of youths' lived experiences of recovery from NSSI, and offer insight into some of the critical factors and change mechanisms that support recovery, as well as address how we as mental health professionals can integrate this knowledge into practice.

Chapter 2: Methodology, Method and Procedures

2.1 Research Question:

This study was guided by the research questions, 'How do young adults, who identify as 'in recovery from youth NSSI,' make sense of their recovery?" and "what do they believe made their recovery possible?" These questions, and the variations on them that became part of my interview schedule, were explored using procedures and methods derived from Interpretive Phenomenological Analysis (IPA).

2.2 Methodological Rationale:

My impetus to explore these questions, intended to further our understanding of the critical mechanisms of change involved in recovery from youth NSSI, through a phenomenological and interpretive basis of inquiry via IPA, was twofold. Firstly, IPA is well suited as a methodology to this particular line of inquiry. IPA's underlying philosophy (interpretive, phenomenological and idiographic) and the methods it relies upon (in-depth, in this case one-on-one in-person interviews) makes it well matched to research endeavours whose intention is to access meaningful, personal, and potentially novel perspectives on a topic (Smith, 2011). By expanding our understanding of the change processes involved in NSSI recovery from the perspective of those who have lived such change processes themselves, the intention is that we may come closer to an more accurate understanding of these changes processes as supported by first hand meaning making (Buser, Pitchko & Buser, 2014; Smith, 2011; Wadman et al., 2016). This close, in-depth or embodied understanding of NSSI recovery from the perspective of the 'recoverer,' may help close some gaps in understanding on the NSSI recovery process that is needed to improve NSSI treatment for youth (Hawton et., 2015; Ougrin et al., 2014; Todres, 2004).

My second reason for choosing IPA as the methodological foundation for this project was upon the basis that IPA's philosophical paradigms match many of the paradigms I hold as a counsellor. IPA's approaches and methods were therefore something I could congruently embody as a researcher as I undertook this project. I consider humans to be experts on the content of their lives. I believe the post-positivistic, psychologist-as-expert philosophy that some quantitative research is based upon, that seeks to verify theory and interact with clients as objectively knowable variables, can limit access to the voices and knowledge of the research subjects we are trying to better understand and help as counselors and researchers (Creswell, 2007; Smith, 2011). I chose IPA as a methodology as it allowed me to approach my subjects and research questions from a constructivist-interpretevist stance whereby: participant generated meaning making was given a platform for influence; where participants were given the space to share information in a way that made sense to them and thus that respected their meaning making systems; where knowledge and truths were seen as co-created between researcher and participant; and where variations in understanding and meaning were allowed to enrich the data set as opposed to muddying 'results' or 'outcomes' (Smith, 2011; Smith, Flowers & Larkin, 2009). I believe the meaning individuals make of their own life experiences can provide critical insight and offer perspectives that we as researchers, despite our in depth theoretical knowledge of a subject, may not have access to otherwise. IPA allowed me to interact with my research participants, and their data in a way that honoured and respected these ideals in the pursuit of further understanding the lived experience of recovery from youth NSSI.

2.3 Philosophical Assumptions of IPA:

IPA was developed in the 1990's by Jonathan Smith and has since been used by researchers in many health and psychology disciplines to better understand and capture meaning related to lived experiences, especially those of a personally sensitive nature (Smith, 2011). IPA combines phenomenological, hermeneutic and idiographic theories to study and report on the

ways individuals make meaning of their subjective experiences and as a qualitative methodology is situated in a constructivist epistemology (Smith, Flowers & Larkin, 2009). In contrast to a post-postivistic epistemology which apprehends the world as objectively knowable, and cause and effect as reliably determinable, a constructivist-interpretivist epistemology is underscored by the notion that, "reality is constructed in the mind of the individual, rather than being an externally singular entity," and "assumes multiple, apprehendable and equally valid realities" (Smith, Flowers and Larkin, 2009, p 9). The aim of IPA is to get as close to the life world – or the meaning making and apprehension system - of the participants as possible, while acknowledging that this can only be done through one's own meaning making system as a researcher (Smith, Flowers and Larkin, 2009).

2.3.1 IPA and Phenomenology:

Phenomenology, as it is understood for the purposes of IPA, is discussed by Smith, Flowers & Larkin (2009, p. 19) in relation to the philosophy of Husserl and is based on the concept that, "experience should be examined in the way that it occurs and in its own terms." Phenomenological knowledge can be understood as that which aims to capture the essence of an experience from its psychological source - that of the 'experiencer'(Smith, Flowers, & Larkin, 2009). Langdridge (2012) underscores, however, that phenomenology in IPA isn't just concerned with cognition around experiences, but rather on interacting with the 'lifeworld' of the participant. This implies a more holistic approach to understanding individual experience than simply interpreting an individual's thoughts on what an experience meant to them (Langdridge, 2012).

2.3.2 IPA, Hermeneutics and the Double Hermeneutic:

The interpretive aspect of IPA is an acknowledgment of the hermeneutic aspect of interacting with individuals' experiences. **Hermeneutic** philosophy, stresses that all experience is filtered through interpretation before it becomes knowledge or understanding (Smith, Flowers, &

Larkin). In the case of IPA a 'double hermeneutic' is present - first the research participant offers a story of their experience, as filtered through their own interpretive mechanisms, and then the researcher must use their interpretive processes to elucidate themes central to that participant's experience (Smith, Flowers & Larkin, 2009).

Smith (2011), suggests that the interpretive involvement of the researcher interacting with the data through this 'double hermeneutic' is a key strength of IPA methodology. As Smith, Flowers & Larkin (2009) explain, researcher interpretation is inevitably present in all research. They argue that in making such researcher involvement explicit and navigating it in a self reflexive manner, as part of the IPA research process - in which one engages as a researcher in an active process of 'bracketing' or intentionally acknowledging and setting aside prior assumptions and weighing personal perceptions when interacting with the data – that any previous assumptions can be used to inform and elevate the research, instead of the researcher's assumptions invariably hiding in the research data without explicit clarification or awareness of their impact (Smith, Flowers, & Larkin, 2009). In this way, the 'double hermeneutic' and presence of the researcher's interpretation in IPA is not seen as compromising new meaning as it emerges through the participants, but rather as interacting with it to create "meaningful insights which exceed and subsume the explicit claims of the participants" (Smith, Flowers and Larkin, 2009, p.23).

While the aim of IPA research is of course to highlight and draw out *participant* meaning making, the 'double hermeneutic' emphasizes that researcher interpretation, as it must occur, can occur in a way that is additive to the participant narrative as opposed to subtractive, as researcher 'bias' in a positivistic sense could imply. The role of the researcher in IPA is, through their own interpretive mechanisms, which are invariably informed by their personal experiences, their awareness of the larger data set, and their awareness of psychological theory, to add meaningful

distillation to participant narratives and draw out latent ideas within and across the accounts of the participants (Smith, Flowers & Larkin, 2009).

2.3.3 IPA and Idiography

This leads to the third basis of IPA. IPA is **idiographic,** meaning that the focus of inquiry and analysis is that of an in-depth understanding of each participant's unique and authentic experience and how they make sense of that experience (Smith, Flowers & Larkin, 2009). The idiographic aim in IPA is for, "the unique story of each participant [to] come through as well as any overall themes" (Smith, Flowers, & Larkin, 2009). Overall themes as well as similarities and differences between participants are generated in IPA at the interpretive level during data analysis, and presented as part of the findings (Smith, Flowers, & Larkin, 2009). However, an important part of the idiographic basis of IPA is that these thematic analyses are not meant to obscure any one individual's accounts or meaning making. These are seen as of stand alone value in addition the value they hold in contributing to the overall data set (Smith, Flowers, & Larkin, 2009).

2.3.4 Summary of IPA in the Context of This Study:

IPA was determined to be the optimal methodology to investigate my research questions and interact with my participants and their accounts in a way most likely to generate rich, novel insight into the mechanisms of change that facilitate youth recovery from NSSI. IPA allowed me to conduct a research project that gave voice to my participant's meaning making around their lived experience of recovery from NSSI and highlighted the factors they deemed crucial to their recovery process. The idiographic nature of IPA allowed me to not only highlight key perspectives from each research participant that I interviewed, but also, through the 'double hermeneutic,' to use my own interpretative abilities to identify common themes of recovery across the participant group (Smith, Flowers & Larkin, 2009). It is these common themes, which

are thought to point to shared elements of what facilitates recovery, that may offer insight into how best to support youth struggling with NSSI (Smith, Flowers & Larkin, 2009).

2.4 Participant Criteria:

With the methodological framework through which this research was conducted, described and set in context of my research questions, I will now move on to a presentation of the core procedures and methods involved in both the inquiry and data analysis phases of this study.

2.4.1 Study Inclusion Criteria:

Participant inclusion criteria was established for this study in effort to collect a homogenous sample of participants who would be able to offer insight and understanding into some of what is currently not well understood in regards to mechanisms of recovery from youth NSSI. In order to collect such a sample, inclusion and exclusion criteria was established that reflected population qualities previously understudied, and that responded to some of the previously discussed ambiguities in regards to how NSSI and NSSI recovery is defined. In line with the aims of this study, which were to enhance understanding of recovery from persistent self-harm that is youth and NSSI construct specific, and to ensure the study remained minimal risk, the following inclusion and exclusion criteria was developed to guide participant selection:

a) Participants engaged in a minimum of 2 incidents of self-harming behaviors that were non-suicidal in intent (e.g., intentionally cut, hit, burned, banged, or otherwise injured themselves) over the course of their adolescence (between the age of 13-20)
b) At the time of recruitment, participants were no longer self-harming, identified as having 'recovered' from self-harm and had not engaged in any act(s) of self-harm for a period of at least two months
c) Participants believed they could speak to key aspects of what made their recovery possible
d) Participants were between the ages of 18-25
e) Participants did not report a current diagnosis of a mental health disorder
f) Participants had not had recent thoughts or plans of suicide, and were not currently abusing substances

g) Participants had considered the emotional impact of discussing their experience of recovery from self-harm and did not believe it would cause them more distress than they were comfortable with
h) Participants had not experienced a recent crisis that could render them more vulnerable to emotional distress
i) Participants were able to conduct the interview in English

2.4.2 Study Exclusion Criteria:

Participants were excluded from this study when they did not meet the aforementioned inclusion criteria. Formal exclusion criteria thus included experience with self-harm that did not reflect persistent self-harm (2 episodes or fewer), experience with self-harm that was intentional, but suicidal in intent or for which intent could not be specified, and incidence of self-harm or current age that did not map onto the above specifications. To ensure this study remained minimal risk, participants were excluded if they had any present mental health concerns that could potentially put them at a higher risk for relapse or distress, such as suicidality, concurrent substance abuse, or a reported mental health diagnosis. To ensure that what this study would capture was experience and understanding related to NSSI 'recovery,' participants were asked to identify as being in recovery (as in that this term accurately described their present state of well being as they understood themselves), as well as meet a 2 month cut off in terms of recency of NSSI episode or lapse. Therefore anyone who demonstrated behavioural cessation of NSSI, but did not identify as being in 'recovery,' anyone who's self-harm had been more recent than 2 months but who identified as recovered, or who identified as being in 'recovery,' but did not feel they had made sense of what contributed to that recovery, were excluded from this study.

2.4.3 Further Reflection on Study Criteria:

This study was designated and intended from the outset to be minimal risk, and for recovery to be the predominant frame through which participant's experience with self-harm was explored. Therefore efforts were made to include only participants who felt they could speak

about their self-harm from a place of wellbeing, and who were presently not in crisis, still actively self-harming, or for whom recovery did not make sense as a way to describe their present mental and physical state.

It would like to acknowledge and elaborate on my choice to include the criterion that participants must not have self-harmed for a minimum of 2 months prior to study participation, as this was a tenuous criterion. This criterion was established as a risk screening precaution, for participants to qualify for the study at a minimal risk designation. However, the '2 months' since last self-harm episode specification, as a minimal risk and 'recovery' designation, was in some ways arbitrary and bears further explication. My initial intent as a researcher, in an effort to allow participant meaning making to drive this study, was to allow for individuals to participate in this study upon their own definition and identification of recovery. I had initially planned to include participants who stated that they were not actively or presently self-harming, and who identified as recovered, but for whom 'lapses' throughout their recovery may have been recently present. For as I understood it, based on preceding literature discussion, NSSI recovery has the potential to look different for every person and does not always look like permanent or total cessation of NSSI behaviours (Hawton et al., 2015; Kool et al., 2009). A common theme from Wadman et al.'s (2016, p. 8) analysis was, that self-harmers felt that even if they were to reduce their self-harm behaviour in recovery, they believed, "they might never stop completely." With lapses and return to NSSI behaviour being potentially common in the recovery process, it seemed more important that participants be able to self-define recovery, in order to find out more about the meaning people made of their recovery, as opposed to restricting them to a set of recovery definitions that I prescribed.

However, in order to ensure that participants were not included in the study who could not reliably be deemed recovered or who were having lapses so frequently that their participation in the study could put them at increased risk for emotional distress and harm, the 'minimum of

two months since last self-harmed episode' cut-off was designated as a criteria for participating in this study. This cut-off was assigned in consultation with my external supervisor, Brianna Turner, an expert in the field of self-harm recovery research. This 2 months designation was deemed a reasonable and acceptable time frame to account for risk and variance in individuals' relationship with recovery and lapses. There is presently no theoretically supported or agreed upon, time based cut-off mark that delineates someone who is recovered from self-harm versus someone who is not. With this 2 month cut off however, I aimed to attain a balance of having a participant basis that was both minimum risk and homogenous in terms of potential recency of self-harm.

The choice to recruit from the age range (18-25) that I did and define youth as 13-20 was informed by reflecting on data on the typical age of onset for youth NSSI, and combining that with data on what is shown to be typical time-frames of recovery from youth NSSI. I considered a prevalence study by Whitlock et al. (2006), that randomly sampled 8300 college students from two large American universities, and found the age of onset for youth NSSI to be normally distributed - 25% reported beginning between 10-14 years of age, 27% between 15-16 and 38.6% between 17-24. Whilock et al.'s (2006) study also concluded that for individuals with a history of NSSI, without an NSSI incident in the past year and with no intention of continuing to self-harm, 79.8% reported stopping within 5 years of onset of their self-harm behaviour, and 40% within 1 year of onset. I thus chose a recruitment age range that, I believed based on this data, would capture individuals who could reliably be expected to have experienced recovery based on the typical age of onset of youth NSSI and average recovery periods. For if the mean age of onset for NSSI is found to be 15-16, with recovery 'normally' occurring within 5 years, this would put a typical age of recovery at around 20-21 years old. I accounted for greater variability and a few years post-recovery with my recruitment age range of 18-25. The choice to set my recruitment age range at 18-25 was also reflective of my intention to have thoughtful, meaningful conversations with my participants about their experience with NSSI and recovery. It was my

sense that in asking young adults about their experiences as youth that they would have been at point of 'recovery' for enough time to have made some meaning about their recovery, compared to a youth whose recovery was more recent, and who may not have yet engaged in reflective processes about their recovery experience.

2.5 Study Procedures:

2.5.1 Recruitment and Data Saturation:

Recruitment occurred over a 2-month period until data saturation was reached. For this study that saturation point occurred once 8 interviews were completed. Saturation for this study was assessed at the point at which no new themes emerged from the data set (Pietkiewicz & Smith, 2014). In order to arrive at an assessment of participant saturation, I was in the constant reflexive process of analyzing each interview as it occurred, and comparing and linking each subsequent interviewees story and themes to the others. Given that IPA is concerned with examining and interpreting, in detail, rich personal idiographic accounts of lived experience as opposed to creating a set of widely generalizeable theories, I approached data saturation with a 'quality over quantity' mentality (Smith, Flowers & Larkin, 2009). This means I deemed it more important, in accordance with IPA standards, especially Smith et al.'s (2009) recommendations for first time IPA researchers, to have small set of rich in-depth interviews with which I could conduct a series of thorough, detailed analyses, as opposed to having many interviews simply for the sake of potentially increasing the generalizability of my thematic conclusions.

2.5.2 Summary of Recruitment:

Of the 8 interviews conducted, only 6 were retained for analysis. Of the two interviews discarded, one was not retained on the basis that the participant did not actually meet the study criteria, and had self-harmed only once and then spontaneously recovered. The second interview

that was discarded was done so on the basis that that participant was not able to speak to what she felt helped her recover. She stated that she did not know and was not able to answer the interview questions with a degree of detail that would have allowed me to enter into her world perspective and make meaning of the information she offered.

2.5.3 Recruitment Procedure:

Recruitment for this project occurred through three key sources. It was my intention for this research to include a mixed community sample and be comprised of participants with varied life experiences and backgrounds, yet who still had the shared experience of having struggled with and recovered from youth self-harm. I recruited via posters on bulletins at SFU Surrey Campus (academic source), via UBC Counselling services where I was doing my MA counselling practicum (clinical source) and through online postings via craigslist in their 'gigs' section in order to access community based participants who might not have come into contact with the aforementioned academic and clinical services.

Purposive sampling was conducted via two levels of screening to ensure participants met the inclusion and exclusion criteria for the study, were not at risk, and were able to speak to what they believed were critical aspects of their recovery process. The inclusion criteria were explicitly stated on the recruitment material (flyers and online advertisements). Once participants contacted me via email to express interest in participating in the study, they were then screened over the phone to allow for clarification about the study and to complete additional screening for risk. Participants were made aware before the phone screening that notes would be taken, and that the in-person interview was going to be recorded and transcribed. Thus participants were fully informed about what they were consenting to before they proceeded. Participants were informed they could withdraw from the study at any point without penalty, and signed informed consent documents at the start of the in-person interview. One interview was conducted via skype and this

individual was emailed a consent form prior to the interview and signed and scanned it back to me.

2.5.4. Risk Management Protocol:

This study was deemed minimal risk by SFU's ORE Board Committee based on its inclusion and exclusion criteria as well as the study's intent. It should be acknowledged however, that due to the sensitive, potentially emotionally difficult nature of the study's subject matter, that risk could have occurred or increased in unforeseen ways during the study process. As such efforts were put in place to mitigate and manage risk and harm to participants that might occur from participating in this study, while respecting the potential dual role conflict of the interviewer as researcher vs. counsellor. As part of informed consent, participants were made aware that they would be asked questions about their experience with both self-harm and recovery, and encouraged to think about their readiness to discuss such material and how it might impact them. Participants who felt it might upset them more than they would know how to manage on their own were not included in the study. Efforts were made to include only mentally healthy individuals who felt they were prepared to discuss their NSSI experience, and to give them as much information about the study experience beforehand so that they could make an informed decision about this readiness.

Participants were also informed that this was a research interview and not a counselling one so that expectations about the intent and process of their experience discussing self-harm could be managed upfront. These efforts to mitigate risk were followed up with two additional efforts to manage unforeseen risks. Participants were made aware that they could stop the interview at any point, and were provided both emergency crisis contact numbers and non-emergency community counselling numbers at the pre-screening and interview informed consent stage (See Appendix C). It was made clear that mental health support would be available to them

at any point during and after the study if their participation in the study triggered high levels of distress. No participant asked to receive additional mental health support during or after participating in this study.

2.5.5 Semi-Structured Interview Schedule:

I designed my semi-structured interview schedule in accordance with IPA guidelines from Smith, Flowers and Larkin (2009). In its final form, this interview schedule consisted of 9 open-ended questions (See Appendix D), written in the spirit of being "exploratory not explanatory," and framed in way so as to elicit participants' insights, meaning making and understanding both of their self-harm experience and their recovery process (Smith, Flowers, & Larkin, 2009).

The first two questions asked participants to share their story of self-harm, and then proceeding questions centered on key aspects of the recovery process and their understanding and meaning making around those recovery elements.

I prefaced each interview by telling participants that there were no right or wrong answers, and for them to answer the questions however it made sense to them to do so. In the spirit of privileging participant meaning making and agency, at the end of each interview I also asked participants if there was anything about their story that they wanted me to know that they hadn't yet shared and what the interview was like for them.

The interviews, ranged between 50 to 80 minutes, were audio recorded, and then the audio files were uploaded to my SFU vault account prior to transcription. Original audio files were destroyed when transcription and data analysis was complete. The only participant identifying documents used in this study were the consent forms, and these were stored at my senior supervisor's office in a locked cabinet for the duration of the study. Participant

confidentiality was maintained through each phase of the research process by using only their initials and pseudonyms as reference.

2.5.6 Data Analysis Procedures:

Data analysis followed the iterative and inductive cycle described by Smith, Flowers & Larkin (2009). In accordance with their IPA guidelines, I began by re-reading each transcript as an individual, idiographic entity in it's own terms, while looking for themes within that participant's account. I relied on participants' use of metaphor, repeated phrases or meanings, the participants process (pauses, stuttering, having difficulty saying certain things) as well as information about values, relationships, and ideas that participants explicitly stated were of high importance to them, in order to arrive at the thematic analysis for each individual's story.

Once I had gone over each participant's transcript with sufficient repetition and consideration, to have extracted and recorded what seemed to be the core messages and themes most central to that individual's understanding of their experience, the themes that emerged from each interview were then held up against each other comparatively. It was through this procedure that I was able to translate six sets of participant themes, into a set of coherent overarching Master themes, using the super-ordinate themes from each participant account. The super-ordinate themes were those that emerged consistently through each narrative, which when compared collectively formed an overarching narrative for the group as a whole (Smith, Flowers & Larkin, 2009).

While both the idiographic themes and the overarching themes were of critical importance to my thematic discussion, as well as interdependent, with the overarching themes not being possible without the super-ordinate ones, it is the themes that reappear across accounts, or the Master themes, and the nuances surrounding them, that have the ability to offer insight, with the potential for some generalizability, into my original research question of what facilitates

recovery from youth NSSI (Smith, Flowers & Larkin, 2009). It is thus the Master themes that are used to organize the findings and discussion section in this thesis.

2.6 Thoughts on Validity and Reliability:

While guidelines delineating IPA analysis protocol exist, with strategies for organizing themes from the data recommended by Smith, Flowers & Larkin (2009 p. 80), these creators of IPA also purport that, "there is no clear right or wrong way of conducting this sort of analysis," and they, "encourage IPA researchers to be innovative in the ways they apply" the research protocol. The essence of IPA is that it is meant to be interactive, and allow for researchers to engage with their participant accounts in a way that stimulates new meaning making and ultimately produce an account of findings that is a dialogue between the meaning offered by participants as it interacts with the researcher's perceptions, lived experiences and academic or theoretical knowledge (Smith, Flowers & Larkin, 2009). The flexibility of such an approach could call into question whether 'validity and reliability' can be found in regards to data generated by IPA as well as if any generalizability is possible from the results obtained.

However, in IPA validity is not assessed by whether or not the analysis is 'true' objectively, as truth is considered something that is arrived at constructively, and which is in a constant state of emergence and co-creation (Smith, Flowers & Larkin, 2009). In IPA, validity is arrived at when a thematic analysis is generated that reliably captures the core emergent and latent understandings in a participant's narrative, in way that matches with what a participant themselves understood and intended to communicate (Creswell, 2007; Smith, Flowers, & Larkin, 2009). Smith, Flowers & Larkin acknowledge (2009, p.80) that, "although the primary concern in IPA is the lived experience of the participant and the meaning which the participant makes of that lived experience, the end result is always an account of what the analyst thinks the participant is thinking."

Todres & Galvin (2006) as well as Cohen & Crabtree (2006) discuss validity in regards to IPA with the explanation that 'trustworthiness' is a better term to use to describe the concept of validity (truthfulness or representativeness) in IPA - validity being a term more consistent with positivistic research approaches where objective truth is considered possible. Todres & Galvin (2006, p. 80) further explain that truthfulness and accuracy of a thematic analysis in IPA is not about perfect correctness of correspondence between a researchers interpretations and a participant's understanding, and that IPA is more concerned with whether an analysis, "carries forward the general structure in plausible and insightful ways," and, "deepens the reader's empathic imagination and enlivens the phenomenon." Thus, as Smith, Flowers & Larkin (2009) acknowledge, the truth claims of IPA are tentative and analysis is subjective. This however is not to say that truth claims that come from a subjective constructivist framework are not useful. Given that such themes or claims reflect an intentionally acknowledged researcher paradigm, paired with insight generated from an open inquiry into a participant's meaning making system, IPA's thematic claims are considered to represent a close, authentic understanding of a phenomenon, that may ring true for others with similar lived experiences (Smith, Flowers, & Larkin, 2009).

2.7 Trustworthiness:

Validity, better understood as 'trustworthiness' in the context of IPA, is thus arrived at when a researcher has sought supervision about the themes they believe to be emerging in their analysis, has original textual support for any conclusions drawn and has gone over the data multiple times to ensure nothing has been missed. In accordance with this framework, I have been in active conversation with both my Senior and External Supervisor at each step of the research process. Trustworthiness in IPA is further achieved by engaging in a rigorous and systematic process of self-reflection on one's own perceptions that may be related to the research topic and process, as well as by making intentional efforts to 'bracket' or set aside pre-conceptions when

interacting with participant data (Smith, Flowers & Larkin, 2009). In such a spirit, I present the relevant aspects of my perspective and experience as a researcher in the proceeding section.

2.8 Participant Checks:

Participant checks, while not unique or specific to IPA and rather derived from attempts to ensure validity or trustworthiness when employing phenomenological approaches more broadly, are an encouraged although non-required adjunct to IPA trustworthiness measures (Creswell, 2007; Pietkiewicz & Smith, 2014). Participant checks allow for researchers to corroborate the validity or trustworthiness of their themes and ensure the meaning made by the researcher matches the meaning that was intended to be conveyed by participants (Cohen & Crabtree, 2006). A participant check is conducted by showing participants their data analysis prior to the results write up. Participants are then given the opportunity to reflect on the understanding and themes generated by the researcher, and are asked to provide feedback on the degree to which the researcher's analysis matches the participant's understanding and intentions (Pietkiewicz & Smith, 2014).

I engaged in participant checks with my participants as part of collaboratively ensuring the meaning making I generated through data analysis matched my participants understanding of their experience. Participants were given the opportunity to consent to the participant check at the end of the research interview, at which point all consented and provided their follow-up contact information. Of the 6 participants contacted for the participant check, 5 responded and were provided a copy of their transcript and thematic analysis charts for review. All respondents indicated support for the themes generated and said they captured well the essence of their experience and the meaning they had intended to convey in the interview. Many participants reported that engaging in the participant check had helped distill their understanding of their narrative, and given them language through which to better organize their experience.

In regards to the feedback generated by my participant checks, Ellie shared,

> I feel that you captured my experience incredibly accurately. I don't think I could have organized the themes better myself - it really feels like you understood my narrative. I tried very hard to find something that didn't fit my experience, but it all seems very congruent and like you really got the meaning of what I was communicating. The underlying themes ring true to me and I even feel like I've learned more about myself.

Kalvin shared,

> you used the things that I said to really explain things about me/self harm in a better way than I could have explained it myself…It felt like I was learning about myself, and I really do not see any untrue statements.

Jane offered an overview of the themes and her assessment of them:

> I've read through the analysis and I think the key themes are quite accurate. Here are my thoughts. In the first section of initiation and maintenance of self-harm, disconnect/disassociation, shame, and power/control were definitely the major factors. I think the invalidation led to shame and I tried to obtain a sense of control by using my physical body to regulate my emotions.
>
> In the second section, as you accurately recognized, connection, acceptance and compassion were significant, on both interpersonal and personal levels. I describe my healing process as "coming back home."
>
> I appreciate the acknowledgement other themes of trauma, recovery as overall healing, etc. as I think they too, are very important. Overall, I agree with your analysis of overarching themes.

In addition to support generated for the themes presented, I had participants disclose that they actively tried to look for contradictory or incongruent claims made by myself and as far as they were concerned didn't find any notable ones. My fourth participant, Fleur, helpfully made a correction to one section of my analysis, which I used to inform and correct my interpretation of that piece of data. She then shared, "I found the rest of the analysis to be accurate and the themes match well with my personal experience given what I conveyed in the interview."

The participant checks also played an important role in showcasing how participants had been impacted by the research experience. It was iterated by many that participating in the study had been a positive and insight generating experience, and for many had increased their motivation to maintain their recovery.

2.9 Perspective of the Researcher:

In the spirit of reflexivity, transparency and the 'double hermeneutic' of interpretation in IPA, where I inevitably am a co-creator of the data and findings, I must acknowledge where I am coming from as a counsellor and researcher. This section will also be well served by a disclosure of some of my own lived experience that has shaped me in ways I unavoidably bring to this research.

My counselling training has changed and shaped the way I see the world and interact with other people. The way I understand human development and functioning is underscored largely by trauma informed practice. A trauma informed paradigm posits centrally that life experiences impact and shape individuals' ways of being in the world, especially how they respond to stress, as well as their identity formation, coping strategies and sense of self (Harris & Fallot, 2001). It did not surprise me that every participant interviewed for this study, without being prompted to, disclosed past trauma as part of their self-harm narrative.

I bring with me as a researcher, the perspective that humans are resilient, capable, adaptive beings, who are the experts on their own lives and stories. I also believe that in response to unacceptable realities humans learn to behave in ways that may look dysfunctional from the outside, or that are potentially pose real tangible harm to themselves and others, but that on a functional level actually reflect an adaptive part of their coping system. I say this not to endorse or support self-harming behaviour, but to emphasize that I come from the perspective that when we try to understand the function of a 'problematic' behaviour, instead of judging, fearing or trying to eliminate it as a first reaction, compassion ensues and healing is possible.

My personal relationship to knowledge and truth is a constructivistic one. I work with clients in my counselling work to help them create meaning and cultivate personal identities that at times involves transforming very difficult and painful experiences into strength, resilience and hope. These values and paradigms in many ways guided this work, including the topic and methodology I chose and the questions I asked. My aforementioned perspectives, values and paradigms were echoed and strengthened by the narrative accounts of recovery from self-harm that I had the privilege of being able to work with. I witnessed strength and resilience in my participants' experiences and stories; stories that affirmed the value of doing this work and that gave voice to the lived experience of 'non-experts' that unsurprisingly offered critical insights into what is takes to recover from youth NSSI.

It is important for me to disclose another aspect of myself that I bring to this research. I was drawn to this research in part, because I myself struggled with and used self-harm as a coping tool in my adolescence. My experience admittedly shapes some of the ways I conceive of and understand self-harm and recovery. This personal experience was one of my greatest sources of motivation for doing this research. However, my background could also understandably be seen as predisposing me to a certain paradigm, or cognitive set, through which I might understand NSSI and recovery – that being one shaped by my own experience and meaning making systems.

This could be called bias by some, likely more positivistic, standards. IPA philosophy however, would not endorse the idea that my personal experience with NSSI and recovery would hinder my ability as a researcher to produce meaningful and trustworthy analyses of this study's data (Smith, Flowers & Larkin, 2009). For IPA explicitly asks researchers to acknowledge the ways in which they interact with the data, especially as a co-creator of meaning, and sees this as a strength of the researcher-data interaction (Smith, Flowers & Larkin, 2009).

I believe, and understanding it to be supported by my research methodology, that my personal experience and first hand understanding of self-harm can add another level of expertise to this project – a level that I believe allowed me to connect deeply and empathically to the meaning my participants brought forward and to form a basis of shared understanding with them through the findings generated. I heard stories that were nothing like mine, and some that had echoes of my own experience. The meaning I have made around my own process of stopping NSSI was different than many of my participants at face value, however resonated at a closer examination with many of the Master Themes from this study that emerged during data analysis.

I choose to disclose my personal relationship with self-harm for two reasons. Firstly, because in explicitly acknowledging this part of my lived experience, I can intentionally 'bracket' it, knowing the potential it may have to influence my interpretations, and thus work *with it* instead of having it subversively influence my conclusions (Smith, Flowers & Larkin, 2009). I believe if anything this should enhance the trustworthiness of my work as opposed to limiting it. For I know where my 'biases' or pre-conceptions exists, what they are and I have made efforts to set them aside and approach my participant accounts afresh with openness and curiosity. That being said, I believe my experience could be seen as enhancing my capacity as a researcher to connect to the data, as I have lived and embodied basis for understanding my research subjects and their meaning making systems. This may allow for what Todres (2004, p. 43) calls 'embodied interpretation' which highlights the lived body's role in understanding meanings and for weighing

what is thematically a 'fit' as a researcher – the point at which the "logic and details of the text" as well "what it feels like to understand" another meet, and insight occurs.

The second reason I chose to disclose my personal self-harm background is to match in process the content of what was deemed to be one of the critical factors in recovery from NSSI – being able to talk about self-harm. Self-harm was echoed across my participant basis as being difficult or unacceptable to talk about. Yet conversations about self-harm in the context of an experience of supportive human connection is one of the things deemed critical for the self-harm recovery process. Thus conversations about self-harm are the ones that need to be had if we are to support, as mental health practitioners, a de-stigmatizing, non-judgmental, open approach to self-harm and healing. I would like, in kind, to support in content, the practice that self-harm is something that is ok to be talked about.

2.10 Participants:

Participant Pseudonym	Age	Period of Self-Harm	Last episode of Self Harm
Sarah	22	2.5 years, age 18-20.5	1.5 years ago
Kalvin	20	1 year, age 14-15	5 years ago
Ellie	23	7 years, age 15-22	1 year ago
Fleur	19	1 year, age 17-18	1 year ago
Sydney	19	1 year, age 15-16	3 years ago
Jane	22	5 years, age 14-19	3 years ago

The six participants whose stories, ideas and meaning became part of this thesis came to this study from a variety of stages in life and recruitment avenues. Four of them came to the study by responding to my craigslist advertisement, one of them saw my flyer at UBC Counselling Services and one of them my flyer on SFU Surrey Campus Bulletins. The participants ranged in age from 19 to 23 years old. Five were female and one was male. Three of my participants identified as Caucasian, one as Mexican/German, one as Korean and one as Indian. Some of them had attended university, others had not. Four of the six participants had received formal counselling, with varied responses as to whether or not it was helpful in their NSSI recovery process, and two participants had never received counselling. It was my intention to conduct this research with individuals with varied life experiences, from different backgrounds with varied levels of experience discussing mental health concerns, and who may or may not have received counselling as part of their recovery process, in order to capture potentially varied narratives of and factors supporting recovery.

2.11 Chapter Conclusion:

During data analysis, Master Themes emerged that allowed each participant's narrative to become part of a larger, collective narrative. The themes in this collective narrative can be understood as potentially speaking to key factors, mechanisms or processes involved in the experience of recovery from self-harm as a phenomenon. These shared processes may point to understanding about recovery that resonates with youth who also have lived experience with self-harm in a way that could be used to support them in recovery (Wadman et al., 2016). While this study will not posit claims to causation or definitively generalizable 'truths' and intends to elevate individual participant meaning making as much as it discusses the Master Themes that emerged, what it will do is demonstrate that our participants and clients have answers to the question of what facilitates recovery from youth NSSI (Smith, Flowers & Larkin, 2009). These answers, as I understood them, are presented in the following section.

Chapter 3: Themes and Findings - What Facilitates Healing From Youth NSSI?

3.1 A Word on the Chapter:

I have approached this chapter much like I would a counselling session - by listening to what my participants said, honing in on what they deemed important and significant, and using that to guide how I respond, or in this case, write the chapter. In this way, it was my intention for this chapter to match in process and design, the content of the Master Themes of Recovery that my participants spoke to. One of the key themes that emerged consistently throughout my participant's narratives of healing was that *understanding from an attuned other* was an important part of their recovery from NSSI. Experiencing that another understood either their self-harm or their life struggles that surrounded it, as opposed to feeling judged, questioned or challenged was indicated in the majority of participant reports as a key factor that facilitated increased levels of self-acceptance, emotional tolerance, and a corresponding reduction in NSSI behaviour.

With this idea that *understanding facilitates healing* in mind, I was motivated to spend some time, before I directly explore the themes of self-harm recovery that emerged from this study, exploring participants' understandings about their experience with self-harm itself. The messages that resounded across my participant basis were, 'we do this for a reason', 'self-harm works,' and having that be understood by others, especially those in a helping position played a significant role in increasing participants' well-being and likelihood of NSSI cessation. I hope to give readers an opportunity for that first hand understanding that was so central to many of my participants' recovery experience, in hopes that this text can further or facilitate that same understanding which seemed to produce real life healing from NSSI.

3.2 Understanding NSSI: Emergent Themes

3.2.1 Narratives of Trauma:

I will start where they started. None of the questions in my interview schedule explicitly asked participants to discuss trauma as it related to self-harm. Yet, each of the six participants who participated in this study reported, within the first *minute* of their interview, having experienced aversive life events, developmentally or leading up to the initiation of their experience with self-harm, that they themselves either named as traumatic or would otherwise map, based on their description, onto a definition of trauma.

This was not something I went looking for despite being aware that correlations have been found between trauma and self-harm in previous NSSI studies, as it would not have been in the spirit of IPA for me to frame my study questions around existing theory explicitly (Smith et al., 2013; Smith, Flowers & Larkin, 2009). However, given that the theme of *trauma preceding NSSI* emerged consistently in each report, organically, and was a shared way in which participant's made meaning of their NSSI experience, it warrants attending to as an important part of how NSSI can be best understood and approached (Smith, Flowers & Larkin, 2009).

Psychological trauma is defined by Trauma Informed Practice (TIP) guidelines, "as experiences that overwhelm an individual's capacity to cope" (Haskell, 2003). "Trauma early in life, including child abuse, neglect, witnessing violence and disrupted attachment, as well as later traumatic experiences such as violence, accidents, natural disaster, war, sudden unexpected loss and other life events that are out of one's control" can produce a state of dysregulated coping in their aftermath, and require particular considerations on the part of mental health professionals when working with such effected clients (Haskell, 2003; TIP, 2013). The participants in this study all framed their NSSI experience with reference to an event that they themselves explicitly identified as traumatic or that would map on to the above definition of trauma.

My first participant, Sarah, reported that her self-harm began during an emotionally and at times physically threatening relationship, in which she was repeatedly shamed, belittled and controlled. In her words, "my ex-boyfriend would be like if you don't do this there is no other way out…he would always say, 'you don't know stuff'… I like I lost my own self-respect, I thought I was just not worth anything I guess." Sarah explained that she felt trapped, hopeless and at odds with herself as a result of this experience and that this directly related to reliance on self-harm as a way to cope, communicate her pain, and attempt to attract attention or supportive reactions from her partner.

Participant 2, Kalvin, stated in his first sentence that his dad died when he was almost 13. From his sense of things he wasn't sure if his father's death was related to his self-harm, however he in process still chose to share the fact of his father's death with me when contemplating the meaning of his self-harm, as well as questioned throughout the interview what it would have been like not to have had this loss at such a young age.

Participant 3, Ellie, reported various experiences of what could be considered developmental trauma, such as being pinched by her father when she was in physical or emotional pain to distract her from her pain – in essence being taught that expressions of pain were undesirable and should be mitigated and controlled through physical and self-directed means. She also reported, "a number of trauma incidents that happened throughout college, like various sexual assaults" that coincided with a return or spike of NSSI after a period of having stopped self-harming for a time. She expressed that, "self-punishing was like, my first reaction, was yeah to assume that it was my fault and the school wasn't exactly saying differently."

My 4th participant, Fleur, also made the connection in her narrative between trauma and her NSSI. In her words, "when I was younger I went through some trauma, I guess that's just how I coped (self-harm) but I never realized it and no one ever picked up on it." This is an example of

a participant making an explicit connection between trauma and self-harm, and stating that she believed NSSI was functionally how she coped with impacts of previous trauma. She also explained that,

> Where we grew up we kind of lived in an environment of like it seems like any sort of negative emotion was like not allowed… It was never like a hey, you know, if you're upset it's ok to angry or annoyed, it was always immediately like no you can't do that, no that's bad.

As Fleur understood it, this environment impacted her psychological functioning, by causing her to take her negative emotions out on herself through NSSI – as NSSI was at times less visible and thus more acceptable way of dealing with her inner pain than an outward verbal or emotional reaction. In this way, NSSI can be understood through Fleur's narrative, as a response to emotionally dismissive and intolerant interactions with her family members.

Sydney, my 5th participant, reported that in her understanding, her experience of NSSI occurred in the context of a depression that was initiated by repeated bullying in her early years at school as well as learning of and watching her younger sister deteriorate from the genetic disorder Batten's Disease. Sydney reported that in response to the above experiences, her self-esteem was highly compromised, and her reaction to her sister's illness was that she was more deserving of the illness, should have been the one that got sick, and was deserving of punishment through self-harm. In her words, "I was watching my sister, like this disease take a lot of the life out of her and umm I just felt guilty that it was her and not me."

The study's 6th and final participant, Jane, clearly articulated that her experience with self-harm was one underscored by trauma reactions. Jane reported on how she became depressed after a previous friend died by suicide, a death for which she felt guilty and responsible. In her words,

> When I was 15 years old a really close friend died by suicide and there was also just a lot of other baggage because we fought and then I sent him a hate message…that was a really traumatic thing for anyone to go through at that age.

She also explained that she, "suffered complex PTSD from emotional manipulation growing up from my parents…but it was really intergenerational trauma" and stated that this was not an un-common phenomenon, from her sense of things, in Korean immigrant families. To Jane, the connection between trauma, shame and self-harm was causal and clear in her mind - "I was just shamed a lot growing up…the shame went to the numbness, which led to the self-harm."

In each interview obtained for this study, my participants reported not only on an early loss or developmentally disruptive experience, but they also reported on how these experiences impacted the way they saw themselves or functioned. If I am to make sense of the fact that each participant, in a self-initiated fashion, made meaning of their NSSI experience by framing it through their trauma experiences, as well as if I am to acknowledge that disclosures of trauma were one of the first thing each participant offered when discussing their NSSI history, it would seem reasonable to conclude that trauma was an important framework through which participants in this study understood their NSSI behaviour. Furthermore, in these narratives, the disclosed traumas preceded the reported NSSI behaviour, temporally, and some participants, particularly Jane, Sydney and Ellie, explicitly named that NSSI was their way of dealing with, mitigating or chanelling their trauma reactions. This suggests these participants' understood their NSSI, at least in part, as a "response" to trauma. Seeing or framing NSSI as a contextual, understandable response to a psychologically and emotionally challenging event or experience is in itself an act of understanding, compassion and of non-blaming.

This understanding motions to a paradigm which reflects the principles that inform the basis of the approach that is trauma-informed practice - in which self-harm would be examined

for the function it served for an individual, and would be seen an understandable coping mechanism to be approached with non-blame and compassionate understanding (TIP, 2013). The importance of approaching NSSI from a trauma informed paradigm and understanding NSSI for the functional, understandable means of coping that it is for many who employ it, will be further explicated in the context of the theme of Healing from Shame (through understanding and compassion) which emerged as a Master Theme of recovery from NSSI in this study.

3.2.2 NSSI Works and that Matters:

If we take the idea that trauma was a contextually important part of how participants in this study understood their NSSI experience, the subtext of this being that on some level, these participants made sense of their NSSI as a 'response' or 'reaction' – whether to the trauma itself, or to emotional dysregulation or self-concept pain that resulted from it - this leads well into another theme that emerged throughout the participants' stories - NSSI 'works.' What emerged over and over again from my participant's accounts was that NSSI helped these 6 individuals in some way, it served a function, and had a purpose. This is what made NSSI something that they returned to repeatedly, with cessation seeming like a less than possible, realistic, or at times desirable option. Self-harm functions that were named included, to communicate pain, to provide relief from intense overwhelming emotions, to generate emotions when in a state of numbness or dissociation, to organize emotional experiences, to access or make concrete intangible, burdensome emotional or cognitive pain, and to self-punish and self-control. Narrative excerpts that reflect participants' understanding of self-harm as functional and purposeful, which allow us to understand self-harm as they understand it, will now be explored, followed by an exploration of the meaning they made around the specific functions of NSSI.

Kalvin reported on how self-injuring relieved his feeling of emptiness to such a degree that the functional or positive effects of the harm were those which stood out to him at the time he

was self-harming, more so than any negative consequences. In his words, "You don't think like about the harm that you do to yourself…you don't think about the bad, you just think about what you get out of it." In this way NSSI was a means to an end, with the end of relief being more important than the means. As I understood it, from Kalvin's experience, harm was almost detached or absent in an evaluation of the actual experience of cutting for him pre-recovery, with the functional benefits of NSSI being what stood out to him the most in his evaluation of his relationship with it. Kalvin also echoed that repetition of his self-harming behaviour was made possible by the 'positive' or 'effective' aspects of self-harm superceding other aspects it. He stated, "I would feel like I was getting something out of it you know, I would feel I want to do more." Sarah also reported similarly on the functional aspect of NSSI precipitating her urges and repeated engagement with self-harm when she remembered, "Ok this works, so we are going to continue to do this thing."

Ellie echoed these ideas about the functional aspect of NSSI being an important way it was understood and experienced, in the meaning she made of what made her keep going back to self-injury, even when she wanted to stop. As I understood it, self-harm worked incredibly well as an emotional regulation tool for Ellie. Her episodes of self-injury provided a break from emotional pain and provided a way for her to organize the chaos and overwhelm she felt she did not know how to deal on a mental level at the time, into a clearly defined physical experience of pain. She also recounted that by substituting physical pain, the aftermath of which she could clean-up and move on from directly and materially, NSSI would allow her to reset emotionally and get on with other things that were important to her. What stood out for E.P was not only that it worked, but that self-harm was the single most effective coping tool she'd ever encountered for emotional regulation. In her words,

> It seemed like just such an amazing strategy for me at that time, it had built up such a quality that nothing else worked as well…it just seemed like why would I give up the thing that works the best.

The integration of an 'NSSI is functional' paradigm into the way I understood youth self-harm, was one of the biggest takeaways I had from engaging with my participant's understanding of their relationship with self-harm pre-recovery. Understanding and explaining that NSSI is functional and useful to them was something my participants did through the course of their accounts. For me to know this seemed important to them. Implications for the importance of this *NSSI is functional* paradigm will become further clarified in the proceeding discussion as a non-shaming, client supportive stance, like this paradigm embodies, was one that was repeated named as facilitating recovery from youth NSSI.

3.2.3 Linking Trauma, NSSI and the Functional Paradigm:

The theme that 'NSSI works' and works well parallels conclusions drawn from studies on the relationship between NSSI and trauma – those conclusions being that self-harm is frequently experienced as an effective and immediately accessible coping mechanism by those who use it, especially to deal with the cognitive, emotional and behavioral manifestations that occur in the aftermath of trauma (Smith et al., 2013). Smith et al. (2013), in their report on the relationship between NSSI and trauma, refer to Connor's (1996) seminal work on the functional aspects of NSSI following adverse childhood experiences such as abuse, neglect, loss and abandonment. Connors (1996, p.199) concluded that self-injury is a, "fundamentally adaptive and life-preserving coping mechanism…that enables people struggling with overwhelming and often undifferentiated affect, intense psychological arousal, intrusive memories and dissociative states to regulate their experiences and stay alive." From this frame of reference, NSSI is documented to be a useful, adaptive coping mechanism and as Connors suggests, highly necessary for those struggling in the aftermath of trauma. NSSI allows individuals to regulate vital emotional and

cognitive processes required for basic human survival and functioning – needs for control, homeostasis and certainty that if not met in healthier ways, can be met through self-harm. This is important to understand as without alternative means to have such needs met, participants may not feel functional or be able to self-manage. In recovery from NSSI, finding alternative ways to meet the needs self-harm is meeting, thus becomes an important consideration, as was echoed by my participants and which will be elaborated on in subsequent sections (Connors, 1996; Smith et al., 2013).

The specific NSSI functions named by my participants, in terms of the needs that their self-harm met are now discussed. The intention of this discussion is to further enrich our understanding not only of what needs might require alternative provision for in the course of NSSI cessation and recovery, but also to give a basis to empathize with the 'NSSI is functional' paradigm that was identified by my participants as an important part of their healing experience.

3.2.4 NSSI and Meeting Needs of Support from Important Others:

As humans we are social beings who require connectivity, support and bonding to others in order to regulate our emotions and feel a sense of purpose and identity in the world. Support and connection comprise some of our basic needs - attachment needs being met forming the basis of our emotional regulation system as children and impacting how we interact and relate to the world around us as adults (Cassidy & Shaver, 1999). These needs do not disappear in the absence of such external supports. Typically when supportive others are not at the ready either physically and emotionally, we adapt to have our needs for support met in other ways (TIP, 2013).

NSSI was understood by many of the participants in this study as being a way to have the need for support and validation by important others met, in the absence of other reliable, or effective means to do so.

Sarah remarked that self-harm became what felt like a last resort that worked when her boyfriend would not listen to her or consider her needs. She explained,

> the argument doesn't work, and then your crying doesn't work and then you don't eat food and that doesn't work and then you come to this extreme…and then at this point I was like OK this (self-harm) works.

She went onto explain that, "if I self-harm and he tries to stop me he probably really cares for me you know." Sarah understood her act of self-harm presented an opportunity for a key attachment other to demonstrate care in a fashion that she initiated and had control over, in the absence of him willingly demonstrating such care otherwise. She reported this was also successful when a threat of abandonment or loss of physical closeness was at hand stating,

> I tried to like cut myself and he said like ok I won't go now, so that was like he would always submit to me if I do any of these things because he doesn't want me to do it anymore.

Ellie reported a similar experience in terms of self-harm allowing her to meet needs for support from a boyfriend stating,

> I might've been trying to show my boyfriend at the time I was in pain…I remember a few times when I was with my boyfriend at the time where I would be very distressed, and I would like reach for scissors…and so I think like showing him..he was causing me pain and I perhaps liked because he would ignore me a lot and that was very painful and he would have to stop ignoring me if I was about to hurt myself.

Fleur echoed this experience in terms of communicating her pain and drawing in others through self-harm. She explained that self-harm allowed her to communicate the intensity of her internal pain in a ways that was harder to ignore and more reliably apprehended by the outside world. In her words,

> it was definitely more of an obvious way of like showing that I was in pain and that I needed help you know…a lot of girls I knew did it for the attention…you know the attention from older males, I mean my dad specifically.

Many of the participants remarked on how their self-harm brought concern and support from important others like family and friends, who they perhaps were unable to ask for help in a more direct fashion. This seemed especially true in cases like Sarah, Jane and Fleur's when asking for help, or sharing pain or emotions was met with dismissal, rejection or ridicule. I came to understand, through my interaction with my participants meaning making around these disclosures, that self-harm was a functional behaviour for them in that it allowed them to meet an important basic need – that of being cared for and supported by others.

3.2.5 NSSI and Meeting Needs for Power, Control and Agency:

Another common theme that emerged in my participant's narratives was that NSSI gave them a sense of power and control, both over themselves and others, during periods when they otherwise felt empty, powerless to their distress and unable to exert any influence or control over important aspects of their external world.

Sarah reported that self-harm allowed her to gain a sense of control over a manipulative and controlling partner in an indirect, but effective way – power and control she was not afforded otherwise being a woman, who was smaller and less powerful than her boyfriend. She explained her self-harm was, "more about having the power in the relationship…I would say like I can't beat that person up, I have argued but that doesn't work." In the way that Sarah understood it, her self-harm allowed her body to become a weapon, or a tool, that indirectly gave her access to agency over her needs and ensured that she was taken seriously - "I would harm myself and show it to him…like so now you have to do things according to me kind of thing." As I understood it, self-harm gave Sarah a sense of agency in a relationship that she otherwise felt powerless in, and

in this way her turning against certain body parts through self-injury allowed her whole person to have higher order needs of met in terms of psychological certainty and effective agency.

The meaning Sydney made about how NSSI allowed her to meet needs for power and control came down to the idea that when she lacked control over one of the most important relationships in her life – her relationship with her terminally ill younger sister - that if nothing more she could control her body and the sensations it felt. She explained,

> I felt really frustrated and there was like nothing I could really do about it…it (sister's terminal illness) made me feel really useless and powerless and I think also a lot of the like, I think not only self-harming, but the ways that I sabotaged my own life were like things that made me feel like that I had that kind of power and that I could control something.

Jane's experience of self-harming with fire embodied the theme of power in both form and meaning. She shared,

> I was just obsessed with the flame and I would just like stick my hand and my forearm around really close to the candle...like wanting the power of the flame, to feel something…I felt so powerless at the time and the flame represented so much power.

Jane also reported on her experience with nail digging self-harm as a way of allowing herself to remain composed in front of her family where she was not given the safety or permission to express her emotions otherwise. Self-harming was a way for her to release her pain while remaining outwardly composed, and thus controlling the degree of her emotional expression. In her words, "It was a kind of sense of control for sure and a sense of umm just like keeping myself together."

Taken quite literally, the connection between self-harm and control makes sense, as it is well documented that NSSI results in the release of neurotransmitters that are involved in

regulating or controlling mood, pleasure and pain (Groshwitz & Plener, 2012). Thus self-harm literally allows one to control their internal world, directly, physically and materially from the outside in. Precedence for this theme and it's function in relation to self-harm maintenance can also be found in Connor's (1996) work, in which she postulated that, "self-injury serves as means to organize the self, regain homeostasis and physiological and emotional equilibrium and to provide a sense of control." Accounts of the ways NSSI allowed participants to gain a sense of control and agency, over important parts of themselves and their environment, emerged consistently across the collective narrative of this study. Thus, as understood it, meeting needs for agency and control was considered an important functional aspect of NSSI. Meeting this need in other ways became an important consideration in the process of recovery for many of this study's participants.

3.2.6 NSSI and Meeting Needs for Emotional Regulation:

According to Gullone et al. (2010) emotional regulation is the ability to, through either intrinsic or extrinsic means, whether being automatic or effortful, manage one's emotions towards goal accomplishment. Emotion regulation includes, "skills and strategies for monitoring, evaluating, and modifying emotional reactions….not only [for] reducing the intensity or frequency of emotional states, but also the capacity to generate and sustain emotion" (Gullone et al., 2010, p. 567). It is essentially the ability or experience of being able to exert some control over your emotional world or feel as though your emotions are manageable. NSSI is reported to afford self-harmers the functional capacity to elevate themselves out of states of hypo-arousal or dissociation as well as afford them the means to collect themselves in response to states of hyper-arousal that would otherwise result in a state of disorganization or overwhelm (Connors, 1996). NSSI and meeting needs for emotional regulation or expression was a function of NSSI reflected across participants' accounts in this study.

Kalvin spoke to NSSI as elevating him from a state of emptiness to happiness, resulting in some sense of fulfillment. In his words,

there was something missing in my life…that's what kept me self-harming…you know having something missing, looking for something to fill the void you know I guess like emptiness in my life.

His reflection maps onto a description of NSSI as functioning to meet needs for emotional regulation by way of removing him from a state of hypo-arousal or emptiness.

Jane also described how her self-harm helped regulate her emotional world and bring her out of a state of intense hypo-arousal or dissociation. As she described it,

> I was on freeze mode, I was numb…and so the candle was more so a form of remembering that I had a physical body…it kept me awake, like I felt more awake during those moments compared to the dissociation and numbness.

Sydney also reported on her self-harm as functioning to elevate her out of state of lowness, with the added consideration that it also helped to organize her emotional experiencing. She commented on the way in which the pain of her self-injury made sense, in terms of it making sense that she would feel pain when she cut, and that this allowed her to discern what she was feeling and organize otherwise unintelligible, disorienting feelings - "it was just kind of an escape and I think at times it helped me feel something because I think with the depression it just got to the point where I didn't know what I was feeling anymore." These experiences all map onto Connor's analysis in which she found a key function of self harm is the, "management and maintenance of dissociative processes, such that it regulates the degree of sensation, as well as provides reassurance about being alive" (Connors, 1996, as described in Smith et al., 2014, p. 42).

In addition to allowing participants to meet needs for regulating hypo-arousal, self-harm was also understood by several participants in this study to be effective for regulating

overwhelming emotional experiences, or states of hyper-arousal, and returning themselves to a state of cognitive and emotional equilibrium. Fleur described that when she self-harmed,

> my mind would be focusing less on anxiety, anxiety, anxiety and kind of briefly skip over to the pain and so it would kind of balance things out I found

Ellie recounted how her self-harm allowed her to collect herself enough that if she was previously overwhelmed or pre-occupied she would be able to focus afterwards on the pursuit of other important tasks or goal directed behaviour. In her words,

> it would allow me by the time I finished cleaning up to be really calm and be able to do what I needed to do…like a reset switch which was very powerful.

Jane echoed an experience of self-harm functioning to attenuate states of intense emotion and hyper-arousal:

> `it was a build up of tension and frustration …I would say yes like it (self-harm) definitely helped in the sense that once the physical pain was painful enough I no longer had to deal with the unpleasant emotions.

Ellie offered another nuance on the regulatory aspect of NSSI, in a way that lead me to understand NSSI in an almost a metaphorical way – with NSSI mirroring or allowing direct, congruent expression of certain overwhelming internal states. She explained that when she was distressed her,

> blood would almost boil…I would feel this physical discomfort…it really felt like pressure umm and so it seemed logical that if I could release some of the blood it would also release some of the pressure…and it did.

To Ellie her self-harm followed a logical sequence of needing to relieve, and having means to relieve, an unbearable emotional pressure, reliably and assuredly through accessible physical material means via NSSI. NSSI was a physical act that allowed her to access and release

a psychological pressure, the release of such pressure being a need that she felt she did not have the means to meet otherwise.

There was a ritual and sometimes procedural quality elicited in these descriptions of NSSI and emotional regulation. Participants who employed NSSI understood that a state of calm, distraction or removal from pain could be reliably achieved through self-harm.

A state of emotional regulation and stability is necessary for most rational pursuits and forward moving goal directed action (Gullone et al., 2010) Without means to reliably and consistently self-regulate, it makes sense that the participants described as they did feeling trapped, unable to move on, numb, confused and overwhelmed. In the absence of any other reliable way of achieving a such necessary states of collected self-organization, it makes sense that self-harm would have seemed a practical, reasonable and functional means of having this basic need of emotional homeostasis met, and thus why it was turned to as a functional coping tool.

The participants of this study asked that this function of NSSI be understood in the way they indicated that an understanding, non-judgmental, non-blaming ally was a key component of many of their recovery experiences. In the way that NSSI helped them achieve a state vital for goal-directed, rational behaviour, NSSI can be seen as, while harmful from a physical standpoint, an act of someone in a dysregulating amount of emotional pain doing the best they can to keep moving forward with the resources they have available to them. This is written not to condone or endorse self-harming behaviour, but to emphasize that while harmful, self-harm can be considered a rational pursuit, and helpful one - while still not being the most healthy or sustainable means of achieving a state of emotional regulation. If intentional self-harm can be seen as a functional, effective means of achieving homeostasis then the idea that NSSI is best understood as a response, and an understandable one at that, is again echoed. Understanding self-

harm in terms of the regulating function that it serves, and in terms of the basic needs that it allows people who employ it to meet, can been seen as a way of approaching and understanding self-harm from the de-stigmatizing perspective that my participants called for in the course of healing from it.

3.2.7 NSSI and Learned Emotional Suppression or Distraction in Family of Origin:

Another theme that emerged in the data from this study, in regards to understanding the function of participants' NSSI, was that their self-harm was related to having been taught, directly or indirectly, in their family origin that overt and direct emotional expression was not acceptable and was not an effective means of garnering responses of care or concern. As a result many participants in this study reported that they had to find alternate means of attaining the needs certain emotions pointed to, and that self-harm in some ways allowed them to do this. This idea bears noting from a trauma-informed and attachment perspective. For messages about emotional acceptability that are impressed upon individuals' developmentally through punishment or reward and message they receive about whether or not important others will reliably and appropriately respond to the needs one's emotional expression signals, can become integrated into one's attachment system and impact how one self-regulates and communicates (Haskell, 2003; In-Albon et al., 2013; Linehan, 1993). In-Albon et al. (2013), explicate this as it relates to NSSI, and purport that an emotionally invalidating rearing environment, in which a child's emotional expressions are not responded to appropriately or consistently by their primary caregiver(s), does not afford individuals' the opportunity to learn to regulate emotions in an adaptive way, and can result in individuals relying on short-term impulsive strategies to return emotions to a tolerable level. An exploration of this theme and how it manifested for the participants in this study may help us better understand why NSSI seemed like a necessary or preferred means of communicating and regulating emotions for them.

Ellie told a story of being conditioned and taught by her father to displace pain through other pain, as well as received messages that in order to feel good you often had to do the hard things first. She explained,

> my father umm kind of raised me with this idea that pleasure and pain balance out and that if you do the things you don't want to do like the difficult things like your homework, you'll feel better afterwards as opposed to always doing the things you like and then feeling really bad….I took them a bit too literally to kind of mean that if I could cause myself pain and like punch myself that it would lead to some amount of happiness…that it was an equation.

While many of us received message about 'work before play' growing up, which could by many standards be seen as responsible and reasonable, Ellie reported that she internalized this message to mean you could punish or harm yourself into feeling good. As I understood it, as a result of her early experiences, she developed a mental set or paradigm that pleasure or goodness was something you had to earn or work for, not something that you innately deserved, and something that could understandably be thus achieved through punishment like self-harm.

Ellie was also directly taught or shown how to displace pain through other, more manageable pain. Ellie offered, when making sense of the origins of her NSSI, the reflection that,

> when I was little if I like fell down and hurt myself instead of offering some sort of comforting emotional reassurance my father would like pinch my ear and be like oh well you're not thinking about the other pain now…and it worked.

Not only did she have the experience of one kind of pain helping distract or displace from another kind of pain, such that it became, as she described, an 'equation' or formula for regulation, but she was given this message from an attachment figure. Developmentally, this is significant, for as part of attachment bonding children internalize, appropriate and re-enact learning passed on from their parents in order to solidify their bond and have attachment needs of

safety, mattering and mirroring met (Cassidy & Shaver, 1999). In this way, Ellie learned a self discipline practice, that in the context of normative, healthy attachment development made sense, despite it corresponding to a belief and experiential system of pain and self-punishment being an effective means to achieve goals and have needs met.

Fleur and Jane described similar experiences, of learning that overt expression of emotions, particularly anger, sadness or frustration, were either not acceptable or would result in rejection from primary attachment figures. They thus effectively learned that emotions needed to be dealt with through other means other than direct expression. Self-harm was experienced in this context as an effective alternative means for emotional regulation and expression.

Fleur explained,

> when I grew up we kind of lived in an environment of like it seems like any sort of negative emotion was like not allowed…It was never like a hey you know if you're upset it's ok to feel angry or annoyed, it was always immediately like no you can't do that, no that's bad…anytime I was angry too when I was younger like I'd take it out on myself you know, instead of like snapping at my siblings I would hurt myself instead

Jane recalled a similar experience,

> there was also a lot of dismissal from my family in regards to my pain…I wasn't provided a safe space to grieve basically and so I had to keep it all in…I was just shamed a lot growing up even with when my friend died, the lack of support was, my mom was like, when I was crying about it every day my mom was like…why are you so sad, I went through much worse than you…the shame went to the numbness which led to the self-harm.

For these individuals, emotions and their expression posed a threat of rejection from primary caregivers; a threat to biologically fundamental attachment bonds. Experiencing emotions and needing to regulate them, placed Ellie, Fleur and Jane in a position in which they

essentially had to choose between a state of internal dysregulation or the potential loss of support from a key attachment other. Self-harm presented an opportunity to regulate their emotions and temporarily avoid emotional expression that would cause them to experience rejection and further pain. In this way, self-harm can be seen as an adaptive, rational response to emotional invalidation that allowed these individuals to preserve key attachment bonds while also allowing them to meet their basic needs for regulation of difficult and intense emotional experiences.

Given that attenuation of self-blame and shame from both intrinsic and extrinsic sources, will be discussed in as a key themes of recovery from NSSI, I presented this section in the hopes of offering another lens of context, that of developmental learning, in which to enter into the participants life-world of why they self-harm. My hope was to advocate for, as my participants stated time and time again was critical for their recovery, contextual understanding of NSSI, rooted in a paradigm of non-blame. It was also my intention to support the message that those who self-harm, do so for a reason, that it makes sense, and although it is may not be the most long-term effective means of self-regulating, it is understandable and works in the absence of effective others means to do so.

3.2.8 NSSI and Narratives of Addiction:

A significant proportion of the participants in this study reported experiencing their self-harm, once initiated and repeated, as an 'addiction.' There is a body of growing research to support an addiction-based model of NSSI that this theme maps onto (Victor, Glenn & Klonksy, 2012). Furthermore, an addiction model of NSSI may make sense from a biological stand point as NSSI is reported to trigger the release of endogenous opioids, which the brain responds to and translates into the feeling of pleasure and relief (Merrer et al., 2009). Over time this opioid interaction becomes reinforced as pleasurable and beneficial, resulting in the 'urge' to repeat acts which produce such stimulation (Merrer et al., 2009). This theme of NSSI as an addiction, if that

is how it is experienced by those with a persistent relationship with self-harm as it was by many of this study's participants, may give us another lens through which to understand the functional benefits of intentional self-injury as well point to possible means through which to support recovery – through an addiction recovery approach.

Kalvin believed,

> the best way I can describe it was like the same reasons a person would continue to use drugs…you don't think like about the harm that you do to yourself…you don't think about the bad, you just think about what you get out of it.

He echoed the idea that the pleasurable aspect of NSSI, like in any addiction involving a harmful, but pleasurable substance, felt like it overrode any negative consequences of NSSI pre-recovery and resulted in his persistent, or 'addicted' relationship to self-harm.

Ellie made similar meaning of her NSSI in a way that she understood her self-harm to be,

> a strange addiction in the sense there was always a possibility [for it]…you could take away all the sharp objects, but I'll always have my nails right.

She highlighted the idea that self-harm, if it is an addiction, is one you can never fully remove yourself from materially - you can always find ways to fulfill it given that it may only require your own body. This subtext of this, as I understood it, seemed to be that recovery may require getting distance and separating oneself from self-harm in non-material or physical ways – so either cognitively or emotionally – as physical removal is not always possible or effective.

Sydney described her self-harm as an addiction as well, explaining that,

> it becomes like, can become, an addiction after a while, and I think it's the same as like any urge to go back to a habit that you've been dealing with.

She also used addiction language when she explained her recovery, stating, “I couldn’t go ‘cold turkey’ ” from self-harm in her recovery process.

I presented this theme, or recurrent idea from this study, in order to again offer a lens of understanding that many individuals who struggled with NSSI identified with and felt was important to share and have others know. This theme was introduced also for the reason that approaching self-harm recovery like addiction recovery, if that is how a given person understands their relationship to NSSI, may be useful for helping individuals heal through their struggle with self-harm.

3.3 What Helps Youth Recover from NSSI? Table of Master Themes:

Master Themes	Super-ordinate Themes
Connection and NSSI Recovery	Recovery through Connection Received
	Qualities of Healing Connection
	Reciprocal Healing through Extension of Care
Healing Shame and NSSI Recovery	Narratives of Self -Acceptance
	Self-Love and Kindness
Living Beyond the moment	Breaking out of Tunnel vision
	Leaning into Purpose and Joy
The Gestalt of Healing	Healing self-harm a product of healing the whole person

3.4 Master Theme 1: Connection and Recovery

3.4.1 Master Theme 1- Connection and Recovery Introduced:

That which resounded across participant accounts and became the single most consistent narrative thread which tied participants' experiences together in this study, to become the sinlge most indicated Master Theme, was the meaning made that recovery from youth NSSI was made possible because of an impactful human bond or **connection**.

In the following section: I will highlight my participant's accounts of how a lack of connection contributed to the incidence and maintenance of NSSI; I will address what individuals' in a state of recovery understood to be the qualities and experiences of connection that most significantly impacted their recovery from NSSI; and I will also provide some literature to discuss why it makes a lot of sense that supportive connection was reported by participants in this study to be the single greatest facilitator of change in regards to recovery from youth Non-Suicidal Self-Injury.

3.4.2 Narratives of Isolation and Disconnect:

To understand the role connection played in facilitating recovery from self-harm for this study's participants, it seems well indicated, to first acknowledge the influence that the opposite of connection, disconnect and isolation, had in the initiation and maintenance of individuals' self-harm. I understood, from the meaning participants made of their experience both with self-harm and recovery, that pain resulting from a deep sense of disconnected to important loved-ones, themselves and their social environment played a key role in their self-harm, while resolving pain, through connection, was a critical factor in recovery.

Sarah described an experience of tunnel vision, of being trapped by aloneness and a feeling of isolation in a romantic relationship when recounting what lead up to and contributed to her self-harm. She shared,

> you're isolated and you think ok this is the only person…this is the only person and you don't want to lose them and you try to prove your point. So that (self-harm) was one of the things I would do like just to show like what extent I can go for that person… it adds on you, you know you grow more emotional at the same time you are so isolated.

Sarah felt like she had no one else, no other options for connection at that time and self-harm became a way for her to gain control over this sense of disconnect and powerlessness, and break free from a feeling which otherwise left her feeling trapped and helpless.

Kalvin also identified that, leading up to his experience with self-harm, he felt disconnected and isolated both from his family, his community, and the world at large. As he understood it,

> it takes a village to raise a child…when I grew up there was kind you know like nothing …you know social services and stuff like that aren't really there to help, you know…the government again doesn't really care about the people…I think it ties in to cutting myself because it takes a village to raise a child. All I got from the village was going to school and public schools nowadays are really horrible places.

Contained in Kalvin's understanding of his self-harm, in context of an experience disconnect, was the sense not only of being isolated and empty, but of being unsupported, not cared for and actively hurt by the systems he was forced to participate in socially.

Kalvin further explained,

> I felt very lonely in the world…I only have like my mother lives here now, like my father was very old when he died…and all of his family is in Germany…and a couple of half brothers who I don't really talk to…there was something missing in my life, that's what kept me self-harming.

In Kalvin's narrative he described a lack of support from and connection to his community as well as explained that important familial bonds were either missing or fractured through loss and separation. In the way he made meaning of it, his disconnect and emptiness, directly lead to his self-harming behaviour which allowed him to 'fill the void' through momentary relief.

Fleur echoed an experience of disconnect and pain that back-grounded her self-harm experience. In her words,

> in high school people were just toxic and horrible, were awful and I was just very much done with it…I was like, I was burnt to the core….I was so done with everyone and everything.

Sydney similarly recounted an experience of isolation and disconnect leading up to her struggle with self-harm. She described her isolation and disconnected as related to dealing with her sister's terminal illness:

> when I was struggling with the depression I think I knew that no one else around me was going through that and I think it made me feel really alone.

The experience of having a terminally ill sister, with a rare disease, was a very isolating one for Sydney. As I understood it, this experience related through a series of other precipitating factors to her self-harm. Sydney recounted that she was bullied a lot growing up, and that a repeated experience of social disconnect and rejection had deeply impacted her developing self-esteem, leading to her depression, to her internalizing blame in regards to her sisters illness and to

her self-harm that followed as a way to deal with the related feelings of guilt and worthlessness. As she described,

> I think it was just like a lot of the guilt because I was watching my sister, like this disease take a lot of the life out of her and umm I just felt guilty that it was her and not me…I think I was just taking it out on myself, I think my-self-worth and self-esteem was really low and I think I just felt like I was more deserving of it than her…that (SH) was a way that I could make my self feel better.

Jane also understood her experience with self-harm to be fore-grounded by many layers of disconnect and isolation - physical isolation when she was bed-bound during her depression, disconnect from her sense of identity as top student and from important people around her. Her illness narrative was as follows:

> I was like a top A student and then when I got sick it was so bad I couldn't even handle a first year arts course…I was stuck in bed all the time by myself and everyone else is going on and having their lives …it was a sunny spring, but I couldn't, I didn't even see the sun.

Jane also reported on several occasions, in relation to the invalidation and shame which she understood to have perpetuated her self-harm, a deep sense of rupture or disconnect between her and her parents.

Fleur also understood self-harm as being derived from, and also being a potential perpetuator of social disconnection, generally speaking. It was her understanding that, "people who self-harm they get put in mental hospitals or like people who self-harm…everyone thinks they're nuts."

In this way self-harm can be understood as being underscored or motivated by feelings of disconnect, but also as perpetuating further experiences of social disconnect.

As I understood it from my participant's accounts, these feelings of disconnect often put people in a state in which they felt at odds with or against themselves. These experiences of disconnect and of feeling at odds with themselves, often resulted in feelings of hopelessness and overwhelm - states of dysregulation which self-harm allowed them to regulate. Alternately, as will be expanded upon next, when the disconnection these participants felt and had internalized, was repaired through supportive bonds of connection with others, participants' recovery from NSSI was facilitated. The narratives of the participants in this study suggest that supportive and empathic connection is a possible antidote to the disconnect and isolation that was repeatedly experienced to be a key precipitator of self-harm.

3.4.3 Recovery Through Connection Received:

In the way my participants told their stories, what seemed to stand out to them most prominently in their healing from NSSI was the presence of a supportive other in their lives. These supportive others, as I understood it, presented a means through which to resolve the states of disconnect and isolation that coincided with their period of active self-harm, thus facilitating recovery. When participants first offered this information on connection and healing as it related to their recovery from NSSI, I noted that this was typically done simply by naming the person they felt critically facilitated their recovery experience.

Sarah understood that her mother, being able to live with different friends, as well as a professor who offered her an alternate perspective to her trapped narrative of having no options, were key factors in her recovery process. Kalvin described a girlfriend at the time who also self-harmed and whom he could be open with as part of his recovery experience, and offered his understanding that, "if I'd had more connection in my community, that would have made a big difference." However he spent the least time describing supportive others as part of his recovery experience. Ellie recounted a girl from university who reached out to be her friend, counselling

support, and most notably her current partner as being critical connections involved in her recovery process. Fleur named a friend and mental health ally that she created an anxiety buddy system with as well as a counselor as being key in her recovery. Sydney named her family, a Batten's disease peer support group and renewing her relationship with God as being key factors in her recovery. Jane recounted a boyfriend and a supportive group of friends who were consistently available to her through her recovery as having been critically impactful to her self-harm cessation.

When I probed further in terms of how these connections had impacted participants, in terms of the specific qualities of connection they understood to have supported their recovery experiences, they were often able to name and describe these qualities. However, in the way participants made sense of their experience of connection and NSSI recovery on their own, as in the way they offered it independently, it was more so the presence of connection, as opposed to the specific qualities of that connection, that were named as supportive in terms of facilitating recovery from self-harm. I understood this to mean that the presence of another and the experience of not being alone in their recovery process was, in itself, supportive and healing. This idea was echoed by self-harm recovery research by Wills (2012, p. 107), who named inclusion as being a key theme of recovery from self-harm, and quoted one of her participants as describing that it's about "having somebody on your journey of recovery, not to hold your hand, but to just walk beside you."

3.4.4 Qualities of Healing Connection that Supported NSSI Recovery:

While the presence of supportive others was identified as a key component of participants' recovery experiences in its own right, participants did identify certain qualities of connection that they experienced as more helpful than others in terms of facilitating their recovery from self-harm. The following discussion pertains to the key qualities of supportive or

connected others, that were shared or emerged consistently across 2 or more participant accounts, as facilitating recovery from self-harm.

3.4.4.1 Compassionate, Empathic and Understanding:

According to participants in this study, a supportive other and ally in healing from self-harm, is one that is compassionate, empathic and understanding. To get to this place of understanding many participants first recounted experiencing, in important relationships, the opposite of empathy and understanding – judgment, and criticism – and reported on the ways this hindered their recovery from self-harm or in some cases, intensified urges to self-harm.

Many participants recounted the experience of being judged for their self-harm by important people in their lives. This was understood to be a painful and recovery interfering experience, as well as one that furthered participants' feelings of isolation and dysregulation. This is problematic as these feelings, as previously explored, were reported to contribute to self-harm itself. Helping relationships in the course of NSSI recovery thus had the potential to be, as I understood from participant's narratives, potentially tenuous in terms of their supportive effect. Connective encounters seemed to possess as much power to interfere with recovery as to assist, depending on the qualities offered. It is therefore further emphasized that paying attention to *how* to be a supportive other, in addition to simply offering presence, is an important part of being an impactful ally in supporting youth recovery from NSSI.

This understanding came from an analysis of the following accounts. Sarah reported after an attempt to reach out and receive support from a close friend in regards to her self-harm, that she was judged and dismissed. In her words,

> I talked to my friend, but like how she saw it when I tried to take help from her, she was like oh you should not be doing that (self-harming) like she was super

> rude to me…she was not understanding it from my perspective …and that's why I never spoke about it to anyone after that you know.

As I understood it, Sarah's experience resulted in her feeling as though she could not share or receive support in regards to her NSSI from anyone else, and also served to increase her feelings of isolation – a feeling that was related to the maintenance of her NSSI behaviour in the first place.

Fleur also told a story of being judged and shamed for her self-harm and the ways this impacted her. In her words,

> I was shamed by my family for it (self-harm)…before they really understood they were like oh you shouldn't be doing this and telling me that it was selfish…you know hurting other people when you did that and you're being a bad example to your younger sister with special needs.

In the way Fleur described this experience, with shame and blame existing in a context of 'prior to understanding,' I took this to mean implicitly that one who approaches self-harm from such a paradigm is not truly understanding self-harm and the ways it functions for an individual. Fleur described being blamed, and having her self-harm not be understood for the request for help and expression of pain that it was, as furthering her sense of isolation, and desire to self-punish in order to resolve her intense, unbearable emotional experiencing.

Alternately, understanding and compassion Fleur received from her therapist as well her anxiety ally/friend was what she understood to be the antidote to the disconnect and experience of the 'self as bad' that perpetuated her urge to self-harm. This understanding and compassion was an important part of what she understood to have facilitated her recovery from self-harm.

Fleur recounted how her counselor's non-judgmental, client centered approach which attempted to connect with her experience as she understood it, and not layer his assumptions on it, was an important part of what facilitated her recovery. In regards to her counselor, she described,

> He was just really chill and really like let's just talk about it (self-harm), like understanding this and what works for you…he was very good at knowing that everyone is different and that his way wasn't the best way.

In regards to F.B's experience with her anxiety ally/friend, she reported on how being able to verbalize how she was feeling, and have that be understood, without judgment, allowed her to emotionally reset in a way that meant she didn't have to use self-harm to do so. As she described it,

> one of my best friends she had some of the same issues that I did…we developed a system you know if one of us kind of started going into panicky feeling we would just kind of just say what we were thinking right then and there...and just kind of like halt and reset you know.

That the experience of receiving connection underscored by compassion, empathy and understanding was an important part of what facilitated healing from self-harm was recounted by several other participants in the study as well. As I understood it, when people had the experience of not being judged, and were instead understood and seen as capable, mattering, making sense and worthy of love despite their suffering and self-harm, their healing from NSSI was supported.

Jane recounted how her process of healing from self-harm was facilitated by an experience of deep empathy offered by her friends:

> It was a learning process for all of us, like I just need you to ask me what I need right now, and like teaching about intergenerational trauma and PTSD until they came from a place of compassion and humility of like I don't know what to do, please help me help you…they made sure to always approach me with compassion.

Jane made meaning of her illness and recovery experience in a way that highlighted that having her experience with mental illness and self-harm be understood not only as making sense, but as being something her and important others in her life could all grow and learn from, was an incredibly powerful and impactful part of her healing experience. She had the experience of not being blamed or dismissed for her self-harm, and instead of being helped to figure out what she was feeling and what she needed. This was markedly different than how her primary caregivers had responded to her expressions of pain and Jane reported how this had reparative effects on her emotional regulation capacity.

Jane further explicated the idea that understanding and empathic connection were key components of what facilitated her recovery from self-harm when she told me that her friends,

> even though they saw me you know, doing self-destructive things and they saw me like in a really shit place they still trusted me to do the best that I could umm in the healthiest ways that I could manage…they realized that it was something that I had to do that I needed at the time to survive and keep myself alive.

As I understood it, her friends communicating that she made sense, and was doing the best she could with the resources available to her, played a critical role in facilitating her healing from self-harm. She was offered deeply empathic responses, ones that demonstrated her friends attempting to connect to and understand her experience as she did. Jane's friends' responses matched a description of empathy as quoted by Watson (2002, p.446) who noted, "Rogers defined empathy as the ability to perceive accurately the internal frames of reference of others in terms of their meanings and emotional components." Jane's friends responses mapped onto the essence of empathic understanding and communication, and Jane reported how this experience of being understood, increased her sense of trust in her friends judgment and boundaries, to the extent that she was willing to listen to them when they asked her not to intentionally burn herself any longer. In her words,

> they were like no it makes sense, I understand why you would do that, but for this instance (candle SH) they were like no. They kind of set those lines and so I was like oh shit….I trusted their perspective, I trusted their opinions on boundaries.

Fleur echoed that having the experience of being understood and seen by a close other was an important aspect of her experience of healing from self-harm. She explained how one of her close friends was not able to meet her in understanding, resulting in isolation and frustration, but when another was, without her even having to ask, this had a powerful impact on her. As I understood it, the compassion and understanding she was shown increased her resolve to love herself and find less destructive means of coping. She recounted,

> You know my best friend didn't quite get it, like she had anxiety, but she like didn't quite understand what it meant for like self-harming, she'd be like well why are you doing that and I'd be like I don't know leave me be. My other friend R she like knew like why my nails were always short like she caught onto the little things because she did them too and I caught onto her little things so sometimes we'd just like hold each other's hands and that kind of thing.

This was a palpably emotional moment in the interview and Fleur paused to cry after sharing this, demonstrating how strong an impact this experience had had on her.

Sydney reported two experiences of compassionate understanding, from both material and non-material sources, that she understood as having played an important role in her recovery process. She described that her faith played a big role in her recovery, as well as the experience of meeting with a group of people who understood what she was going through in regards to her sister's terminal illness. As I understood it, Sydney's faith and her connection to God gave her a source for feelings of unconditional support and understanding. She recounted how she'd stopped going to church when she was at her lowest points with self-harm and depression, and that alternately increasing her investment in her faith coincided with her recovery from self-harm -

"my faith played a huge part in my recovery and so I think I really just turned to prayer." In regards to her recovery as being impacted by the experience of being joined by supportive others, who by empathizing with what she was going through with her sister increased her resolve that she made sense, was not alone and could trust herself to cope in non-harmful ways, Sydney recounted,

> going to the conference I was suddenly surrounded by people whose siblings also had it (Batten's Disease)…where you just got together with like siblings in your age range and you could just talk to anything so I think that was really therapeutic as well.

While this was not an experience of having another understand her self-harm directly, as she explained it, the experience of being understood and connected to in regards to a critical component of her identity had extended benefits over her emotional life, and resulted in her being in a state in which self-harming no longer seemed like a necessary option.

Ellie's narrative also powerfully supported the idea that compassionate connection, which did not directly revolve around empathizing with her self-harm, could indirectly support attenuation of the need to self-harm. She recounted an experience with a friend at college,

> that was the first time I felt I'd had some sort of social support umm that was actually able to bring me out of that place where I really wanted to harm and that was without even talking about it with her without even mentioning it, just felt some kind of love and some compassion…I remember going home that night being like wow that actually worked.

My takeaway from these excerpts, as well as the many others I sifted through during data analysis, was that understanding, compassion and empathy, underscored by the message that one's needs matter and make sense were critical qualities of supportive others and connection received in the context of recovery from youth NSSI.

3.4.4.2 Acceptance and Validation:

"When I was allowed by my friends to be sick, like being allowed to be sick, that was that was phenomenal… and also not rushing my healing process, that made a big difference." The essence of this excerpt from Jane's narrative embodies an experience of radical acceptance – a state or experience of being recognized and appreciated in the totality of who you are without judgment (Linehan &Wilks, 2015). Acceptance was a quality of healing connection that resounded across participant narratives' in their discussion of the supportive others who had played a part in their self-harm recovery process.

Jane recounted having a friend who communicated acceptance to such a degree that she described wanting to befriend Jane's mental illness as having played a big part in her healing from self-harm. In her words,

> I remember my friend telling me, you know what, your mental illness is a part of you and I am your friend so I'm also going to be friends with it and that was huge.

She described this experience as supporting her own process with self-acceptance and compassion, two states that she understood were an important part of what made her recovery from self-harm and mental illness possible. As I understood it, Jane's experience of having the uncomfortable parts of her be accepted and approached as if they were ok, made her feel ok enough that in essence got she better. Acceptance seemed to attenuate the shame and pain that drove her to self-harm, to such a degree that self-harming no longer seemed like a necessary coping tool. In other words, acceptance seemed to attend to the emotional source of what had instigated many of her self-harming urges in the first place. She also had the experience of acceptance in regards to recovery being a process, with friends who communicated that, "this might take a while and that's ok." She recounted that not being rushed or pushed to get better

was also an important part of what facilitated her healing process. Being giving the space to be as she was, was healing for Jane and this makes sense given that feeling like she was not allowed to be as she was had underscored her self-harm.

Ellie's narrative also focused on the healing power of acceptance in her recovery. She told me,

> My partner has helped me a lot…he has been incredibly supportive, more than anyone else….he would always say that I'm not going to get in the way, I'm not going to stop you from cutting, but I will try to talk to you and remind you that it's not going to help in the long run.

Ellie had the experience of being 'allowed,' to be as she was, and of being connected to and supported by someone who, while he accepted, as she did, that her self-harm was not sustainable in the long term as a coping tool, that it was her choice to regulate herself as she chose and needed to. Ellie also had the experience of someone seeing her as more than and as separate from her self-harm and this seemed to contribute to an increase in her sense of well-being that coincided with her recovery as I understood it. She recounted, "My partner was like it's ok just do what you have to do…it says nothing (about you)." Ellie understood her partner's approach to mean that her self-harm did not make her *herself* unacceptable – she was more than her self-harm and still worthy of love and care, even if she had behaviour that at times was undesirable. Receiving the message that she was acceptable and worthy, increased her willingness to love herself, which was another critical aspect of Ellie's healing from self-harm.

For those who did not have the experience of being accepted or seen for who they were as part of their recovery experience, reflections on how experiencing this might have been helpful were offered by several of this study's participants. As I understood it, even when people had not personally had the experience of being accepted or supported as part of their recovery experience, they still believed or knew, retrospectively, that had they had this experience that it would have

facilitated their healing from self-harm. Kalvin's narrative reflected a longing for connection in his community and at school, for the experience of mattering, and for his needs as an individual being accepted and validated. He told me,

> I felt like there was nothing else you know to help me, help the individual person like me in the world…If there was one thing that would have helped me it would've been a little bit more stable life…maybe if I was enrolled in some sports or something or even had a summer job…If I'd had more connection in my community, that would have made a big difference.

Fleur surmised that if her friends had been willing to speak to her about her self-harm - which she explained at a point had been obvious and that her friends must have noticed, but chose not to say anything - that this would have "made a difference." As she understood it, if they'd been willing to accept what was happening for her, instead of dismissing and ignoring her self-harm, she might have stopped sooner. In the way she understood it, their dismissal and ignoring of her self-harm at least in part allowed it to keep going unchecked. She also reported feeling for a long time that her self-harm being of concern, was "just in her head." This changed when she spoke to a high-school peer who also self-harmed, who validated how hard it is to stop and who expressed acceptance for recovery from NSSI being a daily struggle. In Fleur's words, "having a bit of validation and knowing that like it's not just all in your head and it's not just you know something that you're uhh making out to be a bigger deal than it is…that really helped." This experience of acceptance and validation in regards to her self-harm, not only gave her increased resolve to trust in herself and see her experience as mattering, as I understood it, it also allowed her to accept that her self-harm was of concern and commit to a more intentional healing process than she had previously.

In sum, connected others who were able to express or communicate unconditional acceptance and validate participants sense of mattering were named consistently by this study's

participants as being a key part of their recovery experience. Validation and Acceptance, were documented through these accounts as being key aspects of supportive connection in healing from self-harm. Acceptance was named as having helped participants' cultivate greater self-love, trust in themselves and others, and as having engendered increased states of well-being, all of which supported recovery and a decreased reliance on NSSI as a coping tool.

3.4.4.3 Consistent, Reliable, Available:

Of the connections that were named throughout this study as being key to the self-harm recovery process, those underscored by qualities of consistency, reliability and availability, were noted repeatedly as those which facilitated healing.

Ellie recounted on several occasions that her partner's unconditional, consistently available support, his willingness to meet her with emotional presence and express that he would not leave even if she was struggling, contributed significantly to her recovery. In her words,

> having social support and from my partner, knowing he's not going to leave me if I cut, and that he's also not going to treat me differently if I cut, that he's going to kind of comfort me and accept me either way, that made me feel a lot less frantic about it.

That he was not going to leave if she cut, and would still be available to her even if she had lapses into self-harm seemed to, from my understanding, create a sense of safety or in attachment terms, the secure base Ellie needed to be able to self-regulate in a way that could involve, over time, not cutting. It makes sense that this experience supported her healing when reflecting on one of her triggers for self-harm as well. According to E.P, "saying I'll never cut again almost instantly brought the feeling of I want to cut now, just to get it in before I stop doing it forever." A consistent reliable connection in this way seemed to allow Ellie the space to heal,

without the kind of pressure and overwhelm that, from her account, invariably lead to emotional dysregulation and the urge to self-harm.

Jane, Fleur, and Sydney also similarly described reliable connection or set of connections that presented a consistently available source of support, as key components of their healing experience. Jane described a chat group with some friends she felt she could text anytime as supporting her healing process. She understood this chat group and the consistent, reliable support it offered as having facilitated her recovery by decreasing her sense of isolation, and also by giving her a way to remove herself from situations of distress in which she was prone to harm - as friends from this chat group would often meet up with her if she was feeling very badly, knowing this would help, and that she wouldn't hurt herself in their presence.

Fleur also reflected on how a consistent reliable connection she'd had a with a friend with whom she created an anxiety buddy system, had been part of what helped her decrease her reliance on self-harm in order to cope with difficult emotions. As Fleur described it, her and her friend would both tell the other person if they felt they were starting to 'spiral,' which she said helped her emotionally process and 'reset,' making her less likely to self- harm in order to get that reset.

Sydney described how having a Batten's disease support group and her Faith, two connections characterized by consistent available support, helped her heal from her depression and supported her growth into state of well-being where she was better able to self-regulate and less likely to self-harm. The quality of consistent availability was not named explicitly in regards to her Faith connection, although by most interpretations, implicit in an understanding of God is that of a benevolent force who is there for you whenever you need. Sydney recounted many times that her Faith played a big part in her recovery from self-harm, so I've made the interpretive leap of classifying God as a consistent available support or source of connection, in the context of her

recovery. Sydney reported on supportive connection being connection which was underscored by availability and reliability explicitly in regards to her Batten's disease support group. She understood that,

> just having a support group of people that I could just reach out to at any time and they would just be open to talk about anything…like having a team of people that were on your side, that was really healing.

As another layer, I also understood, from the way two of my participants described their relationship with self-harm, that NSSI acted as a source of connection when no others seemed consistently supportive or available. Both Ellie and Jane described their self-harm and mental illness respectively as 'an old friend.' Self-harm presented as a source of reliable and guaranteed comfort, emotional regulation and chemical release when nothing or no one else could offer them such needed things. Self-harm would always be there for them if they wanted. From their narratives, I understood that once these individual's received support and connection that could engender the same the states of relief and release as NSSI, self-harm no longer felt like the only option for having these needs of connection met. In this way, a relationship with self-harm became less desirable compared to a real relationship underscored by reliable, supportive connection – the latter being a relationship with less harmful side effects, that made self-harm seem less appealing and less necessary of a friend to hold on to.

3.4.5 Reciprocal Healing through Extension of Care:

Across participant accounts, another Super-Ordinate theme that repeatedly emerged in regards to the Master Theme of *connection facilitating recovery from self-harm* was the theme of extending care to others having reciprocally healing effects on participants and supporting their own recovery from self-harm. In other words, many participants reflected on having had the experience that continued healing or sustained recovery from self-harm was supported through

the extension of care they gave to others. I present this theme as noteworthy for the ways in which it speaks to doing what works, and accessing healing through whatever means is effective, even if it means healing through others, or from the outside in, when approaching recovery from self-harm.

A recurrent experience had and meaning made in regards to recovery from NSSI, was that participants felt their experience with self-harm and recovery had made them more understanding and empathic people, as well as increased their willingness to support struggling others. Many participants reported experiencing a sense of purpose in being able to extend understanding and care to others as part of their recovery experience. Many participants' experiences, as they described them, mapped onto what is understood by Self Compassion Theory as common humanity, or a meaningful sense of attunement with others (Germer & Neff, 2013). As my participants understood it, this shared sense of belonging, purpose and attunement supported their intentions to not hurt themselves now and in the future (Germer & Neff, 2013).

Two of the individuals who participated in this study, Ellie and Jane, reported engaging in active initiatives to support others, either directly with NSSI cessation or with mental health struggles more generally, as part of their recovery experience. Ellie, who had her M.A. in Counselling Psychology, had done research on self-harm as part of her degree. She reported feeling a great sense of solidarity with her research participants, which corresponded to her internalizing a sense of purpose in recovery and a desire to maintain her recovered status so as to be able to continue to advocate for others with a sense of accountability. In her words,

> I would love to try to help anybody else who's dealing with it (self-harm) because I feel like I have a window into it which a lot of people don't have, and it can be difficult to understand and so kind of trying to turn it into something uhh for the better.

Jane started a mental health advocacy non-profit once in recovery from depression and self-harm. I as understood it, this played an important part in maintaining her well-being in a way that allow her to continue to be in recovery. In her words,

> the whole experience of mental illness in general made me a much more emotionally present and mindful and compassionate person, which has allowed me to do the work that I'm currently doing, so that's been amazing…I learned a lot about the power of pain…I realized that I could actually do something with my life given my experiences with mental illness and that's when I started a non-profit organization.

Other participants reported extending care to others in informal ways as playing a critical role in their healing process, and as engendering healing on them reciprocally. Participant's reported being able to be a better friend because of meaning they had made through their recovery experience. Some of the common reports were that because of having gone through NSSI and having grown through their recovery process, that participants felt capable of being allies to others in pain or to people that self-harmed themselves. Participants also noted that in recovery, the awareness and intention emerged for them to conduct themselves in ways that would ensure others were not harmed as they themselves had been hurt, as they knew the potential consequences of this. From what I understood, in regards to how these experiences of extending care to other's reciprocally supported participants' own self-harm recovery process, they served to support and increase participants own sense of well-being and purpose in a way that made self-harming to achieve relief and regulate stress, less necessary. Sarah shared, *"*I think I can help other people if they have any hard times. Like I won't be judgmental like my friend was that one time with me." Fleur shared that she, "wants to try and eliminate the stigma for people who self harm," and approach others with the empathy and support she knows helped her recover. In her words,

> just like being able to recognize behaviours in other people and kind of say like hey, I do that too, it's ok you know, you can seek help for this and you can get better because you know just sometimes having someone else validate you is really helpful.

Sydney shared that part of her motivation to recover from self-harm was to be a good role model for her younger sister as well as to honour the terminally ill sister she understood she might lose. This intention motivated her to find other ways to cope with her distress through non-self-harming means so that her relationship with these siblings, who she cared deeply about, would be one characterized by well-being and support as opposed to the pain of self-harm. As I understood it, with her love and care for her sisters guiding her, she was able to increase her level of motivation to care for herself and recover from self-harm. As she described it,

> I had another younger sister who was a lot younger at the time…just wondering how that was going to reflect on her…wanting to be a role model for her… [and for] my sister who was really ill so I think living on for her and honouring her in that way, I think that really helped me.

Sydney also explicitly put words to the value or usefulness of this theme of extension of care as being reciprocally healing to the self when she explained,

> I was still trying to work on my relationship with myself, I think a lot of it was for other people…sometimes you don't know yourself well enough for that to be your motivation, so you just need to start somewhere.

This idea of starting somewhere, and doing what works even if that means healing for others in order to heal yourself from NSSI, supports the utility of self-understanding in the recovery process, as well as emphasizes that there are multiple angles through which to increase personal well-being and support the self-harm recovery process.

I understood from these narratives that extension of care, especially care underscored by the meaning and understanding they had generated around their self-harm experience, seemed to

reciprocally support participant's own recovery and engender a sense of purpose and motivation to be well. This extension of care and understanding seemed to coincide with an increased sense of self, in terms of identity and esteem, which made it easier for the participants to approach themselves as someone worthy of care and non-harm and relinquish their relationship with self-harm.

3.4.6 Reflections on Master Theme 1: Attachment, Emotional Regulation and NSSI Recovery:

When this study's findings related to the Master Theme of *connection as a key driving force in recovery from NSSI* – more specifically connection underscored by empathy, understanding, acceptance and reliability – are held up against the literature on attachment security and emotional regulation, I am left thinking "of course." It makes so much sense that this is what helped people recover from self-harm time and time again. What participants from this study reported is essentially that they experienced, through their interactions with the supportive others they named, reparative attachment experiences and increased attachment security within themselves.

As explained by Goodall, Trejnowska & Darling (2012, p.623) secure attachment in adulthood can be understood as and has shown to be, "related to several indices of emotion regulation capacity, such as lower stress reactivity, lower physiological reactivity to ego-threatening stimuli and behavioural self-regulation." What Schore (2001) as well as numerous studies on attachment and emotional regulation have found, is that secure attachment promotes or essentially is the ability to emotionally regulate. Secure attachment is engendered in children, and carries over adaptively into how people relate to the world and others in adulthood, by caregivers who demonstrate consistent and reliable responding to their dependents needs, by support characterized by appropriate or mirrored affective expression, as well as by the experience of

understanding and validation in regards to their emotional world and modeling of effective adaptation to stress (Goodall, Trejnowska & Darling, 2012).

These qualities that promote secure attachment and the ability to self-regulate, were what participants in this study named when describing the supportive others that played a role in their recovery process – consistent, available, appropriately mirroring empathic others. These are also the qualities which underscore empathic responding from a therapeutic conceptualization, which according to Watson (2002, p.445), "in a therapeutic context are [the] active ingredients of change that facilitate clients' meta-cognitive processes and emotional self-regulation." As was discussed in my literature review, self-harm is underscored to a significant degree by attachment needs not being met, which increases an individual's proneness to states of emotional dysregulation, which in turn makes NSSI seem effective as a means of coping and regulating. Alternately, when reparative attachment experiences occur and supportive others are available who offer qualities that lead to secure attachment, the intra-psychic destabilization that gives rise to NSSI can too be resolved (Roussow & Fonagy, 2012).

If this information is held up against the ideas brought forth by studies on the theoretical underpinnings of NSSI (which iterate that a function of self-harm is to emotionally regulate in the absence of the learned capacity or skills to do so otherwise) then the recurrent data from this study, which says support from others who offer empathy and qualities that engender secure attachment effectively supports NSSI cessation and recovery, follows logically. Essentially empathy and secure attachment seem to promote increased self-regulation capacities and increased self-regulation capacities supports NSSI recovery. For the experiential evidence from this study is that connection received from supportive others who demonstrated the qualities necessary for secure attachment, increased participants' capacity to self-regulate and decreased their reliance on self-harm as a means emotionally regulate. At it's most refined level, the

evidence seems to suggest that empathy supports emotional regulation which supports recovery from youth self-harm.

Stories offered by participants in this study also mirror Schore's (2001, p.14) description of how reliable supportive nurturance supports a child's capacity to self-regulate, in that, "as a result of being exposed to a caregiver's regulatory capacities, the infant's expanding adaptive ability to evaluate, on a moment-to-moment basis, stressful changes in the external environment, especially the social environment, allows him or her to begin to form coherent responses to cope with stressors." Ellie reported that her partner's compassion for her when distressed increased her willingness and capacity to love herself and not self-harm in response to stress. Jane reflected that acceptance and understanding from her friends were critical factors in her healing. Sydney described how feeling like she had a "team of people on her side" coincided with her forming new a relationship with herself in which she liked herself enough that self-harming felt like a thing she couldn't even fathom once in recovery. These narratives document that the experience of supportive, secure attachment connections increase one's capacity to respond to stressors through non-self harming means. In essence, what findings from this study suggest, is that reliable, empathic connection provided the basis for emotional regulation that made it possible for individuals to recover from self-harm.

3.5 Master Theme 2: Healing Shame and NSSI Recovery

3.5.1 Shame Introduced:

Shame. This emotion was named both explicitly and implicitly, in every narrative that became part of this study, in regards to what underscored both individuals' experience with self-harm itself as well as with recovery. Shame, and more specifically healing oneself from the painful effects of shame, became the second Master Theme of 'What Supports Recovery From NSSI.' Some participants cited shame explicitly and directly as the reason that they self-harmed

and others shared that being ashamed of their self-harm itself drove them to recover. I also witnessed story after story of individuals healing their shame and understanding this to be a critical part of their NSSI recovery process. While shame seemed to function in different ways for different participants in terms of their experience with NSSI and recovery, it seemed that no one went through their journey with NSSI without being impacted by shame in some noteworthy way.

Shame is described by Velotti et al. (2017) as an intense emotional experience characterized by a pervasive internalized sense of worthlessness, badness and of being wrong. Brown (2006, p. 45) describes it as, "an intensely painful experience of believing we are flawed and therefore unworthy of acceptance and belonging." It is considered enduring, painful to work through both independently and therapeutically, and is noted to produces urges to escape or avoid its experience (Brown, 2006). However as Brene Brown (2006), in her work on shame and shame resilience notes, shame is one of the most primitive, normative and universal emotions that stems from our fundamental human need to belong, be loved and ensure that that need is met. Neff & Germer (2013) further explain the purpose of shame from a socio-evolutionary standpoint to conclude that in its inception it was an incredibly useful survival mechanism. Shame, or the feeling of badness and wrongness, originally served the socio-evolutionary function of alerting us that we have acted in a way that goes against the values or needs of our caregivers or social group (Neff & Germer, 2013). The felt sense of badness and the corresponding urge to do or be different that shame provokes, was originally a powerful motivator to act in ways that promoted belonging and in turn one's chances of group inclusion and survival (Gilbert & Procter, 2006).

However, if we consider our present state of socio-biological development as a human species, where differences or 'going against the group' does not always threaten one's existence and is in some cases celebrated, it can be understood that shame, while once a well intentioned survival emotion, is now in many ways an unhelpful or destructive one. Shame, instead of informing ways to increase belonging, instead leaves us feeling 'bad,' disconnected, in pain and

at odds with ourselves, which can contribute to a lack of mental wellbeing and the recruitment of impulsive and unhealthy coping strategies in order to deal with it (Brown, 2006).

Shame's related emotion, guilt, also came up with noted frequency in the present study as underscoring urges to self-harm and punish. However, guilt is nuanced slightly in that it is the emotional response to feeling as thought one has *done* something bad, behaviourally or situationally, as opposed to shame, which is a state of experiencing the *self as bad* as a whole or as an identity (Brown, 2006). According to Brown (2006), guilt has less pervasive and enduring effects, and can usually be modulated through changing behaviour. Healing shame on the other hand, requires changing one's relationship with one's self, the substrates of one's identity, and the means through which one evaluates themselves and their interactions in their social world (Brown, 2006).

Shame and healing shame, as opposed to healing guilt, will be explored with more emphasis in the proceeding findings section, based on the fact that it was named and described more often as directly impacting people's relationship to self-harm and their recovery process. That healing shame is a core part of the recovery process from self-harm, more so than guilt makes sense on a construct level, in that healing the 'self as bad' (shame) as opposed to healing 'bad behaviour' (guilt) would logically have more sustainable effects on one's ability to cope overall without reliance on self-harm. Guilt, in being a situational construct would in theory only impact one's ability to cope or change in situation specific contexts (Brown, 2006).

The following discussion aims to present an expose on shame, self-harm and recovery from NSSI. I developed the understanding, in interacting with the narratives of recovery from NSSI, that shame played a key part in initiating individual's self-harming behaviour, and that recovery from self-harm was made possible when participant's shame was addressed and healed through validation, acceptance and self-love.

3.5.2 Narratives of Shame and Self-Harm:

Participants throughout this study offered the meaning made that shame had contributed to their use of self-harm as an emotional coping tool. Some participants spoke to a clearly identifiable experience of shame prior to engaging in self-harm, using the word shame explicitly, and others alluded to it in a more indirect way, offering descriptions that would match on to the aforementioned definition of shame.

Jane understood the relationship between her shame and self-harm as clear and causal. In her words, "the shame went to the numbness which went to the self-harm." She cited shame as leading to her self-harm in several descriptions of her NSSI episodes and recalled that self-harm had helped to attenuate or mitigate her experience of shame. As I understood it, shame was both the chicken and the egg in terms of what drove her to self-harm. Shame gave rise to the urge to self-punish and harm, and shame could also be attenuated through self-harming acts. Jane reported experiencing, "extreme grief and extreme shame and anger" in a self-directed fashion as a result of her friend's suicide, and then of being further shamed by her family for feeling such anger and shame. For her shame lead to self-harm in the way that it,

> was just my way of expressing my anger but it was self-destructive…once the physical pain was painful enough I no longer had to deal with the unpleasant emotions.

As Jane understood it, in the context of already feeling an immense amount of guilt and shame for her friend's suicide, she was further shamed and given the message that her emotions, and on some level her herself, were unacceptable and that she would be rejected for having such emotions. As I understood it, this resulted in an understandable experience of relatively constant, anger, shame and numbness for Jane, which was then directed internally and mitigated through NSSI.

Ellie similarly recounted an experience of shame driving her urges to self-harm. She reflected on shame leading to NSSI in two cases. First in the context of not being able to better regulate herself in regards to a struggle she was having with binge-eating and purging and secondly in another context whereby because she, "hadn't finished an assignment and really guilty and just really ashamed" she cut herself 50 times afterwards. She reported how her shame resulted in a desire to self-punish to resolve the shame and hopefully give her an experience that was painful enough that she wouldn't repeat the shame inducing behaviour or experience again. Ellie also spoke directly to the idea of shame as being a state of selfhood, and also of self-harming and self-hating as being an identity that she almost felt she was betraying when she began her process of recovery. In her words,

> It really felt like such a fundamental part of my existence, that I was not a good person…for as long as I remember I always just felt a little bit guilty about quite a lot of things….I was always looking for ways to relieve my guilt…the dirt on my soul so to speak, I really felt like I was born bad.

Sydney similarly described shame and a low sense of self-worth as giving rise to her self-harm, especially in the context of her sister's illness. She felt she was not as good of a person as her sister and was more deserving of pain and being sick. She told me,

> I think I was just taking it out on myself. I think my-self worth and self-esteem was really low and I think I just felt like I was more deserving of it (illness) than her…that (self-harm) was a way that I could make my self feel better.

Many of the other participants noted feelings of badness, emptiness, guilt or self-hate, substrates of shame as defined by Velotti et al. (2017) and Brown (2006), as coinciding with their urges to self-harm - even if they did not use the word shame explicitly when describing what was responsible for their self-harm. Sarah reported feeling as though self-harm was what she deserved, as well as feeling shamed by her boyfriend as impacting her urges to self-harm. Kalvin

reported feeling a lack of belongingness that matches a description of shame, in the way that he described feeling unsupported by the world, angry and empty. These were the states and feelings he cited as giving rise to his NSSI. Fleur also named her self-harm a symptom of 'self-hate' which is also a substrate of shame as it is defined. In this way many participant's understood their self-harm as being highly related to and often a product of experiencing shame and its related states.

3.5.3 Shame, NSSI and Identity Congruence:

In reflecting on participants' accounts of shame and self-harm, and the ways they described feeling shame for who they were and their basic human emotional processes as leading them to self-harm, I came to understand self-harm almost as a behavioural manifestation of the emotional state associated with shame, or as 'shame embodied.' Austin (2016) in her study on chronic self-hatred, self-harm and existential shame, presents the idea that self-harm for the self-hating person is an identity preserving mechanism. Shame followed by self-harm is said to result in a state of congruence, between the self that feels bad and unworthy of acceptance and love and the body as deserving of punishment (Austin, 2016). In this way it makes sense that self-harm, when no other means felt as reliable or available or effective, served to relieve feelings of shame by essentially matching them, validating them and creating room for a state of internal congruence and emotional regulation (Austin, 2016).

3.5.4 Healing Shame and NSSI through Self-Acceptance:

In sifting through the narratives of shame and healing from NSSI, I came to understand that when the shame that gave rise to the urge to self-harm was healed through self-acceptance that recovery from self-harm was supported.

In Sarah's words, her recovery, "was just about accepting who you are and then moving on with it kind of thing…ok I'm like this and that doesn't matter." When Sarah accepted herself as she was, she did not feel bad, she did not feel shame, disconnect, or like she was stuck. As I understood it, self-acceptance resulted in healing the state that had given rise to her self-harm in the first place, which allowed her reconnect to her life and "move on" in ways that did not involve harm in order to do so. As part of the theme of healing the shame that lead to her self-harm, Sarah also reflected on how she gave herself permission to be as she was, and relinquished the need to prove herself as valid to others. Instead she began to validate herself, which involved having acceptance for others' differences as non-threatening and non-invalidating. Sarah reported with this approach she did not feel the pressure or urge to self-harm. In her words,

> I tried to not expect out of people, if I don't expect then I don't have to prove my point…and then I don't have to self-harm again.

Through acceptance of herself and her world just as it was, self-harming no longer seemed either necessary as an emotional relief or communication tool, nor as something that matched with who Sarah wanted to be as person. She shared,

> I want to respect my own self. I was having those thoughts in conflict with me, like why am I hurting myself. I mean it's just like thinking about your body as a temple.

Ellie recounted how having *acceptance for her emotions* attenuated the intensity of shame's presence in her life and played a key part in the cessation of her self-harm. For when her emotions were experienced as acceptable, they were less distressing and no longer something she needed to cope with and resolve through self-harm and punishment. Key moments that she presented from her recovery experience were the realizations "that it was ok to feel that bad," "it's ok to have emotions and to be affected by them, and it's not messy or dirty." She also presented, as part of her recovery narrative, the idea that, "if I was experiencing these emotions

there was a reason" and that instead of this being a shameful thing that needed to be punished and eradicated through self-harm, that she could approach her emotional life, "with more of a curiosity about myself and a willingness to tolerate more distress and know that it's going to be ok." Shame and an identity of badness, of 'having dirt on her soul' as she described, were replaced in recovery with experiences of self-acceptance, tolerance and curiosity. Ellie made the meaning that these were the experiences that supported cessation of her NSSI and helped to sustain her recovery over time.

Jane also understood her recovery from NSSI as having involved increased emotional acceptance, self-acceptance and tolerance. In her words,

> I also started crying more so that definitely helped, I started to melt out of the freeze, to thaw and let myself cry and just like feel the emotions more…not feeling ashamed felt like I had a right to exist…giving myself time and not shaming myself for the way I was coping was huge.

As I understood from her narrative, Jane approached her recovery process with patience and self-acceptance even when that process involved lapses into self-harming behaviours (self-burning as replaced by a sex addiction which she also defined as self-harming). In her understanding, healing shame through acceptance and giving herself permission to feel and be as she was had a direct impact on her increased desire to live a full life of purpose that did not include self-harm.

Acceptance, if considered as it is defined as, "a state or experience of being recognized and appreciated in the totality of who you are without judgment," seems to be a logical antidote to shame and thus an understandable component in healing from NSSI (Linehan & Wilks, 2015). As I understood it, self-acceptance resulted for Sarah, Ellie and Jane, in an attenuation of the presence of shame in their lives and produced a state of increased internal stability and peace. Self-acceptance diminished shame and NSSI's power over them by giving these individuals

permission to exist and belong just as they were – a an experience of being and selfhood which was felt as incompatible with the need or urge to self-injure or punish. This makes sense, as acceptance is in essence an antithetical or opposite experience to that which underscores shame; shame which says you must be different in order to be acceptable, loved, valid or to belong. As participants in this study seemed to understand, once they had an enhanced level of self-acceptance for their emotional life and themselves, self-harming felt less necessary as a means of attenuating overwhelming emotions or negative evaluations of themselves and recovery was possible.

3.5.5 Healing Shame and NSSI through Self-Love and Kindness:

Experiences of self-love, appreciation, worth-whileness and compassion, another set of theoretical and experiential antitheses to shame, recurred thematically in my participant's narratives as being a key part of what facilitated their recovery from NSSI. It could be argued that self-acceptance and love share similar qualities. However, I understood them to be different in that acceptance was typically underscored by participants' descriptions of tolerance or allowance while self-love and kindness had more of an affectionate or actively supportive quality to it. Self-love is used less commonly in literature related to shame and self-compassion, and therefore it seems more fitting to turn to a term commonly employed by Kristin Neff, a seminal Self-Compassion Researcher, 'Self-Kindness', in order to anchor our understanding of what the participants in this study were describing throughout their healing journey from NSSI.

Self-Kindness, which is considered one of the active manifestations of self-love or compassion is reportedly the act of, "being warm and understanding towards ourselves when we suffer, fail, or feel inadequate, rather than flagellating ourselves with self-criticism" (Neff & Germer, 2013, p.856). Through it's definition, which reports that self-kindness involves doing the opposite of punishing ourselves, involves not judging our suffering and instead creating an

experience of belonging within ourselves, I came to understand self-kindness as effectively the antidote to shame – a state which entails the opposite of self-kindness in the form of self-blame, punishment, judgment and real or feared disconnect. Self-kindness and love as proponents of NSSI recovery, were iterated throughout my participant's narratives as possible antidotes to shame, inadequacy, rejection and thus an antidote to the feelings that give rise to the urge to self-harm. There were different manifestations of self-kindness in the accounts of recovery in this study and they are presented below.

3.5.5.1 Self-Kindness, Recovery and Starting Somewhere:

For participants who struggled with self-concept, worth or esteem as part of their self-harm experience, it seemed their first foray into self-kindness often involved a step of simply not being unkind to themselves, if not being explicitly kind. Sydney reported being, "fed-up with being in pain" and, 'being tired of feeling bad' as precipitating her relationship with self-kindness and worth. Part of her recovery was the intention of simply to find a relationship with herself that she "hated less." Jane similarly described that the first part of her recovery from self-harm was simply not shaming herself, and that afterwards came the self-kindness.

Sarah reported that an increased belief in her capacity and worth coincided with her recovery from NSSI. With this she remembered feeling an increased sense of motivation to live in congruence with a version of herself that aspired for more, respected herself, and did not want to harm herself. Yet it was still difficult at times for her to use language that was explicitly self-kind when approaching herself. She told me,

> I got a nice research scholarship at university…I was appreciated. I started to think like I'm really not that dumb kind of thing and that really sparked things in me.

Fleur's self-harm recovery interview echoed the experience that it can be difficult to relate to and talk about the self in explicitly kind terms after having a relationship with the self based in shame and disconnect. When telling her story of recovery, Fleur shared with me some of the ways she would talk to herself in order to coach herself out of urges to self-harm, or what she might say to someone else if they were struggling, and one point caught herself and said, "I guess that's not really as compassionate as it was in my head." Also when I asked Fleur if she would elaborate on her statement, that what stood out to her as having helped maintain her recovery was, "most of it, I mean, was just finding ways to find self-love" her response was a 'no' followed by laughter.

What I understood from these interchanges and accounts was that talking about, and explicitly expressing self-love and kindness, was not always comfortable or possible for participants even though it was also part of what facilitated recovery from self-harm. As I understood it, this makes sense given that these individuals' primary means of coping for so long had been the opposite of self-kindness and love. With this information I propose that when working with self-kindness and love that it may be important to gauge one's level of comfort or readiness with this practice, and make incremental adjustments on that basis so as to gradually increase one's capacity for this quality or state of being that was reported to facilitate recovery from self-harm.

3.5.5.2 Explicit Messages of Self-Kindness in Recovery:

Several participants named an intentional practice of self-kindness or compassion as playing a key role in their recovery from self-harm and as supporting an experience of the self as valued and worthy of care, as opposed to shameful or bad and deserving of harm. Fleur explicitly named self-love as maintaining her recovery, as quoted in the above section. Ellie and Jane spoke to self-kindness and the processes through which they enacted it as having played a role in

mitigating their urge to self-harm and in supporting improved overall mental health (which too coincided with reduction in self-harm urges). Ellie reflected upon a process she engaged with when trying to actively attenuate urges to self-harm in which she imagined,

> how I would feel towards a girl that was in the same situation…would I want to cut her? Of course not, I would want to hug her and tell her it's ok.

Through this statement, Ellie powerfully mirrored the essence of how Kristin Neff describes a practice Self-Compassion and Kindness as will be explored in the discussion section. For me, Ellie's description created a visceral understanding and experience of warmth and self-love, in which an act of self-harm, as she described it, no longer made sense and could not exist.

Jane similarly recounted using self-kindness and compassion to tend to her emotional world as part of her recovery from self-harm. As I understood it, self-kindness resulted in an experience of increased peace and sense of regulation for Jane, which resulted in a decreased reliance on self-harm to generate emotional regulation. In her words, her self-harm recovery was made possible by approaching herself in the following way,

> I was like these are my thoughts and that's ok, and practicing self compassion…so I literally just started talking to myself the way I talk to my friends.

These accounts reflect the meaning made that self-kindness and compassion, states that represent the theoretical antidotes to shame, played an important part in the process of recovery from self-harm. These accounts of self-compassion also reflect ideas that will be elaborated on in the discussion section in regards to Neff & Germer's (2013) work – these being that compassion is often easier to give to others than to the self. Thus, when starting self-compassion and kindness, it can be helpful to, "talk to the self as you would talk to a friend" (Neff & Germer, 2013, p.857).

3.5.5.3 Self-Kindness, Valuing the Body and Recovery:

Repeated narratives of paying attention to the body, and seeing it as valued and mattering, also emerged in the context of caring for and approaching the self with kindness as part of an experience of recovery from self-harm. Ellie told me that part of her motivation to heal from self-harm, or at least to curtail it, was so as to not damage her tendons. She was a piano player and wanted to be able to continue to use her body to express her "talent." Kalvin similarly described not wanting to damage his body as part of his motivation to heal from self-harm. In his words,

> I didn't want to mess up and maybe you know I might like lose control of my arms or like damage tendons or something…I didn't want to mess up my person you know, I didn't want to mess myself up like that…I value myself.

Both of these individuals explicitly identified connecting to their body as useful and valued, an experience which could be considered one of self-love, as part of their recovery from NSSI. Other participants identified more implicit ways of connecting to their body in appreciation to facilitate well-being and healing from self-harm, either through exercise and yoga, as well as by using the body to make art. As I understood it, this supported their healing process, by making them feel healthy and purposeful, which in turn resulted in an overall experience of themselves as valued and a decrease in their desire to punish, harm or control the self through NSSI. These narratives suggest that self-love and appreciation can take various forms, not only cognitive and emotional, but also physical or embodied, as part of connecting to the self as worthwhile and deserving of healing from self-harm.

3.5.6 'Coming back home' – Recovery and the Self as Safe and Trustworthy:

'Coming back home' was a phrase offered by Jane to describe her journey of healing from self-harm and mental illness. I understood this meaning she'd made of her recovery process,

to be a felt sense that the recovered self was as a self that would not harm itself or 'its home' - a self that felt comfortable and safe in its body as well as one that did not feel shame, or badness for who and what it was. In the way Jane described her recovery as 'coming back home' she also highlighted the process quality that healing from self-harm entailed as reflected across participant accounts. The self as home was echoed by other participants as being part of their recovery narrative in the way that they described feeling trust in themselves as helping to maintain their recovery experience.

Sydney recounted how as she was able to attenuate her self-harm more and more over time, she developed an increased sense of trust in herself, which helped her believe that she could continue to cope in non-self harming ways. In this way she continued to reinforce for herself the experience that she was not trapped by self-harm and that it was not her only option of support. In her words,

> If you get through it for long enough it will kind of pass and the moment will fade and it will happen again, but you knew you could get through it that time so that you will be able to get through it again.

Sydney also offered the idea that trust, not only in the non-harming self, but in the self as a whole, helped facilitate her recovery from NSSI. She reflected,

> I think just when I ultimately had a lot more trust in who I was it wasn't something that immediately crossed my mind anymore either.

Her story reflects the idea of gradually rebuilding the self, of coming back home, to a body that has more and more evidence over time, that it does not need to harm itself in order to function.

Jane echoed the idea that building trust in herself helped maintain her recovery from self-harm, and made her body(home) feel like a more resourced place where self-harm was not the only tool she had to create stability. In her words,

> the recovery process has definitely helped me learn to trust myself, with like hey I have a choice and self-harm is not the only way to manage all of these things and recognizing that to go beyond avoiding pain and to seeking joy.

Sarah also noted that increased trust in herself and her abilities, coincided with her ability and willingness to heal from self-harm. In her words,

> there were times before I would just like underestimate myself, but I took a lot of ownership and power when I did this job last year. I worked as part time security. And like OK I can achieve more you know.

Trust in the self seemed to have the repairing quality not only of rebuilding these participants' identities, but also of giving them an increased sense of options, and motivation to move towards positive stimuli. Self-harm in being incongruent with this more trusting, optioned self, seemed to naturally decrease in appeal as a way of self-managing, resulting in the recovery experience reflected across these narratives.

3.5.7 NSSI Recovery and Healing Shame For the Love of the Future Self:

While loving the self in the present, by approaching it with kindness, care, respect and appreciation, recurred as a core feature of what facilitated participants' healing from NSSI, many participants also reported motivating themselves to recover by connecting to an ideal future self. As I understood it, this ideal future self and the love they had for it served as a guide for their present behaviour, in that it encouraged them to make choices congruent with the ability to someday meet with or become that loveable future self. In all of the related accounts, self-harm

was seen as incongruent with the ability to attain this state of ideal future selfhood, and this motivated individuals to recover.

Kalvin reported that one of his biggest incentives to recover came to him when he connected to his future self. This was a self that had children, and one that excluded self-harm as part of embodying respect and love for the sake of himself and his future family. In his words,

> If I wanted to improve my life I needed to you know work for myself and not harm myself and yeah not think backwards anymore…if I like had children I wouldn't want them to see that, I think that would be very irresponsible.

Kalvin supported himself in his recovery from self-harm by connecting to the love of a future, ideal self, one that was responsible, caring and respectful to himself and his loved ones. This reportedly resulted in an increase in his motivation in the present to attenuate his NSSI.

Fleur similarly reported connecting to an ideal self as part of healing from self-harm. In her words, this ideal future self was one that believed,

> I'm better than that, I'm not doing that…I'm better than this…I don't want to be like them, my parents deal enough with these troubled youngsters, I don't want to become one of them.

For Fleur, recovering from self-harm would, in its future projected state, allow her to distance herself from a version of herself that she didn't identify with. As I understood it, this motivated her to end a behavioural manifestation of an identity that she felt was with incongruent with her ideal self and who she wanted to 'become' (in the future).

Sydney also shared an experience of connecting to and developing love for an ideal self as part of her self-harm recovery process. This ideal self for Sydney was one who accepted her differences and opinions as things of value and worth, and wanted to amplify these qualities as she became who she truly understood herself to be. In her words,

> being on your own allows you to grow more into who you are…focus on myself and who I wanted to become and what my opinions on different things were and I think that really helped.

These individuals recruited a future or ideal self, one that they believed they could more reliably love and respect, in order to increase their motivation to stop self-harming in the present. This ideal self and the desire to be congruent with it in the present, in action and deed, was reported across participant accounts as facilitating recovery. It seemed to give participants' recovery meaning and left them with the sense that their choices now would result in them becoming someone they would be proud, or at least not ashamed of, in the future.

3.5.8 Concluding Thoughts on Recovery from Self-harm and Healing Shame:

One of my biggest takeaways from understanding and making meaning of my participant's narratives of self-kindness, healing shame and recovery from NSSI, was that there are different versions of self-love, and many ways of connecting to the self as valued, safe, liked, purposeful as a part of healing from self-harm. As my participant's accounts demonstrated, healing shame through self-acceptance and kindness, may manifest as being kind to the physical body as valued, the ideal self or future self, the self as deserving of respect from others, or self as worthy of kind words and thoughts. Helping individuals connect to their readiness to engage with the varying intensities of self-love and kindness, and modulating that to sustain motivation for this process seems to be an important takeaway from these narratives of healing and recovery from self-harm.

3.5.9 Shame as Motivation to Recover from Self-harm:

While most of the participants in this study spoke to self-love, appreciation, purpose and acceptance, and thus variations on healing shame as being what supported their recovery from NSSI, an equally significant number of participants, Sarah, Kalvin, Fleur, and

Sydney, reported using shame at some point in their recovery experience to motivate themselves not to self-harm. This should not be overlooked. When I initially considered this data, it seemed to contradict the idea that healing from shame or working to dissolve shame, was a key factor that consistently supported participants' recovery from NSSI. For several participants said they *shamed* themselves into self-harm cessation, either out of shame in regards to the appearance of the marks, out of what they feared others would think or say about them if they saw their cuts/marks, or out of a sense of guilt for burdening their family with their pain.

Shame being a powerful motivator to be different was explained previously, in regards to the social and emotional processes shame stimulates for people to act in ways that preserve belonging (Gilbert & Procter, 2006; Velotti et al., 2017). Thus that shame was a powerful motivator for reducing NSSI behaviour is not surprising – especially if a deep sense of rejection or badness corresponded to participants' relationship with self-harm. Shaming the self into recovering from self-harm, or in essence punishing the self-harming self to be different, seemed to work as cessation motivation for participants in moments where they wanted to self-harm.

Upon further consideration, into to the context of these statements in which shame helped participants stop themselves from self-harming, I realized almost of these narratives of shame supporting or motivating cessation, occurred in the context of participants' describing acute instances or urges to self-harm. However, when considering narratives of NSSI recovery as an overall healing process, and not simply an act of behavioural cessation, shame was not often named as that which supported what could be considered participants overall recovery process or experience. Instead the opposite, connection, purpose, and self - appreciation seem to coincide with participants sense that they were overall mentally healthier or well and recovered. While I cannot say conclusively, and more research would need to be done into the nuances of this 'pro-shame' strategy of using shame to motivate self-harm cessation, it seemed to me from the narrative accounts that I analyzed, that shame worked as a motivator to reduce individual, acute

acts self-harm (as a cessation through punishment approach) while self-compassion, appreciation and acceptance, supported an increase in participants overall wellbeing (cognitive, psychological, emotional, social) and played a more significant role in their long-term or sustained recovery. This idea is supported in part by the matter that shame as motivation to heal was not offered as a response to my question of what had sustained or allowed them to maintain their recovery from NSSI, whereas self compassion, purpose and meaning were. This nuance could be an important distinction to be clarified in future research on self-harm and factors that support recovery.

3.5.10 NSSI - The Thing You Can't Speak About (Shame, Breaking Silence and Recovery):

I would like to close the discussion on healing shame and recovery from NSSI with a reflection on an experience that was iterated in every participant account at the explicit, thematic and semantic level - NSSI is a thing you can't speak about. There is a culture of silence and shame around NSSI. This was demonstrated by the participants in this study, in terms of their willingness to speak about 'it' with important others in their lives and other helping professionals, in terms of the way they understood their own relationship with self-harm as well as in the way they spoke about self-harm with me. Reflection on this bears importantly on the relationship between silence and the perpetuation of self-harm, as well as on how breaking the silence around NSSI can bring opportunities for healing and recovery.

Sarah repeated several times throughout her interview that I was the only person she had ever shared her story of self-harm and recovery with and that 'it' (self-harm) wasn't something she talked about. She also recounted how the only other person she had ever told about her self-harm, a friend, had shamed her for her disclosure, resulting in her choosing not speak about her NSSI with anyone else afterwards, including any helping professionals.

Kalvin reflected several times on his fear of others knowing about his self-harm. He shared how his concerns about how others might perceive him if they knew resulted in him keeping his self-harm a secret, as well as shared a memory of a girl who did make her self-harm known or visible and how the silence and rejection she was met with increased his resolve both to recover, and also not let anyone find out about his NSSI. In his words,

> I saw this girl in the classroom, she had like horrible gashes on her arms…everyone felt really bad for her, they didn't really know how or like didn't even want to talk to her because it was just too serious of a problem.

Fleur iterated throughout her account the experience of not wanting to be known as a self- harmer, or in her words one of 'them.' She recounted keeping her scars secret in both action and word as well as shared explicitly that her self-harm was not something she talked about. Fleur reported she'd had a hard time even talking to herself about her self-harm, or acknowledging it:

> I'd been self-harming since I was about 17, but I never really talked about it, I never really admitted it, even to myself.

Fleur also echoed Kalvin's sentiment of there being a proverbial social silence around NSSI when she said, "no one really knows how to talk about it." Each of the participants in this study reflected in some capacity, either by naming the difficulty speaking about it, or by sharing their fear of what would happen if they did, that an association of shame around their self-harm lead to their silence around it.

This notion of self-harm and silence was even reflected in the way self-harm was spoken about in the research interviews themselves. Participants rarely named self-harm directly in their accounts. Instead they referred to NSSI or self-harm as "it," "that," "my problem," "my experience," or some other euphemistic, softened suggestion of NSSI. I myself had a version of

the experience of self-harm being a thing that could not be spoken about, when using auto-dictation software to transcribe the interviews. The software, without fail, almost every time corrected 'self-harm' as I'd spoken it to another set of less 'taboo' words, sell farm, self arm, etc., and I would have to go back and manually correct it to 'self-harm' for the transcript to be accurate. It seemed as though on every level there was not space, permission or the ability to name or speak about the thing that had taken up so much of our energy, time and life.

This matters. If self-harm is considered a physical manifestation of shame, as I have suggested, it will flourish in silence. As Brene Brown explains about shame, "If you put shame in a Petri dish, it needs three things to grow exponentially: secrecy, silence and judgment. If you put the same amount of shame in a Petri dish and douse it with empathy, it can't survive" (Brown, 2012). It seems, based on the data obtained from this study and the Master Themes of recovery that emerged, that the same may be true for NSSI. Almost all of my participants thanked me for giving them the space to talk about their experience with self-harm. Sarah told me it had helped her put it behind her, Ellie told me it had helped her better understand herself and gave her motivation to continue her recovery. Kalvin, Fleur and others reported that we need to be able to speak about self-harm to end the stigma around it and that doing so had been part of their motivation for participating in the study.

I would like to suggest, as a reflection on the culmination of the data obtained from this study, that like Brown suggests, the shame that feeds NSSI cannot survive being spoken to. The shame that feeds NSSI cannot thrive and is attenuated in an environment in which it is given the space and permission to be shared, and understood and empathized with. I shared reflections on my own experience with self-harm in part to support the stance that my participants called for: let's make it ok to talk about this. Let's create the space in our systems and communities speak to and empathize with the pain that gives rise to self-harm. That in itself can be healing.

3.6 Master Theme 3: Recovery from Self-Harm Through Living Beyond the Pain

3.6.1 Intro to Theme 3:

The third theme of recovery from youth NSSI, that emerged across participant accounts in this study, was that recovery from self-harm involved learning a way of being that made it possible to move past the 'moments of pain' that gave rise to the need to self-harm. Learning to live beyond and cope with intense moments of pain was achieved by participants in this study in various ways - by some through cognitive strategies, by others through emotional regulation strategies, by some through distraction, for others through activity, and for most a combination of these strategies. However, all participants noted that being able to actively create a shift in perspective in regards to the pain that propelled their NSSI, when the urge to self-harm arose, played an important part in their ability to recover.

3.6.2 Recovery, Breaking out of Tunnel Vision and Perspective Taking:

Almost all of the participants in this study reported feeling trapped at some point, either by their circumstances, their relationship with self-harm itself or their inability to escape from the scars or shame surrounding their self-harm. Their stories of recovery involved various forays into processes and learning that directly and indirectly allowed them to break out of this tunnel vision and conceive of ways of achieving stability and well-being through non-self harming means. The narratives of recovery I heard consistently involved individuals either directly initiating, or having the externally prompted experience, of shifting and expanding their mental set and perspective as part of healing from self-harm.

Sarah told a story of having conversations with friends, her mother and a professor that allowed her to take a step back from the situation that gave rise to her self-harm and consider that there were many ways to experience life, that she wasn't wrong or bad for being a certain way

and that if someone was causing her pain enough that she wanted to damage herself that, "no one should be worth more than what you are." She described her process of perspective taking and recovery, as having been supported by integrating useful perspectives from other people, as well as by looking to the possibilities contained in life as a whole. As I understood it, this increased her sense of feeling like she had options, and the belief that 'self-harm' was the only way to get her needs met and seek relief, no longer felt true for her. With this new cognitive set or perspective she was able to turn to other means to self-soothe and find stimulation, like art, meditation and career pursuits. In her words,

> I put different peoples examples and say like what would this person do? Like not everybody goes and self-harms so like why should I…life is like super big, we don't have to be…like we don't just have to hang onto one person for our happiness.

Kalvin reported engaging in a perspective taking practice as part of his healing process from self-harm as well that involved coming to some of the same conclusions as Sarah. He reported that part of his motivation to recover was the realization that life contained more than the painful moments he'd had and was experiencing, and that it contained more possibilities than he had even seen yet. As I understood it, this gave him a sense of freedom and hope and the desire to live beyond his moments of pain and towards a future he could take stock in. He shared that his motivation to recover from self-harm was spurned by,

> thinking of life you know…I guess just like experiencing life, seeing all these things and umm thinking about the future and how it would impact my future.…As I grew older I got more smarter and realized more about the world and realized more that this wasn't doing anything good for me.

Ellie further discussed using perspective taking around self-harm as well as shared the specific ways she did this, mainly through assessing short-term and long-term costs of self-harm,

and how this impacted her recovery process. In her words she recalled how she talked herself through urges to self-harm:

> if I can just make it through the present distress at least I wouldn't also have to deal with the cutting, that it's a quick fix strategy that yes it's really appealing and yes it really works, but it comes with a whole host of other problems that won't make me feel good in the long run.

In this way her self-harm was acknowledged for its function, but also held up against values of long term sustainability and functionality – a perspective in which the costs seem to outweigh the benefits and made self-harm seem less appealing and recovery more desirable.

The meaning that stood out to me from these narratives was that when people felt like they had more hopeful, expanded perspectives and a greater sense of options for having their needs met, the appeal of self-harm was diminished and recovery was made possible. Fleur said this explicitly herself when she told me, "just knowing that I had other options besides self-harming you know…like there are other ways to do it," made her recovery possible. In all of the preceding accounts the act of taking the self out of the present moment of pain, meta-cognitively, seemed to recurrently and powerfully allow participants to break out of tunnel vision, in which self-harm felt like their only option for relief, and adopt the perspective that hope and more functional options for support were real and that recovery was possible.

3.6.3 Intra-psychic Recovery Strategies:

While this section will be kept brief and then elaborated on in the discussion section, for the sake of avoiding repetition, I understood from the body of data that this study's participants offered, that a variety of intra-psychic strategies - cognitive, emotional, psychological and behavioural strategies – that were named either explicitly or at the descriptive level, facilitated healing from self-harm. Ellie and Jane, who of the participants had had the most experience with

counselling, named Dialectical Behavioural Therapy and mindfulness practices as supporting an increased ability to tolerate emotional pain and respond to it in non-self harming ways that supported their recovery from self-harm. Sarah and Fleur also reported using mindfulness strategies to create a sense of distance from their urges to self-harm and regroup in moments when it felt they were being trapped by the urge to self-harm.

Several participants also described processes reminiscent of mentalization - the ability to reflect upon and understand one's state of mind, and to have insight into what one is feeling and why - a process critical for emotional regulation, as having played an important part in their self-harm recovery process (Hoermann, Zupanick & Dombeck, 2013).

Fleur reported that in recovery her mindset was one characterized by increased mentalization (my words) and a tendency to reflect on her emotions more before responding. In her words,

> I do tend to think more about like behaviours and my reactions, like if I had a bad day and I feel like crap about myself I'd be able to say ok why was that?

Ellie echoed this idea that increased levels of mentalization supported recovery from self-harm. She reported that when she had been self-harming that it had been very hard to discern what she was feeling, her emotions felt, "like a big jumble" that she could untangle through self-harm. Through DBT however, Ellie reported an increased ability to,

> recognize what emotions were and be able to umm distinguish when it was sadness or anger or guilt umm really helped. I felt that I really didn't have an emotional vocabulary before or at least really poor one that was kind of just like good and bad.

As I understood it, Ellie's increased ability to understand her emotions, which was relieving in its own right, also lead to her ability to formulate more effective responses to her emotions, which was a critical factor in her healing from self-harm.

MBT, from which mentalization theory emerged, has demonstrated efficacy in supporting emotional regulation skill development. Given that increased mentalization capacity, in description, was echoed by my participants experientially as an important part of their recovery process, it can be concluded that MBT may offer skills that may support NSSI recovery, by increasing skills which promote the management of emotions that give rise to self-harm.

3.6.4 Recovery and Resolving the Self-Harm Identity:

Another important aspect of recovery and 'breaking out of tunnel vision,' as reported by participants in this study, was having the experience of no longer identifying with either their self-harm, or the circumstances that gave rise to it, as deterministic of who they were. As I understood it, almost all participants' recovery process involved an experience of taking perspective on who they were, which allowed them to create distance between themselves and their self-harm and motivated them chose non-self harming means to create alignment with their ideal self.

Jane described this process most accessibly when she recounted that, "recognizing that my thoughts weren't me, that my emotions weren't me…an acknowledgment of my emotions and my thoughts while also not identifying with them" helped her move away from a reliance on self-harm in order to cope. As I understood it, her experience of seeing her pain as in some ways separate from herself as a whole person allowed her to see herself as more resourced and capable. In this way, she increased her sense of resolve that she could deal with her distress in non-self harming means, as it was no longer who she was and how she coped.

Ellie recounted that in order to get the point where she considered herself recovered, that this also involved identity work. In her words,

> the scars fading really helped…it became a lot easier not to think that it was as much of my identity…like ok if they're fading like I can try to honour that and not make any fresh ones.

The fading of the physical embodiment of being harmed or scarred seemed to facilitate, for Ellie, the ability to recreate her identity on a psychological level. As such, she said that what helped maintain her recover was the identity affirmation and reformation that, "I'm not betraying myself my not being a cutter anymore." As I understood it, de-identifying with self-harm as something that explained or defined her, and finding new ways to understand herself, allowed her to break free from the trap that made self-harm feel like her only, or best option, for coping. She echoed this again when she shared, "the more distance I get the more I realize that it was not myself." Part of her recovery involved gradually strengthening her resolve in the idea that self-harm was not truly who she was. With this awareness it seemed she had the option to be an alternate, preferred version of herself, and this turned out to be someone who was in recovery from self-harm, and who loved and accepted herself for the totality of who she was.

Sydney and Fleur also both recounted taking time to figure out who they were and reflect on what they wanted for themselves, as an integral part of their self-harm healing and recovery process. These acts of 'sitting with the self' allowed them to chose ways of being that would allow them to align themselves with a more 'authentic and free' version of themselves, a version that did not include self-harm. This was done in part independently, and with the help of supportive others, as their narratives reflected.

3.6.5 Distancing and Distracting:

As part of the narratives of 'breaking out of tunnel vision' in order to recover from self-harm, each participant recounted some strategy or means they had for creating distance from their pain, and in some cases their self-harm itself. Sarah recounted using art and exercise as a way of channeling her energy and finding something to occupy her hands and body in a way that was not self-harming. Jane and Fleur reported that exercise played an important role in their recovery, by giving them an outlet for their energy and emotions, and an alternate source of endorphin release that was non-self harming, but still physical. Kalvin reported using drugs (type not specified) as an interim strategy for him to create distance from the urge to physically harm before he had fully recovered. Like Kalvin, Ellie also recounted an experience of using a substance, marijuana, to create distance from the emotional pain that fed into her self-harming behaviour. In her words,

> Marijuana has helped a lot as well, I've found that it's been the most effective and probably the only thing when I'm really distressed….if I can manage to smoke it will postpone the urge long enough that I will calm down and I will no longer feel the need to cut….it felt distanced, I felt like I was gaining distance from whatever was upsetting me, also from this really strong urge to take it out on myself.

Fleur reported how just being able to talk to someone, a close friend in particular, allowed her to separate herself from her pain and externalize her internal chaos, in a way that facilitated distance between herself and her emotions and increased her capacity to self regulate in non-harmful ways.

While there may be debatably healthier or more accessible ways of gaining 'distance' from one's suffering, whether it be through self generated psychological or physical means, perspective taking or substances, what stands out from these narratives, is that regardless of how it was achieved, *distance* held a repeatedly functional quality for participants in their process of

recovery from self-harm. I understood, from the meaning these individuals made of their recovery experience, being able to break free from the tunnel vision and sense of entrapment they felt in regards to their emotional life, moments of pain, and their relationship to self-harm itself, and find distance, perspective and options, allowed them meet the needs that NSSI was meeting in alternate ways and thus recover from self-harm.

3.6.6 Recovery and Leaning into Purpose and Joy:

The last expose under the theme of 'recovery and living beyond the pain,' came into focus when I attended to the parts of participants' accounts, which reflected an expanded perspective in the form of an exploration of meaning, purpose and joy. I understood that not only was their recovery facilitated by healing and gaining distance from the pain that perpetuated their self-harm, it was also facilitated and motivated by finding and leaning into experiences of joy and purpose. Participants described that immersing themselves in fulfilling hobbies, finding a community or work environment that encouraged and supported a sense of purpose and meaning, as well as using the meaning made from their experience with self-harm and recovery to actively help others, were key aspects of what encouraged them to recover and maintain their recovery.

Ellie told me how she found a sense of solidarity, and value in her experience and struggle with NSSI when she began researching self-harm herself. While she reported that doing this was incredibly challenging, and even triggering at times, it motivated her to see her identity as that of someone who was recovered, and help others find that too. As I understood it, this gave her recovery an added layer of meaning and motivated her to maintain her recovery.

Jane explicitly reflected in her narrative that cultivating joy and purpose facilitated her recovery from self-harm. She shared, "self-harm is not the only way to manage all of these things and recognizing that to go beyond avoiding pain and to seeking joy" was part of her healing journey.

Sarah echoed the idea that part of her healing experience was opening herself up to joy and new possibilities, realizing that "life is big" and that there will be many more people and experiences which she can connect to. As I understood it, this realization allowed her to release the feeling of being trapped by the pain of her bad relationship, see it as just one relationship, and thus relinquish her relationship with the self-harm that had grown in the context of it.

Fleur also expressed that part of what gave her resolve and motivated her sustained recovery from self-harm, was a desire to help others, to end the stigma around self-harm, as well as to intentionally approach people she encountered in her life with the empathy and understanding that she knew had helped her heal. As I understood it, she was able to transform her struggle with self-harm, as well as what she had learned through recovery, into a sense of purpose and an opportunity to support others struggling with recovery from self-harm.

These participant accounts and the meaning made, that leaning into purpose and joy was part of what facilitated and sustained recovery from NSSI, maps onto some of the core tenets of positive psychology. Park and Peterson (2008, p.87) aptly summarize the paradigm of positive psychology as, "a scientific approach to studying human thoughts, feelings, and behavior with a focus on strengths instead of weakness, building the good in life instead of repairing the bad, and taking the lives of average people up to "great" instead of focusing solely on moving those who are struggling up to 'normal.' " I came to understand, in the way my participants echoed the tenets of a field of psychology that has made significant contribution to the practice and study of wellbeing, that it is important to remember that healing from a relationship with self-harm involves not only repairing the negative, but attending to sources of joy, strength and meaning. This is a process of cultivating a life in which pain has less room to exist and can be mitigated by the valued aspects of one's life as a whole (Park & Peterson, 2008). This idea transitions well into the last theme of recovery, which is that healing from self-harm is a holistic process that involves healing the self as a whole, not just healing a series of discrete dysfunctions.

3.7 Master Theme 4: The Gestalt of Recovery

3.7.1 Healing Self-harm the Product of Healing the Whole Person:

In the course of Jane's narrative, she said something that helped me hone in on something that every participant seemed to be saying about recovery from self-harm. Healing from self-harm wasn't just about healing the self-harm. It was about healing their relationship with themselves in the totality of who they were and wanted to be. Jane described that in her process of recovery from NSSI she,

> healed from all the things, all the self destructive things, I don't think I went through a recovery process that was specific to the self-harm.

This statement was echoed implicitly and explicitly in the other narratives as well – that recovery from NSSI wasn't just about stopping the cutting, the burning, the pinching or the banging, and it wasn't just about connection received or being mentally healthy now or in the future – it was about all of these things. It was a sum that was greater than its parts. Recovery from self-harm took time, patience, and an appreciation of things changing in all the wounded and yet to be fulfilled aspects of their lives. It was not merely a choice, but rather a process, a holistic process, and it could not be forced. As Sarah put it, "you just can't change your mind in a day, you know it's like it's not a bot." Recovery was a process of learning new ways to be with oneself, in identity and emotion. In Ellie's words healing was an experience that involved, "more of a curiosity about myself and a willingness to tolerate more distress and knowing that it's going to be ok." It was a process of learning new way of being with oneself now, and continuously. This sometimes occurred in an active fashion, with statements like, "recovery is always ongoing you know it's like a battle, usually every day" as understood by Fleur, and sometimes in a passive one of experiencing life and trusting in its resolve, as Kalvin understood, "it's not about if you're going to stop, it's about when."

I presented this theme to close the findings of this study, with the emphasis as I have come to understand it through my participants' experiences, that recovery from self-harm is not just about healing from the physical harm as cutting, banging or burning. Through my participants' meaning making in regards to youth NSSI and recovery, I have come to understand self-harm as an understandable response to a host of interacting internal and external dysregulations that produce a state of pain, that in the absence of other coping means, can be resolved through intentional, self-directed physical injury. Self-harm can be understood as underscored by a web of interacting internal, external, socio-environmental and developmental factors. Thus recovery will be best addressed with a similarly holistic approach that gives people the means to reliably meet the needs that they were meeting through self-harm. Whether this be through - as the individuals who participated in this study corroborated - understanding, connection to self and others, healing shame, finding purpose and taking oneself beyond moments of pain, or a combination of all of these factors, each person undertaking the process of recover from self-harm seems to know what they need, if we just learn to ask.

Chapter 4: Discussion

4.1 Summary:

The intent of this study was to draw on phenomenological accounts of young adults' lived experiences of recovery from youth Non-Suicidal Self-Injury. It was my hope that insights derived from the personal meaning making of the individuals that participated in this study could add valuable insight into the question, "What do young adults who identify as in recovery from youth self-harm, understand to have facilitated their recovery or made it possible?" I received many answers, thoughts and ideas. Some answers pertained to what had clearly helped my participants themselves recover, and some ideas were offered in regards to what participants believed were needed for anyone in their position to be able to recover from NSSI. While there were idiographic differences in terms of the surface content of each recoverer's narrative of recovery from self-harm, there was also collective meaning made, which emerged by way of the Master Themes of Recovery that were present on some level in all accounts offered.

What the youth I interviewed collectively told me, as I understood it, was that supportive, reliable, non-judgmental, and empathic connection received, that made them feel understood and accepted, played a critical role in their healing from youth NSSI. Connection Received thus became the most predominant Master Theme of Recovery from youth NSSI. The narrative accounts from this study's also supported the Master Themes of Healing Shame, learning to live and see beyond moments of intense pain and healing holistically in mind, body and identity, as that which facilitated recovery from youth NSSI. The individuals I interviewed also all iterated that self-harm is a coping tool, and that it works or is functional. While my participants also acknowledged that it may not be the best coping tool, many of them reporting having wanted to stop self-harming or recover as soon as they had started, they also all expressed the importance of having self-harm be understood for what it was by others, on their terms. Self-harm was

understood as being a means through which to have needs met, whether that be needs for emotional regulation, control and power, expressing pain, shame and guilt to others, and for mitigating that same pain, shame and guilt for themselves.

I will now elaborate on the ways the Master Themes generated by this study, can offer insight into ways helping professionals, allies and those struggling with self-harm themselves, can address the needs self-harm meets, in alternate ways that will facilitate healing from the emotional, cognitive and behavioural roots of NSSI. I situated my findings in relevant contextualizing literature as I went so that I can now turn in this discussion section to literature on approaches matched to the themes this study's participants named as having been critical to their recovery process. Currently, there are therapeutic modalities, models and research being done on what were named as the core mechanisms or themes of recovery from self-harm in this study – Connection, Shame, Cognitive Flexibility, and Trauma Informed Practice (which I will suggest addresses the holistic aspect of healing). I would like to suggest, upon this basis, that the following approaches and ideas may prove useful in working in a professional, or social support capacity, to facilitate self-harm recovery for youth affected by NSSI.

4.2 Therapeutic Implications of the Theme of Recovery and Connection Received:

As human beings, with a socio-evolutionarily informed need for belonging and connection - the absence of which can literally be compared on a biological level to the pain of the threat of death – it makes sense that repairing disrupted experiences of connection facilitated healing from self-harm (Neff & Germer, 2013). For the participants in this study, receiving connection underscored by qualities of unconditional support, empathy and reliability, corresponded to increases in wellbeing and a felt ability to better self-regulate as well as decreases in desires to punish and control the self through self-harming means. Connection

received allowed participants to have a vital need for belonging and mirroring met directly - the need for connection being met through connection - instead of indirectly through self-harm.

Based on this insight, it seems what we must ask ourselves as counselling practitioners and helping professionals is, "how do we facilitate and extend connection and assist those struggling with NSSI to have their needs for connection met in direct and reliable ways?" As practitioners I believed this is a call to look within ourselves and assess our own barriers to connection and assist those we intend to help with self-harm recovery to do the same.

The concept that connection is a fundamental component not only of personal wellbeing, but also of client change in therapy, has been emphasized and documented by Common Factors work for decades (Duncan, 2002). Common Factors (CF) theory, which Laska, Gurman & Wampold (2014) argue can be considered an evidence based practice, is derived from meta-analytical and comparative studies across varying therapeutic modalities (Duncan, 2002). CF theory suggests that the therapeutic relationship (in essence the experience of connection) is more deterministic of client change and wellbeing than technique or intervention (Imel & Wampold, 2008). Lambert's (1992) work suggested that the therapeutic relationship, which is considered a common factor as it is something present across counselling paradigms, is responsible for roughly 30% of client wellbeing outcomes. Imel & Wampold's (2008) review suggested the therapeutic relationship is responsible 30-70% of client change and Laska, Gurman & Wampold (2014) broke down this common factor into its sub-parts to conclude that variance in therapeutic outcomes was attributed 11.5% of the time to the presence of consensus between therapist and client and an experience of collaboration, 9% to empathy, 6.3% to positive regard, and 5.7% to the client experiencing congruence and genuineness from the therapist. According to their review, treatment method accounted for only 1% of outcome variance in successful therapeutic treatment (Laska, Gurman & Wampold 2014).

What the sum of the above findings suggest, in alignment with the conclusions related to the theme of connection received and NSSI recovery as generated by participants in this study, is that if we as helping professionals spent more energy investing in the therapeutic alliance and facilitating experiences of authentic connection, as opposed to perfecting a method guaranteed to treat self-harm, we might more reliably be able to offer our clients what they need to help heal from NSSI – empathic connection.

In terms of supporting individuals with recovery from NSSI, through increasing their access to a higher quality and quantity of the connective experiences that were suggested in this study to support recovery, this may involve having explicit conversations about attachment patterns, needs and interpersonal communication styles. It may involve having practical conversations with our clients about ways to increase access to and availability of effectively supportive others. Intentional conversations with clients, that encourage them to explore their understanding of healthy support, as well as teaching emotional awareness skills - in terms of having clients learn to check in with themselves about when they know and feel they are receiving supportive connection - could also support this endeavour of increasing client's access to the type of connective experiences that facilitate recovery. DBT's program on Interpersonal Effectiveness comes to mind at the level of assisting participants with finding, repairing or maintaining supportive bonds that are underscored by respect and need fulfillment and that could support self-harm recovery (Linehan & Wilks, 2015).

4.3 The Case for Addiction-Based Approaches to Self-Harm Recovery:

Given the number of participants in this study that spoke to and understood their relationship to self-harm as one of addiction, it seems fitting, in line with advocating for treatment approaches informed by participants meaning making, to consider strategies which are effective for addictions recovery when approaching self-harm treatment. Further research would need to be

done to determine the exact clinical utility of using specific addiction models to treat those who experience their NSSI 'as an addiction ' although there exists an addiction model of NSSI, which has some emergent empirical basis (Victor, Glenn & Klonsky, 2012). Based simply on the matching of constructs and findings from this study - in terms of participants understanding their NSSI as an addiction - to a successful addiction treatment model, I would like to suggest that Motivational Interviewing (MI), if done with a high level of empathy, may prove useful for initiating recovery motivation in those wanting to decrease their coping reliance on self-harm (Prochaska & DiClemente, 1983).

MI, an evidence based practice with documented efficacy in the attenuation of substance addictions, helps individuals explore reasons to stop engaging in a practice that is self-destructive, but that also involves physiologically pleasurable or psychologically beneficial experiences and thus can be difficult to recover from (Prochaska & DiClemente, 1983). MI can help participants articulate the costs and benefits of changing or not changing, help ascertain what needs their addiction behaviour meets and alternate ways to meet such needs, as well as highlight discrepancies between how their current behaviour is in conflict with important values or goals they have for themselves (Prochaska, DiClemente & Norcross, 1992). In this way MI can enhance individuals' motivation to change otherwise difficult to attenuate habitual behaviours or addictions (Magill et al., 2017; Prochaska, DiClemente & Norcross, 1992).

Given that participants in this study articulated weighing costs and benefits, as well as contemplating important identity issues and future aspirations as part of their recovery process, MI could assist participants, in an intentional way, to do what many already reported was helpful in facilitating healing from NSSI. Further researcher would be needed to determine the specific modifications or adaptations needed for a model of MI that supported working with NSSI recovery within an addictions framework.

4.4 NSSI Recovery as Supported by Shame Resilience Theory:

Shame, or the self as bad, and related experiences of guilt, self-hate and disconnect, were states articulated by participants in this study as playing an important part in the initiation and maintenance of their self-harm. Attenuation or healing of these shame states and experiences were, inversely, repeatedly recounted as supporting a process of recovery from self-harm. I have understood from engaging with my participants and their accounts, that recognizing and working intentionally, openly and patiently with the shame and its manifestations that underscore NSSI, can be an important means through which to support youth recovery from self-harm.

Brene Brown (2006) has spent the past decade researching shame, resulting in the development of Shame Resilience Theory (SRT). While SRT does not translate into a counselling model explicitly, it does have recommendations for practice and healing shame that match the needs articulated by the participants in the study in terms of healing shame in order to facilitate recovery from NSSI.

Brown (2006) in her paper, *Shame Resilience Theory: A Grounded Theory Study on Women and Shame*, proposed and defined Shame Resilience Theory, as well as named and substantiated the core features of shame as an experience. The core features of shame Brown identified from her study were feelings and experiences of isolation, entrapment and powerlessness. These feelings and experiences were, to an uncanny degree, the same shared experiences and feelings that were iterated across participant accounts in my study in terms of the states which had initiated and maintained participant's relationship with NSSI – isolation, disconnect, tunnel vision, and powerlessness. In Brown's (2006, p.46) analysis she concluded that shame is best described as a web of, "layered, conflicting and competing expectations that are the product of rigid socio-cultural expectations," at the centre of which are deeply painful, "feelings of being trapped powerless and isolated." The similarity between the constructs Brown

generated in her shame study and the themes generated in my study in regards to NSSI recovery, can be seen as giving support to my theory that NSSI can be described as shame embodied, or a behavioural manifestation of shame.

Brown (2006) explicated SRT in language and terms that in many ways are reminiscent of the accounts of self-harm harm offered by my study's participants. In Brown's (2006, p.46) words,

> the concept of a shame web illustrates how options are limited and expectations are far reaching, re-enforced at every turn and woven through numerous experiences and relationships…participants often found themselves in situations where feeling trapped was inevitable; the shame web entangled them with unattainable expectations or multiple conflicting expectations that could not be simultaneously met; therefore, connections had to be severed or forfeited.

Brown's analysis of the manifestations and felt experience of shame not only offers experiential accounts that map onto the experiential antecedents of NSSI as understood by participants in my study, but SRT which she developed, also offers an explication of factors that support shame resilience and wellness. These factors, in the terms I have come to understand shame and NSSI, may prove useful in therapeutic application to healing the shame that may underpin self-harm.

According to Brown (2006, p. 47) and SRT, "shame resilience is best understood on a continuum that represents on one end the main concerns of participants; feeling trapped, powerless and isolated… [and] on the opposite end of the continuum the concepts participants viewed as the components of shame resilience: empathy, connection, power and freedom." Brown (2006, p. 47) goes on to explain that her research participants, "clearly identified 'experiencing empathy' as the opposite of 'experiencing shame' – empathy being the experience of having an other see, hear and feel your unique life-word and communicate understanding and

acceptance of it. Brown's description of the qualities that promote shame resilience are highly reminiscent of the qualities of supportive connection that participants in my study reported as having played an impactful role in facilitating their recovery from NSSI.

According to Brown (2006, p. 51) the sum of shame resilience and the goals for therapeutic practice when working on shame related issues are having clients, "identify personal vulnerabilities, increase critical awareness of their shame web, develop mutually empathic relationships that allow them to reach out to others, and learn to speak to shame." Brown says developing shame resilience, given that shame's antidote is empathy, is best done in relationship, but states this can only be done with reliably supportive others in whom we have confidence that our needs will be met with understanding. Brown (2006) thus recommends support groups, individual work as well as public psycho-educational work in order to increase individuals' access to such others who can hold space for vulnerability.

These constructs for healing shame, proposed by Brene Brown, are in many ways what participants already told me repeatedly throughout this study were the experiences that helped them heal from self-harm – connection received, reciprocal extension of care, healing shame through understanding and self-acceptance, breaking out of tunnel vision, and being able to speak about their self-harm experiences. Brown's (2006) approach as it reflects a continuum of needs that shame points to, the deficits that occur in their absence as well as ways to meet them, also corresponds to what participants in this study spoke to about having their self-harm be approached and understood for the needs that it meets, and in the course of recovery finding other ways to meet them.

I would like to recommend, based on the already apparent overlap between the findings of this study and those that lead to the development of SRT, that an application of SRT to the facilitation of recovery from NSSI could be an important future research endeavour. It could be

useful to substantiate and confirm the clinical efficacy of working with self-harm recovery from a shame resilience perspective, with youth specifically, in order to integrate SRT as a potential therapeutic approach for youth NSSI treatment.

4.5 NSSI Recovery and Self-Compassion Practice:

Learning to approach the self and one's thoughts and emotions with kindness, care and understanding were named, both in description and explicitly, by participants in this study as being a key part of their recovery process from NSSI. Kristin Neff (2003), Self-Compassion researcher and developer of the MSC (Mindful Self-Compassion) program - a therapeutic modality that teaches self-compassion skills and practice to assist individuals with a variety of mental health concern - "proposes that self-compassion involves being touched by one's own suffering, generating the desire to alleviate one's suffering and treat oneself with understanding and concern" (p.86).

Self-compassion is essentially empathy turned inwards, offered by the self for the self. Given that empathy is thought to promote states of emotional regulation and shame-resilience, while a deficit of emotional regulation capacities and high levels of shame are proposed to underscore self-harm, based on the present study's findings, self-compassion practice may prove useful in assisting individuals in recovery from self-harm by promoting capacities which encourage self-regulation through non-harming means (Brown, 2006; Neff & Germer, 2013).

According to Neff & Germer (2013, p. 28), "self-compassion comprises three interacting components: self-kindness versus self-judgment, a sense of common humanity versus isolation, and mindfulness versus over-identification when confronting painful self-relevant thoughts and emotions." The three components of self-compassion are at each turn reminiscent of themes of recovery from self-harm as articulated by participants in this study - self-acceptance and healing

shame, connection received, and breaking out of tunnel vision, respectively. The type of mindfulness that is required for self-compassionate practice, is nuanced from a general stance of present moment awareness and acceptance, and involves specifically attending, with balanced awareness to the negative thoughts and feelings involved in one's suffering (Neff & Germer, 2013). While self-compassion theory, and its related therapeutic modality MSC, is presented as a stand-alone potential intervention for NSSI recovery - based on the ways in which MSC matches and supports experiences that were understood to support recovery from NSSI by participants in this study - self-compassion could also arguably be considered a strategy of cognitive flexibility, as is requires new, intentional re-appraisals of one's experience and state of mind.

Self-compassion has furthermore been evidenced as being an important mediator among emotional dysregulation and resilience in response to trauma, with higher levels of self-compassion being directly correlated with reduced negative trauma appraisals and emotion regulation difficulties (Barlow, Turow & Gerhart, 2017; Scoglio et al., 2015). Neff and Germer's (2013, p.28) Mindful Self-Compassion program is reportedly, "effective at enhancing self compassion, mindfulness and well being" at both 6 month and 1 year follow ups. Self-Compassion practice is evidenced to address both the underlying proponents of NSSI - shame and emotional dysregulation - as iterated by participants in this study as well as to provide explicit training on skills and ways of approaching the self that participants reported played an important role in facilitating their self-harm recovery. While research into the specifics of using self-compassion training with youth self-harmers, to facilitate recovery, is needed, MSC training to assist with NSSI recovery, looks promising from a theoretical and experiential standpoint.

4.6 NSSI Recovery and Cognitive Flexibility:

A discussion on increasing cognitive flexibility in order to support NSSI recovery is offered in response to participants' accounts that iterated that 'breaking out of tunnel vision' and

'increasing their perspective on their suffering' was an important aspect of their self-harm recovery process. As defined by Rende (2000), Cognitive flexibility (CF) is one component of executive functioning that refers to the ability to freely shift cognitive sets to perceive or respond to situations in different ways, such as by generating multiple ideas, switching between different classes of knowledge, and inhibiting habitual responses in favor of alternative responses when required by changing environmental circumstances. Participants in this study reported: seeing beyond and detaching or distracting from acute moments of pain; mindfully attending to and naming thoughts and feelings involved in their suffering; turning to mental states they ascribed to their ideal or future self; imagining how others would respond their situation or how they would talk to a friend in their circumstances, as tactics drawn upon in the course of recovery to facilitate NSSI cessation. These are all examples of cognitive flexibility. These tactics gave participants the feeling of options, power, self-worth and reduced the trapped feeling that often produced or compounded the urge to self-harm and thus were an important part of what made their recovery from NSSI possible.

Cognitive Flexibility involves exposing the mind to and learning a diversity of ways of experiencing and thinking about one's thoughts, feelings, behaviour and the world (Rende, 2000). Participants in this study named various cognitive strategies that they used, some informal (perspective taking, present vs. future assessments, weighing costs and benefits, putting themselves in others shoes) and others based directly in cognitively focused schools of psychotherapy (DBT, CBT, mindfulness and acceptance based training), as part what facilitated their recovery from self-harm. Based on the findings of this study, I propose that therapeutic strategies that promote cognitive flexibility, namely those that give individuals an increased range of options for responding to internally and externally threatening stimuli, should pose useful for assisting youth with recovery from NSSI. I chose the term cognitive flexibility, for my recommendation, over one particular version of cognitive based therapy/support as there was not

an overall consensus, by any standard from participants in this study, in regards to one particular cognitive strategy being more helpful compared to another in assisting with recovery from self-harm. A more general, all encompassing term for the cognitive based strategies that may support NSSI recovery was thus chosen reflect the idea that these strategies should be based in and matched to individuals' understanding of themselves and the function their NSSI serves. Such CF strategies will thus be best matched to participants on a case by case basis.

4.7 NSSI Recovery and Trauma Informed Practice:

My final recommendation for practice supporting youth NSSI recovery, based on the findings of this study - based more specifically on the call my participants made for us as helping professionals to understand self-harm for the functional, understandable behaviour that it is experienced as - is a therapeutic model and approach whose foundational paradigm is understanding the function and context of behaviour and distress. I would like to advocate for the benefit of approaching NSSI treatment through a Trauma Informed Practice (TIP) framework. I make this recommendation on the basis that TIP's underlying principles map onto the NSSI healing factors reiterated by participants in this study, and also on the basis that NSSI, as was reflected across accounts from this study, may itself be a reaction to lived trauma experiences and thus best supported through a trauma specific approach.

Trauma Informed Practice, as substantiated by the Trauma Informed Practice Guide (TIP, 2013) is not a specific treatment strategy or method, but rather a way of approaching and being in a helping or therapeutic relationship. TIP does not necessitate disclosure of a trauma, and TIP services are provided in a way that prioritize client's emotional and physical safety, relying on harm reduction strategies for behavioural or substances concerns, and prioritizing individual's needs for choice and control at all levels of service delivery and treatment planning (TIP, 2013, p. 16). Trauma informed approaches seek to facilitate understanding for any behaviours contributing

to distress or that destabilize safety, and consider all coping efforts to be contextually understandable adaptations and responses that reflect an attempt on the part of the individual to functionally take care of themselves the best they can with the resources available to them.

To approach NSSI treatment and recovery from this perspective would be to, in a non-shaming or blaming way, approach self-harm as an understandable, functional response to distress in the absence of effective internal coping resources or external allies. NSSI recovery, from this approach, would be treated in a collaborative way that ensured an individual's *choice* and *agency* were respected throughout treatment. Choice and agency were two things those who participated in this study iterated were lacking in their life at the time they were self-harming. Therapy that intentionally and collaboratively increased participants' access to these experiences could have a reparative and regulating effect on 'recoverers' as TIP would highlight the needs being met through self-harm, while encouraging emotionally and physically safer, alternate means of having those needs met. TIP (2013) is also a strengths based approach that encourages individuals identification with the strengths present in their struggles, and also teaches skills for recognizing triggers, calming, centering, and staying present.

Based on the above discussion, it can be concluded that a TIP approach to youth NSSI recovery treatment would address the core features of self-harm recovery as they emerged from the themes in this study. Trauma informed NSSI treatment would reflect a collaborative, empathic approach that would match the theme from this study of empathic connection received as supporting NSSI recovery. Such treatment would also embody the principles of non-shaming, de-stigmatization and cultivating acceptance that would match this study's finding that healing shame reliably facilitates youth NSSI recovery. Trauma informed NSSI treatment would also teaching skills for coping, resilience and grounding, that would match the theme generated by this study that recovery is facilitated by enhancing cognitive flexibility and breaking out of tunnel vision. Trauma Informed Practice has guidelines informed by practice and research that could be

easily layered over other models of care. This would make TIP an adaptable and versatile approach for supporting the core features and processes of recovery from NSSI as described in this study.

4.8 Study Limitations:

As with any interpretive, phenomenological and qualitative research, it must be acknowledged that this study does not purport to be able to address causality or to make generalizable claims about the data presented. While repeated presence of an experience or theme across participants accounts within IPA, can suggest understanding and findings that my be applicable to others who share similar lived experiences (youth NSSI), it stands that such claims have not been verified by randomization or control, or by accounting for all confounds, and thus would not be considered 'generalizable' from a positivistic paradigm (Smith, Flower & Larkin, 2009).

I also acknowledge that while the study population was homogenous in terms of meeting the study criteria, the participants in this study did come from a variety of backgrounds and have various levels of experience thinking and talking about self-harm and with self-harm itself. As a result certain narratives were richer, or more accessible in meaning, and those tended to the be ones that were drawn on more heavily as they clearly and explicitly spoke to emergent themes with less interpretation on my part – thus in a way that stayed as close as possible to my participants meaning making. Furthermore, as IPA asks participants to generate meaning mainly of their own accord, with as little researcher influence as possible, and the use of open-ended question based interview scripts, this type of research tends to result in findings developed from meaning made by individuals with a high self-reflective capacity (Smith, Flowers & Larkin, 2009). Thus it must be acknowledged that the findings from this study may not be as useful for

supporting recovery for individuals who do not have or have not yet developed a relatively high capacity for self-reflection and meaning making.

Another potential limitation of this study was its non-specification of gender in its inclusion and exclusion criteria. In an attempt to extract a sample that was homogenous solely in terms of NSSI specified criteria, gender was not given explicit consideration as an inclusion criterion. Thus there was a disparity of gender, with a higher proportion of females to males in this study (5:1). While this is not conclusively problematic, and can be considered representational of the self-harming population, which is predominantly female, the lack of males in this study may make it difficult to know if different themes would have emerged with a larger male participant basis (Muehlenkamp et al., 2012). Gendered implications on recovery mechanisms involved in self-harm may thus be a useful avenue of further study.

I must also acknowledge that my role as a researcher and interpreter played a role in the data that emerged. While this is an understood and appreciated part of IPA, and while I did my best to 'bracket' my personal and professional assumptions while engaging with the data, another researcher could have interpreted the findings differently.

Despite these limitations, which could be addressed in future research, this study allowed for an in depth examination of first-hand lived experiences of understanding and meaning made in regards to youth NSSI and recovery. This process resulted in the generation of themes and insight that was deemed meaningful and accurate to the participants from this study and to myself as a researcher, as confirmed by this study's participant check. Furthermore, the meaning made and Master Themes generated by this study spoke to and supported ideas from current therapeutic developments and research in the field of self-harm recovery, shame resilience, self-compassion and trauma informed practice - applications of which may prove useful in future treatment endeavours for youth NSSI.

4.9 Recommended Future Directions in NSSI Recovery Research and Support:

Based on the findings from this study, two recommendations for future directions in youth NSSI recovery research and practice seem fitting. My recommendation for future NSSI treatment research would be to study the therapeutic approaches that aligned functionally and theoretically with themes of recovery from this study, in the context of youth and NSSI recovery, directly. Such research would involve conducting studies on the impact of Shame Resilience Training, MI, MSC Training or Trauma Informed Practice on NSSI recovery treatment with self-harming youth to ascertain if the conclusions about self-harm recovery mechanisms generated by this study could be supported more broadly and clinically.

My second recommendation for future approaches to youth NSSI treatment, based on my participants' accounts and the themes of shame, silence and disconnect that emerged in regards to NSSI maintenance, is a call to action to de-stigmatize speaking about self-harm. NSSI, as I have understood it from the data generated by my participants, is a coping mechanism that flourishes in and is compounded by silence, dismissal and shame (Brown, 2006). Based on the available literature on Shame Resilience and the NSSI recovery accounts offered by this study's participants, there is much evidence to support the value of having supportive, non-judgmental dialogues rooted in understanding NSSI, as way to advance the field, study and treatment of self-harm recovery. These dialogues could be supported at the one-on-one, professional therapeutic level, through psycho-educational groups that teach about emotional regulation and stress responding, or by increasing public awareness about effective emotional regulation and tolerance. Opening the dialogue about self-harm and emotional coping, and building a culture of acceptance and understanding in our communities, mental health organizations, and in particular our school and family systems – the contexts in which youth NSSI first emerge– could create space to attend to the experience of shame and disconnect that each individual reported played a role in their NSSI, in functional healthy ways that supports recovery from self-harm.

Chapter 5: Conclusion

The findings of this study suggest that, not only to do youth who identify as recovered from NSSI have insight and understanding into their relationship with self-harm and the factors that supported their recovery, they also suggest that this understanding is underscored by common or shared themes of experience. These Master Themes, which indicate shared narratives and experiences of recovery, may have according to IPA, implications to the treatment of self-harm recovery in cases beyond those studied (Smith, Flower & Larkin, 2009).

The meaning made by my 6 participants in regards to the question, *what facilitates recovery from youth self-harm?* resulted in common narrative threads that spoke to connection received, healing shame, breaking out of tunnel vision and a gestalt of healing as being key components of what made recovery from youth self-harm possible. Recent and developing therapeutic approaches and theory exist, that address the Master Themes of recovery that emerged across this data set. I have suggested these therapeutic modalities could be of use in working with youth to better support NSSI recovery. While research would need to be done into the specifics of using these approaches in a youth, as well as NSSI specific context, based on the findings of this study, I have understood that approaches which prioritize authentic, empathic connection, hold a shame resilience paradigm, and increase cognitive flexibility, as well as Motivational Interviewing, Mindful Self-Compassion Training, and Trauma Informed Practices modalities, may hold important value for better facilitating youth self-harm recovery.

Regardless of whether the answers to the question, "what do young adults in recovery from youth self harm understand to have facilitated their recovery?" generated by this study are *the* answers, or will be applicable to *all* youth struggling to heal from NSSI, they are answers that mattered to six individuals from a breadth of life backgrounds and circumstances. They are

answers that reflect commendable efforts made by six courageous young adults to make sense of an enduringly painful phenomenon, one that many felt was hard to talk about.

The themes generated by this study, in terms of what best facilitates recovery from youth self-harm, do not suggest clearly delineated protocols or highly specialized techniques and interventions are needed to facilitate recovery from NSSI. Instead, the themes of recovery from NSSI in this study represent calls for genuine, supportive connection, and for understanding and empathy that allows for the fundamental and basic human needs for belonging, mattering, validation and acceptance to be met. They are calls to heal deeply painful, yet understandable experiences of shame, guilt, emotional disorganization, and self-worth and identity dissonance that give rise to NSSI. They are calls to see self-harm not as a purely behavioural disturbance, but as an understandable, even functional and adaptive response to an interacting web of emotional and situational distresses, that in turn can be healed when the person is addressed holistically and in context.

The individuals who participated in this study offered narratives of great distress and pain, but also of great hope and strength. They offered stories of healing from NSSI through the support of their own personal development and care and through that of friends, partners, parents and therapists. I was renewed in my conviction and purpose in this work through engaging with their life stories and the meaning making they offered. It seems clear that those struggling with NSSI often know what they need to recover and are often not able to access it because of their circumstances and the social systems in which they operate. It is my urging that we take heed of the insight and understanding offered by Sarah, Kalvin, Ellie, Fleur, Sydney, and Jane and create, as mental health professionals and allies, opportunities for education about NSSI and healing experiences characterized by breaking down barriers to connection, healing shame and promoting self-compassion. For these were the experiences and mechanisms of change that were understood, time and time again, to support and make recovery from youth NSSI possible.

References:

Austin, S. (2016). Working with chronic and relentless self-hatred, self-harm, and existential shame: A clinical study and reflections (Paper 2 of 2). *Journal of Analytical Psychology, 61*(4), 411-433. doi:10.1111/1468-5922.12241

Barlow, M. R., Turow, R. E., & Gerhart, J. (2017). Trauma appraisals, emotion regulation difficulties, and self-compassion predict posttraumatic stress symptoms following childhood abuse. *Child Abuse & Neglect, 65*, 37-47. doi:10.1016/j.chiabu.2017.01.006

Barrocas, A. L., Giletta, M., Hankin, B. L., Prinstein, M. J., & Abela, J. R. (2014). Nonsuicidal Self-Injury in Adolescence: Longitudinal Course, Trajectories, and Intrapersonal Predictors. *Journal of Abnormal Child Psychology, 43*(2), 369-380. doi:10.1007/s10802-014-9895-4

Bateman, A., & Fonagy P. (2006). *Mentalization-based treatment for borderline personality disorder:A practical guide.* Oxford: Oxford University Press.

BC Provincial Mental Health and Substance Use Planning Council, TIP Project Team. (2013).*Trauma Informed Practice Guide* [Press release]. Retrieved from http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Bleiberg, E., Rossouw, T., & Fonagy, P. (2012) *Adolescent breakdown and emerging borderline personality disorder,* in Eds. Bateman & Fonagy, Handbook of mentalizing in mental health practice. 463 – 510. American Psychiatric publishing, Washington.

Brent, D. A., Mcmakin, D. L., Kennard, B. D., Goldstein, T. R., Mayes, T. L., & Douaihy, A. B. (2013). Protecting Adolescents From Self-Harm: A Critical Review of Intervention Studies. *Journal of the American Academy of Child & Adolescent Psychiatry, 52*(12), 1260-1271. doi:10.1016

Brown, B. (2006). Shame Resilience Theory: A Grounded Theory Study on Women and Shame. *Families in Society: The Journal of Contemporary Social Services, 87*(1), 43-52. doi:10.1606/1044-3894.3483

Brown, B. (Writer). (2012, March). *TEDx Listening to Shame* [Video file]. Retrieved from https://www.youtube.com/watch?v=psN1DORYYV0

Cassidy, J., & Shaver, P. R. (1999). *Handbook of attachment: Theory, research, and clinical applications*. New York: Guilford Press.

Chapman, A., Kuo, J., Linehan, M., Lynch, T., & Rosenthal, Z. (2006). Mechanisms of Change in Dialectical Behavior Therapy: Theoretical and Empirical Observations. *Journal of Clinical Psychology, 62*(4), 459-480.

Cohen, D., & Crabtree, B. (2006). Qualitative Research Guidelines Project. Retrieved from http://www.qualres.org/

Connors, R. (1996a). Self-injury in trauma survivors: 1. Functions and meanings. *American Journal of Orthopsychiatry, 66*, 197–206. doi: 10.1037/h0080171

Creswell, J. W. (2007). Qualitative inquiry and research design: Choosing among five approaches (2nd ed.). Thousand Oaks, CA: Sage Publications.

Csorba, J., Dinya, E., Plener, P. Nagy, E., Pali, E. Clinical diagnoses, characteristics of risk behaviour, differences between suicidal and non-suicidal subgroups of Hungarian adolescent outpatients practising self-injury. *European Child & Adolescent Psychiatry* (2009) 18:5 309- 320. doi:10.1007/s00787-008-0733-5

Duncan, B. (2012) The founder of common factors: a conversation with Saul Rosenzweig. *Journal of Psychotherapy Integration. 12*(1), 10–31. doi:10.1037/1053-0479.12.1.10.

Fonagy, P., & Bateman, A. (2006). Mechanisms of change in mentalisation-based therapy with BPD. *Journal of Clinical Psychology, 62*(4), 411-430.

Fonagy, P. (2000). Attachment and borderline personality disorder. *Journal of the American Psychoanalytic Association*, *48*, 1129-1146.

Fortune, S., Sinclair, J. & Hawton, K. (2008). Help-seeking before and after episodes of self-harm: A descriptive study in school pupils in England. *BMC Public Health*. *8*, 369–381.

Gelinas, B. L., & Wright, K. D. (2013). The Cessation of Deliberate Self-Harm in a University Sample: The Reasons, Barriers, and Strategies Involved. *Archives of Suicide Research, 17*(4), 373-386. doi:10.1080/13811118.2013.777003

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy*, *13*(6), 353-379.

Glenn, C. R., Blumenthal, T. D., Klonsky, E. D., & Hajcak, G. (2011). Emotional reactivity in nonsuicidal self-injury: Divergence between self-report and startle measures. *International Journal of Psychophysiology, 80*(2), 166-170. doi:10.1016/j.ijpsycho.2011.02.016

Goodall, K., Trejnowska, A., & Darling, S. (2012). The relationship between dispositional mindfulness, attachment security and emotion regulation. *Personality and Individual Differences,52*(5), 622-626. doi:10.1016/j.paid.2011.12.008

Groschwitz, R., & Plener, P. (2012). The Neurobiology of Non-suicidal Self-injury (NSSI): A review. *Suicidology Online, 3*(24), 24-32.

Guerry, J. D., & Prinstein, M. J. (2009). Longitudinal Prediction of Adolescent Nonsuicidal Self-Injury: Examination of a Cognitive Vulnerability-Stress Model. *Journal of Clinical Child & Adolescent Psychology, 39*(1), 77-89. doi:10.1080/15374410903401195

Gullone, E., Hughes, E. K., King, N. J., & Tonge, B. (2009). The normative development of emotion regulation strategy use in children and adolescents: A 2-year follow-up study. *Journal of Child Psychology and Psychiatry, 51*(5), 567-574. doi:10.1111/j.1469-7610.2009.02183

Harris, M., & Fallot, R. D. (Eds.). (2001). *New directions for mental health services. Using trauma theory to design service systems.* San Francisco, CA, US: Jossey-Bass.

Haskell, L., First Stage Trauma Treatment: A guide for mental health professionals working with women, 2003, Toronto, ON: Centre for Addiction and Mental Health.

Hawton, K., Bergen, H., Waters, K,. Ness, J., Cooper, J., Steeg, S., Kapur, N. (2012) Epidemiology and nature of self-harm in children and adolescents: Findings from the multicentre study of self-harm in England. *European Child & Adolescent Psychiatry,* 21, 369–377.

Hawton, K., Witt, K. G., Salisbury, T. L., Arensman, E., Gunnell, D., Townsend, E., Hazell, P. (2015). Interventions for self-harm in children and adolescents. *Cochrane Database of Systematic Reviews Reviews*. doi:10.1002/14651858.cd012013

Hoermann, S., Zupanick, C., & Dombeck, M. (2013). Attachment Theory Expanded: Mentalization. Retrieved from https://www.mentalhelp.net/articles/attachment-theory- expanded

Hume, M., & Platt, S. (2007). Appropriate interventions for the prevention and management of self-harm: A qualitative exploration of service-users views. *BMC Public Health, 7*(1). doi:10.1186/1471-2458-7-9

Imel, Zac E; Wampold, Bruce E (2008). The Importance of Treatment and the Science of Common Factors. In Brown, Steven D; Lent, Robert W. *Handbook of counselling psychology* (4th ed.). Hoboken, NJ: John Wiley & Sons. 249–262.

In-Albon, T., Bürli, M., Ruf, C., & Schmid, M. (2013). Non-suicidal self-injury and emotion regulation: A review on facial emotion recognition and facial

mimicry. *Child and Adolescent Psychiatry and Mental Health, 7*(1), 5. doi:10.1186/1753-2000-7-5

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27*(2), 226-239. doi:10.1016/j.cpr.2006.08.002

Kool, N., Meijel, B. V., & Bosman, M. (2009). Behavioral Change in Patients With Severe Self-Injurious Behavior: A Patients Perspective. *Archives of Psychiatric Nursing, 23*(1), 25-31. doi:10.1016/j.apnu.2008.02.012

Lambert, Michael J. (1992). Psychotherapy outcome research: implications for integrative and eclectic therapists. In Norcross John C., Goldfried, Marvin R. *Handbook of psychotherapy integration* (1st ed.). New York, Basic Books. 94–129.

Lamblin, M., Murawski, C., Whittle, S., & Fornito, A. (2017). Social connectedness, mental health and the adolescent brain. *Neuroscience & Biobehavioral Reviews, 80*, 57-68. doi:10.1016/j.neubiorev.2017.05.010

Langdridge, D. (2012). *Phenomenological psychology: Theory, research and method*. Harlow, Essex: Pearson Prentice-Hall.

Laska, Kevin M; Gurman, Alan S; Wampold, Bruce E (2014). Expanding the lens of evidence-based practice in psychotherapy: a common factors perspective. *Psychotherapy: Theory, Research, Practice, Training*. 51(4), 467–481.

Linehan M. Cognitive–behavioral treatment of borderline personality disorder. New York: Guilford Press; 1993.

Linehan, M., & Wilks, C. (2015). The Course and Evolution of Dialectical Behavior Therapy. *American Journal of Psychotherapy, 69*(2), 97-110.

Magill, M., Colby, S. M., Orchowski, L., Murphy, J. G., Hoadley, A., Brazil, L. A., & Barnett, N. P. (2017). How does brief motivational intervention change heavy drinking and harm among underage young adult drinkers? *Journal of Consulting and Clinical Psychology, 85*(5), 447-458. doi:10.1037/ccp0000200

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*(6), 570-579. doi:10.1111/inm.12093

Mehlum, L., Tørmoen, A. J., Ramberg, M., Haga, E., Diep, L. M., Laberg, S., Grøholt, B. (2014). Dialectical Behavior Therapy for Adolescents with Repeated Suicidal and

Self-harming Behavior: A Randomized Trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 53*(10), 1082-1091. doi:10.1016

Merrer, J. L., Becker, J. A., Befort, K., & Kieffer, B. L. (2009). Reward Processing by the Opioid System in the Brain. *Physiological Reviews, 89*(4), 1379-1412. doi:10.1152/physrev.00005.2009

Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(1), 1-10. doi:10.1186/1753-2000-6-10

Mummé, T. A., Mildred, H., & Knight, T. (2016). How Do People Stop Non-Suicidal Self-Injury? A Systematic Review. *Archives of Suicide Research,* 1-20. doi:10.1080/13811118.2016.1222319

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223–250.

Neff, K., & Germer, C. (2013). A Pilot Study and Randomized Controlled Trial of the Mindful Self-Compassion Program. *Journal of Clinical Psychology, 69*(1), 28-44.

Ougrin, D., Tranah, T., Stahl, D., Moran, P., & Asarnow, J. R. (2015). Therapeutic Interventions for Suicide Attempts and Self-Harm in Adolescents: Systematic Review and Meta-Analysis. *Journal of the American Academy of Child & Adolescent Psychiatry, 54*(2), 97-107. doi:10.1016/j.jaac.2014.10.009

Palmer, E., Welsh, P., & Tiffin, P. A. (2015). Perceptions of family functioning in adolescents who self-harm. *Journal of Family Therapy, 38*(2), 257-273. doi:10.1111/1467-6427.12069

Park, N., & Peterson, C. (2008). Positive Psychology and Character Strengths:Application to Strengths-Based School Counseling. *Professional School Counseling, 12*(2), 85-92. doi:10.5330/psc.n.2010-12.85

Pietkiewicz, I. & Smith, J. A. (2014) A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology, Psychological Journal, 20, 1, pp. 7-14.

Preyde, M., Vanderkooy, J., Chevalier, P., Heintzman, J., Warne, A., & Barrick, K. (2014). The Psychosocial Characteristics Associated with NSSI and Suicide Attempt of Youth Admitted to an In-patient Psychiatric Unit. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 23*(2), 100-112.

Prochaska, J.O., DiClemente, C.C. (1983). Stages and processes of self-change in smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology* (3), 90–395.

Prochaska, J. O., Diclemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychology, 47(*9), 1102-1114.

Rende, B. (2000). Cognitive flexibility: Theory, assessment, and treatment. *Seminars in Speech and Language, 21*, 121–153. doi:10.1055/s-2000- 7560

Rossouw, T. I., & Fonagy, P. (2012). Mentalization-Based Treatment for Self-Harm in Adolescents: A Randomized Controlled Trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 51*(12), 1304-1313. doi:10.1016/j.jaac.2012.09.018

Rossouw, T. (2012). Self Harm in Young People. Is MBT the answer? In N. Midgley, & I. Vrouva (Ed.), *Minding the Child: Mentalization-Based Interventions with Children, Young People and their Families*, 131-146. East Sussex: Routledge.

Schore, A. N. (2001). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*(1-2), 7-66. doi:10.1002/1097-0355(200101/04)22:13.0.co;2-n

Scoglio, A. A., Rudat, D. A., Garvert, D., Jarmolowski, M., Jackson, C., & Herman, J. L. (2018). Self-Compassion and Responses to Trauma: The Role of Emotional Regulation. *Journal of Interpersonal Violence,33*(13), 2016-2036. doi:10.1177/0886260515622296

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

Smith J.A., Flowers P., Larkin M. (2009) Interpretative Phenomenological Analysis: Theory, Method and Research. London: SAGE

Smith, N. B., Kouros, C. D., & Meuret, A. E. (2013). The Role of Trauma Symptoms in Nonsuicidal Self-Injury. *Trauma, Violence, & Abuse, 15*(1), 41-56. doi:10.1177/1524838013496332

Spears, M., Montgomery, A. A., Gunnell, D., & Araya, R. (2013). Factors associated with the development of self-harm amongst a socio-economically deprived cohort of adolescents in Santiago, Chile. *Social Psychiatry and Psychiatric Epidemiology, 49*(4), 629-637. doi:10.1007/s00127-013-0767-y

Swahn, M. H., Ali, B., Bossarte, R. M., Dulmen, M. V., Crosby, A., Jones, A. C., & Schinka, K. C. (2012). Self-Harm and Suicide Attempts among High-Risk, Urban

Youth in the U.S.: Shared and Unique Risk and Protective Factors. *International Journal of Environmental Research and Public Health, 9*(12), 178-191. doi:10.3390/ijerph9010178

Todres, L. & Galvin, K. (2006) Caring for a partner with Alzheimer's disease: Intimacy, loss and the life that is possible. *International Journal of Qualitative Studies on Health and Well-being, 1(*1), 50-61, DOI: 10.1080/17482620500518085

Todres, L. (2004). The meaning of understanding and the open body: some implications for Qualitative Research. *Existential Analysis,15*(1), 38-54.

Velotti, P., Garofalo, C., Bottazzi, F., & Caretti, V. (2017). Faces of Shame: Implications for Self-Esteem, Emotion Regulation, Aggression, and Well-Being. *The Journal of Psychology, 151*(2), 171-184.

Victor, S. E., Glenn, C. R., & Klonksy, E. D. (2012). Is non-suicidal self-injury an "addiction?" A comparison of craving in substance use and non-suicidal self-injury. *Psychiatry Research, 197*(1-2), 73-77.

Wadman, R., Clarke, D., Sayal, K., Vostanis, P., Armstrong, M., Harroe, C., Townsend, E. (2016). An interpretative phenomenological analysis of the experience of self-harm repetition and recovery in young adults. *Journal of Health Psychology, 1*(11), 1-12. doi:10.1177/1359105316631405

Watson, Jeanne C.; *In:* Humanistic psychotherapies: Handbook of research and practice. Cain, David J. (Ed); Publisher: American Psychological Association; 2002, 445-471.

Wills, K.A. (2012). What Does Recovery Mean to Adults who Self-injure? An Interpretative Phenomenological Analysis. *International Journal of Psychosocial Rehabilitation. 17*(1) 93-116.

Whitlock, J., Eckenrode, J., & Silverman, D. (2006). Self-injurious behaviors in a college population. *Pediatrics*, 117, 1939-1948.

Whitlock, J., Prussien, K., & Pietrusza, C. (2015). Predictors of self-injury cessation and subsequent psychological growth: results of a probability sample survey of students in eight universities and colleges. *Child and Adolescent Psychiatry and Mental Health, 9*(1). doi:10.1186/s13034-015-0048-5

Appendix A:

Recruitment Flyer

Recovery from Youth Non Suicidal Self Injury (Self Harm) Research Study

Did you struggle with **self-harm** as an **adolescent** and are now at a point of **recovery** from self-harm?

I am looking for participants to answer questions about the **meaning** they've made and the **process** of their experience with **youth self-harm** and **recovery.**

If you qualify for this study, you are invited to participate in 1-1.5 hour confidential interview with the researcher to answer questions about your experience. Interviews can be conducted at any SFU campus or via skype. You will be providing valuable information about a critical topic in mental health and will be compensated $20 for your time.

Please contact the studies Principle Investigator at [...]@sfu.ca if:

a) You are between the ages of 18-25

b) You self harmed as a youth (age range 13-20)

c) You no longer engage in self harming behaviour, you identify as having 'recovered' from self harm, and you have not engaged in any act(s) of self harm for a period of at least 2 months to date

d) You do not have a current diagnosis of a mental health disorder

e) You have not had recent thoughts or plans of suicide, and are not currently abusing substances

f) You have not experienced a recent crisis that could render you more vulnerable to emotional distress

g) Able to conduct the interview in English

Appendix B:

Prescreening Questions

1. Do you have a current diagnosis of a mental health disorder?
2. Are currently struggling with thoughts or plans of suicide?
3. Are you currently struggling with a substance abuse issue?
4. Have you experienced a recent crisis that would make you more vulnerable than normal to emotional distress?
5. Take a moment to consider what it would feel like to talk about your experience with self-harm and the meaning you have made around your recovery process. Do you feel as though discussing your experience of recovery from self-harm will cause you a higher level of distress than you are comfortable with?
6. Please state your age.
7. Did you struggle with self-harm, or Non-Suicidal Self-Injury as a youth? (NSSI is defined for the purposes of this study as an intentional act of self directed or injury such as cutting, hitting, burning, banging, that was not motivated by suicidal intent. Youth is defined for this study as beginning ages 13-20)?
8. For how many years did you self harm? How often during this period of time?
9. Would you consider yourself recovered in regards to your experience with NSSI?
10. When was the most recent/last time you self harmed?
11. Do you feel you have a good sense of what helped you recovery from NSSI, and would you be willing to speak to that in a confidential interview?

Appendix C:

Consent Form

Faculty of Education

Department of Education and Counselling Psychology

250-13450 102 Avenue
Surrey, BC, Canada
V3T 0A3

Young Adults Experience and Meaning Making of Recovery

From Adolescent Non-Suicidal Self Injury (NSSI)

Principal Investigator:

Carly Degenstein (M.A. Candidate)

Faculty of Education, Simon Fraser University

Department of Education and Counselling Psychology

250-13450 102 Avenue
Surrey, BC, Canada
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Faculty Supervisor:

Masahiro Minami, Ph.D., Assistant Professor

Faculty of Education, Simon Fraser University

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Disclaimer

This research is conducted in partial fulfillment of the degree of M.A. Counselling Psychology for Carly Degenstein. The word 'researcher' in this document refers to Carly Degenstein (Principle Investigator), supervised by Masahiro Minami (Faculty Supervisor)

Study Purpose

The purpose of this research study is to, better understand the process involved in recovery from youth Non-suicidal Self Injury (NSSI), as well as the meaning young adults make about that recovery. You are being invited to participate in this research because:

j) You self harmed as a youth (ie. intentionally cut, hit, burned, banged, or injured yourself), beginning in the age range of 13-20 (min. 2 episodes)
k) You are no longer engaged in self harming behaviour, you identify as having 'recovered' from self harm, and you have not engaged in any act(s) of self harm for a period of at least 2 months to date
l) You are willing to discuss your experience of recovery from self harm and feel able to speak to key aspects of what made your recovery possible
m) You are between the ages of 18-25 living in Vancouver, Burnaby, Surrey, or surrounding area
n) You do not have a current diagnosis of a mental health disorder
o) You have not had recent thoughts or plans of suicide, and are not currently abusing substances
p) You have considered the emotional impact of discussing your experience of recovery from self harm and do not believe it will cause you more distress than you are comfortable with
q) You have not experienced a recent crisis that could render you more vulnerable to emotional distress
r) Able to conduct the interview in English

Study Procedure

This study will consist of an in-person semi-structured interview conducted by the Principle Investigator, Carly Degenstein. The interview will be held for a maximum of 1.5 hours in a private, sound-proof room, to ensure confidentiality of information shared, at either SFU Surrey, Burnaby or Vancouver Campus. You will be asked a series of questions that will have you reflect on and discuss your experience with recovery from youth Non-suicidal Self injury, important or significant aspects of your recovery process and the meaning you make of these experiences. These interviews will be audio-recorded for the purposes of transcription and data analysis.

You will have the opportunity to review the analysis associated with your interview transcript within 1 year from your interview for the purposes of ensuring accuracy of researcher interpretation. This is called a Participant check and would require you to come to SFU surrey to a secure room in the Faculty of Education. Travel expenses would be paid

for this portion of the research as well as well as a $10 honorarium for your time. If you are interested in completing a participant check, you may provide contact information at the end of this form.

Potential Risks

Given the personally sensitive/emotional nature of the topic to be discussed, there is a chance that you will have uncomfortable emotional reactions during the interview, or afterwards. If you experience emotional distress, more-so than you normally experience or feel unable to manage these emotions on your own, please inform the researcher immediately. You have the right to stop the interview and withdraw participation at any time. The following support will also be available to you if you wish to speak to a trained professional about your distress:

1) Distress line (crisis line) (number omitted in publication)

2) Counselling Services Referral – SFU Counselling Services (students), SFU Surrey Counselling Clinic (community referral, minimal wait list

-appropriate community referral sourced upon request

Right to Withdraw

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time. You have the right to refuse to do anything that is requested by the researcher at any time.

Potential Benefits

Potential Benefits to participating in the study include:

a) potential to contribute to an increased understanding of recovery from youth NSSI, in a context that will help improve future counselling approaches and treatments for youth NSSI

b) An honorarium of $20, will be offered to thank you for your time and participation in the interview. An honorarium of $10 will be offered to thank you for completing the participant check.

Confidentiality and Consent to Audio-recordings

It has been explained to you that for the purposes of this study, your in-person interview will be audio-recorded and transcribed. It has also been made clear, and as part of your consent you understand that:

a) Your identity shall be kept confidential at each stage of research and data collection
b) audio-recordings will not be associated with any identifying information, nor will your transcripts or any published data contain or involve any identifying information.
c) Only the Principal Investigator (Carly Degenstein) and the Faculty Supervisor (Masahiro Minami) will have access to your original audio files, which will be stored on recording device in a locked cabinet at Faculty Supervisor's office until transcription is complete
d) Original audio files will be destroyed when transcription is complete
e) Transcripts will be stored in password protected/encrypted USB drives, and in locked filing cabinet, at the Faculty Supervisor's office at SFU Surrey campus during the study period
f) Transcripts and your signed consent form will be destroyed when final thesis is submitted and accepted
g) You will have the opportunity to review your transcript analysis, prior to final thesis publication to ensure accuracy of researcher interpretation of your account (participant check)
h) In line with current best practices in research, an anonymized version of your transcript will be preserved for future research use in open access initiatives. Transcripts will be uploaded to an online repository, SFU RADAR, and these files will be stripped of any information that could identify participants (e.g., names, places, dates) to ensure confidentiality (optional)

Contact for Information about the Study

If you have any questions or desire further information about this study, you may contact the Principle Investigator/Researcher Carly Degenstein or Faculty Supervisor, Dr. Masahiro Minami.

Contact for Concerns about the Rights of Research Subjects

If you have any concerns about your treatment or rights as a research subject, you may contact the Office of Research Ethics of Simon Fraser University via Jeff Toward, Director, reachable by email at jtoward@sfu.ca or 778-782-6593.

Participant Consent

Your signature below indicates that you (a) fully and clearly understood all the information written in this consent form, (b) agree to all the conditions specified in this consent form, and (c) agree to participate in this research study.

Participant Name: _____

Participant Signature: _____

Researcher Name: _____

Researcher Signature: _____

Date: _____

○ **Indicate here if you consent to retention of your anonymized transcript in SFU RADAR open access research database**

○ **Check here if you are consent to follow up contact for purposes of arranging Participant Check**

○ **Check here if you would like to be contacted to receive copy of final thesis**

Optional Provision of Follow up Contact information:

Appendix D:

Interview Script

Young Adults' Experience and Meaning Making of Recovery From Adolescent Non-Suicidal Self-Injury (NSSI)

Intro-script:

Thank you for your willingness to participate in this study. By asking you these questions, we hope to get a better sense of what helped you recover from youth Non-Suicidal Self-Injury, referred to hereafter more simply as self-harm. I will be asking you to reflect on your experiences with self-harm and recovery as well as what these experiences mean to you.

You have the right to not answer any of the questions posed. You have the right to stop the interview at any point without penalty. If you become distressed at any point in the interview, please let me know, and we will discuss your options for pausing or stopping. If after or during this interview you become aware that you would like to discuss any mental health concerns with a professional, please advice me, and an appropriate referral will be made.

Experience with Self-harm

1. **What was your experience as a youth with self-harm?**

2. **What sense do you make of what kept you self-harming for the time that you did?**

Recovery Process

3. What made you decide that you would like to stop self-harming, or motivated you begin the process of healing from self-harm?

4. You told me in the pre-screening that the last time you self-harmed was_____. Did you know at the time that this was going to be the last time you self harmed…explain if possible?

5. I'm going to ask you to think of a time when you had a strong urge to engage in self harming behaviour, but stopped yourself from self-harming.

a) What did you do in that moment to prevent yourself from carrying out your urge to self-harm?

b) Can you remember what you thought or told yourself at that time or what you do or tell your self if the urge ever comes up now?

c) What did you or do you do until the urge had or has passed?

Key Factors, Understanding of Recovery Process, Definition of Recovery

5. How do you personally make sense of your experience of recovery from NSSI and the key factors involved in that recovery?

6. How do you understand your process of recovery? In other words what made your recovery possible or helped with that process?

7. When or how did you know you were at a point of recovery from self-harm?

8. What understanding do you have of what has helped you maintain your recovery efforts?

9. What is your understanding of how your experience with and recovery from youth self harm has shaped you into the person you are today, if it has?