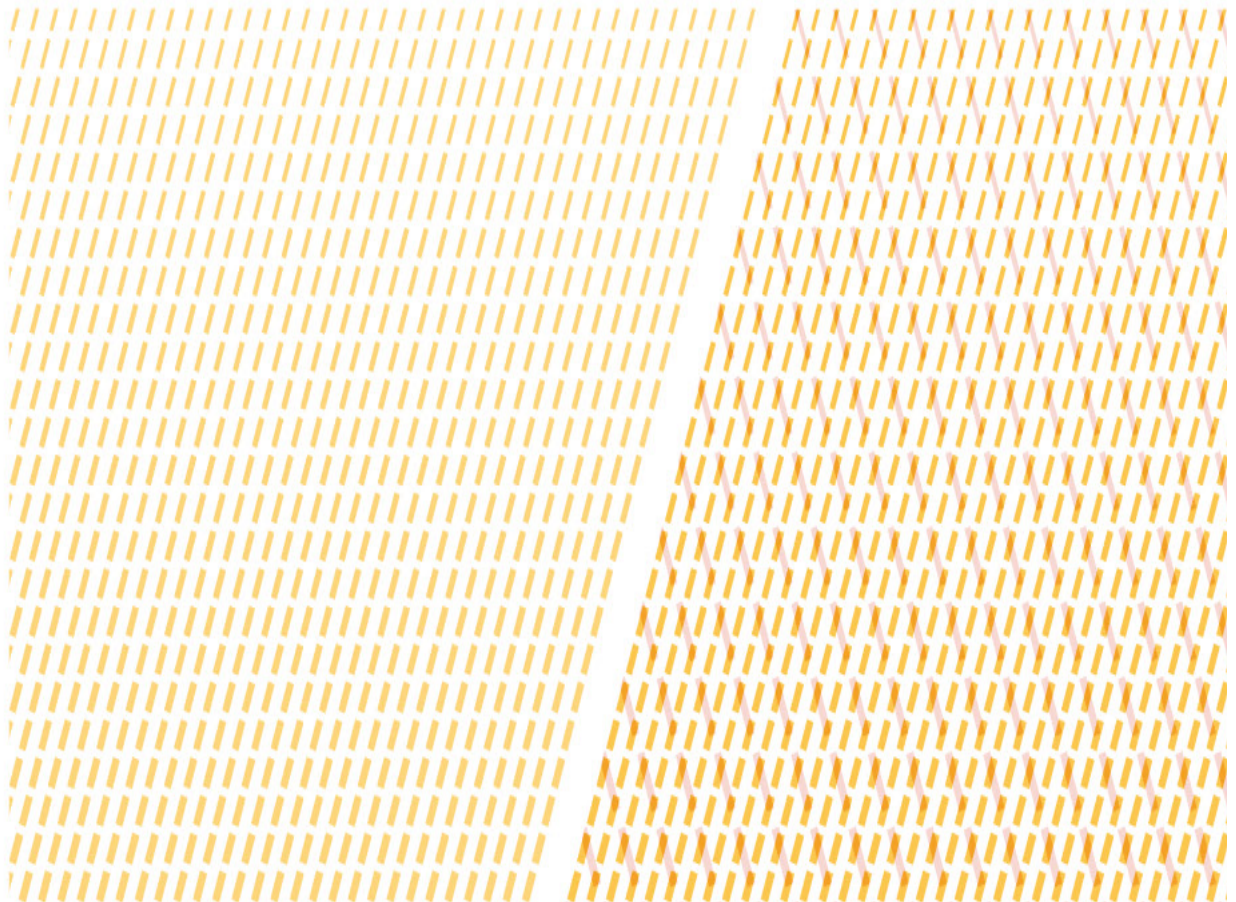


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Recovery from self-harm
A qualitative study

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A Dissertation for the degree of Philosophiae Doctor – January 2018.



Hurt

*I hurt myself today
To see if I still feel
I focus on the pain
The only thing that's real
The needle tears a hole
The old familiar sting
Try to kill it all away
But I remember everything*

*What have I become?
My sweetest friend
Everyone I know
goes away
in the end
You could have it all
My empire of dirt
I will let you down
I will make you hurt*

*I wear this crown of shit
Upon my liar's chair
Full of broken thoughts
I cannot repair
Beneath the stains of time
The feelings disappear
You are someone else
I am still right here
You could have it all
My empire of dirt
I will let you down
I will make you hurt
If I could start again
A million miles away
I would keep myself
I would find a way*

Nine Inch Nails (Lyrics)
&
Trent Reznor (Songwriter) (1994).

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(Selvskade - det stumme språket. Fra en ensom kamp med lidelsen – til fellesskap og dialog?).

Appendix 2: Approval from the Norwegian Social Science Data Services (NSD) for project: No. 2824 (Selvskade – det stumme språket. Fra en ensom kamp med lidelsen – til fellesskap og dialog?).

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Appendix 4: Information folder to mental health nurses

Appendix 5: Information folder to former patients

Appendix 6: Semi-structured interview guide for mental health nurses

Appendix 7: Semi-structured interview guide for former patients

Norwegian abstract

Avhandlingens hovedhensikt er å øke forståelsen av recovery prosessen fra direkte selvskade hos voksne mennesker gjennom tre del-studier: En teoretisk evolusjonær begrepsanalyse for å tydeliggjøre innholdet i begrepet selvskade avgrenset til fagområdene medisin og sykepleievitenskap. To intervjustudier ble gjennomført: I den første intervjustudien utforskes spesialsykepleiere sin erfaring med utøvelse av sykepleie til voksne pasienter som selvskader i akutt fase. I dette del-studiet anvendes manifest og latent innholdsanalyse av data. I det andre intervjustudiet er hensikten å utforske, beskrive og forstå tidligere pasienters recovery erfaringer fra selvskade. I dette del-studiet anvendes en fenomenologisk-hermeneutisk analyse av data.

En sammenstilling av funn fra de tre delstudier resulterte i følgende hovedfunn: Personer som skader seg selv har sitt eget personlige selvskademønster med ulike intervall mellom selvskadesituasjoner og med ulik alvorlighetsgrad. Personer som selvskader kan bruke flere selvskademetoder samtidig. Tiden før personen erkjenner et vendepunkt fra å selvskade, lever han/hun med selvdestruktive selvskademønstre hvor en recovery prosess ikke er et personlig mål. Flere personer har ikke et språk for å kunne uttrykke sin lidelse og dette kan også bidra til at personen erfarer en forlenget recovery prosess. Når pasienten ønsket å selvskade i klinikk hadde spesialsykepleierne ulike tilnærming til det; Noen lot pasienten få skade seg i klinikken, mens andre stoppet selvskadeadferd med bruk av ulike tvangsmidler. All alvorlig selvskade ble stoppet.

Etter at personen erkjenner et vendepunkt og velger livet og/eller kontakt med nære relasjoner, blir de motivert til å motta profesjonell hjelp og starte en individuell læringsprosess mot recovery fra selvskade. En personlig recovery prosess der de lærer å gjenkjenne personlig stress, hva som trigger dem til å skade seg selv, lærer å avlede seg selv fra å selvskade og mestre egne grunnleggende behov som å sove nok, spise ernæringsrik kost og være i fysisk aktivitet.

Spesialsykepleiere motiverer hver pasient til å delta i en dialog om sin situasjon og hvilke signaler pasienten erfarer før selvskadesituasjonen. De oppmuntret den enkelte

pasient til å sette ord på selvskaedesituasjonen. Spesialsykepleierne bidrar til å lære pasientene hvordan de kan avlede seg selv fra selvskaedesituasjoner med egne individuelle aktiviteter. Sykepleierne søker å fremme håp om recovery ved å styrke pasientens selvbilde.

Å selvskaede kan for personen innebære å ha psykisk smerte/lidelse, skade på kroppen, sosial skam, isolasjon og eksistensiell smerte. Dette samtidig som at hun/han erfarer at å skade seg selv på kroppen kan gi lindring av psykisk smerte/lidelse i et kort tidsrom - men også at å selvskaede over tid av mange må økes og/eller endres for å oppnå samme opplevde lindring noe som kan medføre avhengighet av selvskaeadferden. Implikasjoner for sykepleieren er å kartlegge når personen må øke nivå av selvskaeadferd for å få samme erfarte spenningsreduksjon med økt suicidfare. Dette samtidig som personen kjemper med å ivareta sin verdighet og kontroll på selvskaeadferden. En sentral implikasjon for sykepleieren er hvordan hun/han kan veilede personen før og etter pasientens erkjente vendepunkt. Før vendepunktet er ikke recovery et personlig mål for personen. Etter et vendepunkt er personen motivert for å motta profesjonell hjelp med ønske om en være i personlig recovery prosess.

English abstract

The overall aim of this dissertation was to expand understanding of the recovery process from direct self-harm for adult persons who self-harm through three partial studies. Study I included a theoretical evolutionary concept analysis to clarify the content of the concept self-harm as delineated to the disciplines of medicine and nursing. Studies II and III were interview studies. In study II, mental health nurses' experiences of caring for adult inpatients who self-harm during an acute phase were explored using manifest and latent content analyses. In study III, the aim was to explore, describe and understand former patients' experiences of recovery from self-harm, and a phenomenological hermeneutical approach was used in the analysis of data.

A compilation of the findings from the three partial studies resulted in the following overall results. Persons who self-harm have their own personal self-harm "rhythm", with different intervals and degree of severity. Persons who self-harm can use several different self-harm methods simultaneously. Before an acknowledged turning point persons who self-harm live with a self-destructive self-harm pattern, where a recovery process is not a personal goal. For some, there may be an absence of a verbal language with which to express their suffering and this can contribute to a prolonged recovery process. Mental health nurses have different approaches to whether patients should be allowed to self-harm or not while in care; some allowed patients to self-harm while others stopped patients' self-harm behavior through various forms of coercive methods. All serious self-harm was stopped.

After persons who self-harm acknowledged a turning point and chose life and/or contact with close relatives, they became motivated to receive professional help and start the individual learning processes toward recovery from self-harm. A personal recovery process was begun where they learned to recognize personal stress, what it was that triggered their self-harm, how to distract themselves, and how to master their own basic needs such as sleeping sufficiently, eating nutritious food and/or engaging in physical activity.

The mental health nurses motivated each patient to engage in a dialogue about the patient's situation, including which signals are experienced prior to a self-harm act. The nurses encouraged patients to learn how to distract themselves from self-harm situations through individual activities. The nurses sought to promote hope for recovery by strengthening patients' self-image.

For the person who self-harms, self-harm can entail having mental pain/suffering, scars on the body, social shame, isolation and/or existential pain. At the same time, he/she can experience that the act of self-harm can alleviate mental pain/suffering for a short period of time – but also that over time the self-harm must be increased and/or changed to achieve the same experienced feeling of relief, which can result in an addiction to the self-harm behavior. The implication for mental health nurses is that they should chart the scope of a person's self-harm over time, to see when an increase in the self-harm behavior is needed to sustain the experienced reduction in tension, including increased risk for suicide. At the same time, nurses should also understand that persons who self-harm may be struggling to maintain dignity and control of their self-harm behavior. One central implication for each nurse is the question of how he/she can guide the patient to recovery, both prior to and after the patient's acknowledged turning point. Prior to a turning point, recovery is not a personal goal for the person who self-harms. After the turning point, the person is motivated to receive professional help as a start to the personal recovery process.

Original papers

I Toftthagen, R. & Fagerström, L (2010). Clarifying self-harm through evolutionary concept analysis. *Scandinavian Journal of Caring Sciences*, V 24, 3, pp 610-619

II Toftthagen, R., Talseth, A-G. & Fagerström, L. (2014). Mental Health Nurses' Experiences of Caring for Patients Suffering from Self-Harm. *Nursing Research and Practice*. Volume 2014, Article ID 905741, 10 pages

III Toftthagen R., Talseth A-G. & Fagerström L. (2017). Former patients' experiences of recovery from self-harm as an individual, prolonged learning process. A phenomenological hermeneutical study. *Journal of Advanced Nursing*. Accepted 24.01.2017. DOI: 10.1111/jan.13295

1.0 Introduction

Undoubtedly, the phenomenon that is direct self-harm existed prior to being studied as a clinical concept. In the Bible, 1 Kings 18:28, the prophets of Baal cut themselves with swords and lancets until blood gushes out, as was their custom (Norwegian Bible Society, 2011). Skårderud (2008) describes two saints who both died due to some form of self-harm, St. Catherine of Siena (1347-80) and St. Veronica (1660-1727). To this day, others still suffer from this same affliction, and an increase in the incidence of self-harm among young people has been seen throughout the Western world (Hawton et al., 2002; Magde et al., 2008; Whitlock et al., 2011).

The concept self-harm encompasses various synonyms such as deliberate self-harm, self-mutilation, self-cutting, burning, attempted suicide, non-suicidal self-injury, et cetera (Toftthagen & Fagerström, 2010a). Due to the varying nature of the synonyms' substance, one sees that it is challenging to assimilate the synonyms used and seen in relation to previous research on self-harm when reviewing various previous studies (Mangall & Yukovich, 2008). *Self-harm is defined as intentional self-poisoning or injury with a non-fatal outcome, regardless of intention to die. It can include poisoning, asphyxiation, cutting, burning and other self-inflicted injuries* (Hawton, 2002; Skegg, 2005). In this dissertation, the concept of self-harm is limited to direct injury. Direct self-harm can consist of cutting or scratching the body, punching surfaces, burning skin, sticking objects into the body, strangulation or even other forms (James et al., 2012; Kashyap et al., 2015).

During the first literature search I conducted in 2008, which pertained to recovery from self-harm, I found that self-harm without suicidal intent was relatively unresearched from a nursing perspective in an acute mental health care context and that mental health nurses did not differentiate between the various synonyms used to describe the concept self-harm in their clinical follow-up of patients (O'Donovan & Gijbels, 2006). Mental health nurses found it difficult to describe the nursing interventions needed in their meetings with persons who self-harm, and they experienced that a medical model of

care dominated their actions in clinical practice (O'Donovan & Gijbels, 2006). I found such results to be easily transferable to my own eight-year experience as a mental health nurse in acute mental health care. While international scientific studies on what promotes recovery for persons with mental illness do exist today, there are few studies on what promotes recovery from direct self-harm for adults and how mental health nurses can systematically support persons who self-harm during the recovery process (Andover, 2012; Kapur et al., 2013).

Investigation into further research domains linked to recovery, such as resilience, salutogenesis or work with families and networks, is also limited (Andersen, 1987; Anderson & Goolishian, 1988; Topor, 2001; Davidson, 2003; Karlsson & Borg, 2013; Seikkulla & Arnkil, 2013). As a concept, recovery from mental illness stems from the independent living and civil rights movements of the 1960s and 1970s and has also been influenced by the self-help community's campaign against substance abuse. The movement for democratic psychiatry that emerged during the 1970s and 1980s is one example of the fight against the "closed system" previously used in institutions, through which patients became passive and subdued and lost their initiative and belief in the future (Skårderud, 1984). The intention underlying the drawing up of the Ottawa Charter for Health Promotion (World Health Organization, 1986) was that it should represent an ideological perspective on recovery, with a clear link between health-promotive initiatives and politics. The five main action areas for the charter are: build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services. In its mental health action plan for 2013-2020, the World Health Organization (2013a) emphasized that the conditions for recovery, empowerment, community-based services and community inclusion should be improved.

Mental health services in Norway have changed over time, from institution-based care to at-home or close environment follow-up under the care of district psychiatric centers. This focus on recovery coincides with a refocusing of central political priorities in mental health care in Norway over the past three decades: for example, the

Coordination reform (Norwegian Ministry of Health and Care Services, 2009), where patient rights, community-based services, improved professional knowledge, social inclusion, interaction and patient participation are central.

This dissertation includes a conceptual analysis of self-harm (study I). Also, mental health nurses in an acute mental health care context in Norway were interviewed about the interventions they experienced promoted recovery for persons who engage in repetitive direct self-harm (study II). Former patients in Norway who had experienced recovery from self-harm were interviewed about their individual recovery processes toward improved well-being (study III). In study III, the participants were preoccupied with perceiving their individual recovery processes from a holistic perspective rather than a concrete context such as acute mental health care; during the study the context was therefore changed in accordance with their wishes.

2.0 Background

2.1 Descriptions of self-harm

The way in which self-harm is described has changed over time, and in literature various synonyms are used to describe self-harm: for example, the psychoanalyst Karl Menninger's classifications of *self-mutilation* (1938). Menninger differentiated between organic, psychotic, neurotic and religious self-mutilation.

Favazza drew up suggestions for the criteria to be used for the classification of *self-harm syndrome* for the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) in 1992. In this suggestion, self-harm was defined from criteria that distinguished it from suicidal attempt, swallowing of objects and substance-related overdoses, which were instead classified as *direct self-injury* (Favazza, 1992). Later Simeon and Favazza (2001) developed a four-category classification of *self-injurious behavior* as follows: Stereotypic self-injurious behavior, Major self-injurious behavior, Compulsive self-injurious behavior, and Impulsive self-injurious behavior. Sutton (2007) built upon Simeon and Favazza's (2001) classification of *self-injurious behavior* and laid a focus on that the person's need to regulate affect was both a compulsion and an impulse. The International Society for the Study of Self-Injury (2007) does not include the regulation of negative affect in its definition of *non-suicidal self-injury* but does maintain that it is a deliberate, self-inflicted and socially unacceptable action such as cutting, burning, self-bruising, et cetera that has an immediate effect on the person but which nonetheless is done without suicidal intent (International Society for the Study of Self-Injury, 2007).

Pattison and Kahan (1983) described the clinical characteristics of *deliberate self-harm* syndrome as consisting of three forms: direct and indirect, greater or lower risk for lethality and repetitive. They excluded attempted suicide from their definition and differentiated between self-harm and suicidal behavior.

Fjellidal -Soelberg (2013) referred to “*bodily self-harm*” in her dissertation, citing Goffman (2004/1964), who maintains that each and every action that is directed toward the body is also directed toward the person him/herself.

Persons who self-harm can be ambivalent toward engaging in self-harm or suicide attempts, and it can be difficult to differentiate between self-harm and attempted suicide (Hawton et al., 1982; Diagle & Cote, 2006). The extent to which a person self-harms can change over time and he/she can use various ways to self-harm simultaneously.

In a study of 7 344 persons in England, Liley and colleagues (2008) found that about 1 234 participants engaged in repetitive self-harm and that one-third of these changed the method of self-harm they used. The intention underlying self-harm can also change over time: for example, from using self-harm to alleviate difficult emotions or thoughts to punishing oneself with the intent to die. The conscious intention to self-harm can even be absent (Scollers et al., 2009). Today the concept of self-harm is strongly linked to mental pain, but also to harm to the body as a continuum of self-harm behavior (mild, moderate, severe and attempted suicide/suicide) (Muehlenkamp, 2014).

Persons who self-harm can have one or several diagnoses, such as posttraumatic stress syndrome, borderline personality disorder, depression, substance addiction, et cetera (Yates, 2004; Nock et al., 2006; Muehlenkamp et al., 2008; Oh et al., 2011; Chung et al., 2012; Bentley et al., 2014). Thus, self-harm can be considered a transdiagnostic phenomenon linked to more than one diagnosis (Bentley, 2014). In a study by Hawton and colleagues (2013) of persons receiving inpatient care for self-harm, 80 % of participants had an additional psychiatric diagnosis.

A unique diagnosis code is not given for self-harm in the International Statistical Classification of Diseases and Related Health Problems - Tenth Revision (ICD-10), which is used in Norway (World health organization, 2010), nor in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association, 2013). In the ICD-10, self-harm is sorted under a Z diagnosis code (Factors Influencing

Health Status and Contact with Health Services) (Z 72.8 or z91) or an X diagnosis code (External Causes of Morbidity) (x60-84) (Landmark & Stänicke, 2016). For example, trichotillomania, also known as hair-pulling disorder, is sorted under an F diagnosis code (Mental and Behavioral Disorders, F63.3) in the ICD-10 and under Obsessive Compulsive Disorder in the DSM-V (321.39). Skin picking is also sorted under Obsessive Compulsive Disorder in the DSM-V (698.4). Non-suicidal self-harm (self-injury) is included as a criterion for borderline personality disorder in the ICD-10 (Møhl, 2015).

Non-suicidal self-injury is included in the appendix of the DSM-V and referred to as a hypothetical diagnosis for which more research is needed. In various studies, researchers recommend that non-suicidal self-injury be listed as a separate diagnosis distinct from borderline personality disorder in the DSM (Muehlenkamp et al., 2012; Zetterqvist et al., 2013; American Psychiatric Association, 2013). Shaffer and Jacobsen (2009) and Plener and Fegert (2012) argued that a distinct diagnosis for non-suicidal self-injury is needed in the DSM-V, because this could facilitate a greater focus on interprofessional communication, more research that would yield better understanding of self-harm, the guaranteeing of the quality assurance of clinical care and greater validity in relation to the prevalence of self-harm.

2.2 Prevalence of self-harm

Of those who self-harm, a number do not seek professional help (Whitlock et al., 2006; Deliberto & Nock, 2008). In New Zealand, only 1 out of every 5 who self-harm sought professional help (Nada-Rajah et al., 2003), while in a case-study in Europe (Magde et al., 2008), only 1 out of 10 sought professional medical help. In one case study in Norway with 3 060 students 15-16 years only 14,7 % had sought help following their self-harm (Ystgaard, 2003).

Studies indicate that more girls than boys engage in self-harm (Ross & Heath, 2002; Ystgaard et al., 2003; Magde et al., 2008; Landstedt & Gillander Gådin, 2011; Hartberg & Hegna, 2013). Still other studies have determined that an equal number of girls and boys engage in self-harm (Klonsky et al., 2003; Muehlenkamp & Gutierrez, 2004; Marcketto, 2006). Hawton and Harriss (2008) investigated self-harm (including overdoses and poisonings) relative to gender at a clinic in England for over a decade. They found that the ratio for self-harm between females and males was 8 to 1 for the 10-14 age group and 3 to 1 for the 15-19 age group. The ratio was 1 to 6 for the 20-24 age group, with males self-harming more than females in this group. This trend continued for the older age groups as well, with the ratio of females to males being 1 to 2 for the 25-29 age group and 0 to 9 for the 50-64 age group. Seen across all age groups, spreading from 10-80 years of age, the ratio of females to males was 1 to 5. Hawton & Harriss's study (2008) included 2 189 females and 1 439 males, and more males than females were found to self-harm across a lifespan. It is clear is that the number of men engaging in self-harm is increasing in the Western world (Loyd-Richardson et al., 2007; Adamson & Braham, 2011).

In a study from 2006-2011 in the U.S.A., Torio et al. (2015) found an increase of 104 % in the number of children under the age of 17 being remitted to inpatient mental care facilities for self-harm and an increase of 151 % for children 10-14 years of age. Also in Norway, an increase in the number of youths who self-harm has been seen. In one case study in Norway with 3 060 students 15-16 years of age, 10,3 % of girls and 3,1 % of boys had self-harmed (Ystgaard, 2003). In 2012, a nationwide Norwegian "Youth Today" study revealed that 32 % of girls and 16 % of boys of school age in Norway had self-harmed (Hartberg & Hegna, 2013).

Olfson et al. (2015) found that from 2001-2011 in the U.S.A. the number of middle-aged patients in care for self-harm behavior increased from 5,1 % to 5,7 % per 10 000 inhabitants. One international study comprising the populations of 17 different countries showed that on average 2,7 % of the adult population reported that they had self-harmed at least once (Nock et al., 2008a).

Self-harm can be a secret behavior, and as such persons may not seek hospital care (Cooper et al., 2011). Consequently, hospital statistics on self-harm do not reveal the entire extent to which self-harm occurs, and this in turn influences understanding of self-harm in relation to gender, age, type of self-harm, et cetera.

2.3 Biological vulnerability and self-harm

In Linehan's biosocial theory, the development of personality traits such as personality disorders can lead to the development of impulsive self-harm behavior with suicidal and non-suicidal tendencies, as a result of transactions between own biological vulnerability and psychosocial risk factors (Linehan, 1993).

Looking at parasuicidal behavior and borderline personality disorder in a selective review of studies on the neurobiology of self-harm, Groschwitz and Plener (2012) found little evidence of changes in brain morphology relative to self-harm, yet noted that hyperarousal in the limbic structures was seen. They found that the evidence relative to whether serotonin deficiency can be associated with self-harming behavior was inconsistent. Serotonin was instead more related to aggressive or violent behaviors - and concluded that further research was needed on the relationship between serotonin, dopamine and self-harm (Groschwitz & Plener, 2012). They also found lower levels of endogenous opioids in persons who repeatedly self-harm and that these, in the event of stress, can be restored by engaging in self-harm. Groschwitz and Plener (2012) even found that research on the subject was lacking and indicated that the findings in their review could be interpreted as indicating that persons who self-harm display an insufficient stress response; therefore, one can conclude that self-harm is used as a mastery strategy to regulate strong/intense emotions.

In a study by Carpenter & Timothy (2015), many of the participants diagnosed with borderline personality disorder who engaged in nonsuicidal self-injury reported a relative absence of acute pain. In West et al. (2013), participants described self-harm as a nice and pleasurable ritual that, in the moment it was being done, helped them focus.

In their systematic review, Kirtley et al. (2016) concluded that more research was needed on the link between emotional pain and a tolerance for physical pain in relation to self-harm. They found that those who engage in non-suicidal self-injury may do so because of a poorly regulated stress response related to a non-cognizant altered pain tolerance that can arise from, among other things, strong/intense emotions (analgesia) or reduced sensitivity to pain (hypoalgesia). Other studies show that persons who self-harm are sensitive to emotional pain (Nock et al., 2008b; Glenn & Klonsky, 2011) yet less sensitive to physical pain during the act of self-harm (Jacobsen & Gould, 2007; Hicks & Hinck, 2008; Gratz et al., 2011; Franklin et al., 2012; Chandler, 2013; Kirtley et al., 2016).

Girls who engage in non-suicidal self-injury become impulsive when the serotonin levels in their brains were temporarily lowered, with the implication that low serotonin levels can trigger girls to engage in impulsive self-harm (Fikke, 2011). Young persons who engage in self-harm also do not perform as well on tests for executive function when compared to young persons who have never self-harmed. Such findings correlate with statements made by young persons who self-harm, who state that they self-harm in order to regulate their emotions (Fikke, 2011). Nevertheless, in one doctoral dissertation (Roaldset, 2010) no correlation between serotonin levels and aggression was found. Still, more research on biological vulnerability is needed, including why persons feel the need to self-harm.

2.4 Emotions and self-harm

The term emotion is an umbrella term that includes the concepts of affect, feelings, sensations and mood/state of mind. (Petzold, 2003). Affect is a conscious, intense, biologically-based emotional reaction, whereas feelings are localized in the heart and/or stomach regions and are more strongly felt than affect; they last longer and are less physiologically-based. Sensations can include feeling tense or as if in a special state. Mood/state of mind are longer lasting than feelings or affect and can be considered a psychological state (Petzold, 2003).

A person can initially experience self-harm as a form of coping and a way to regulate negative emotions (Rossouw & Fonagy, 2012; Stoffers et al., 2012; Hawton et al., 2015), but self-harm can also be understood as an expression of a person's inability to correctly regulate emotions (Bateman & Fonagy, 2007). Repetitive self-harm can lead to an addiction to self-harm and a self-destructive circle that results in stress and a lack of behavioral control (Favazza & Conterio, 1988; Tiffany & Thomas, 2013).

Persons who self-harm experience that, when self-harming, their emotional tension is reduced (Klonsky et al., 2011), their ability to master stress is improved (Edmondson et al., 2016) and they feel something other than a sense of emptiness and numbness (Klonsky, 2011). They use self-harm as a form of self-punishment (Klonsky et al., 2011), to escape something, as an attempt to gain attention (Klonsky et al., 2011, Edmondson et al., 2016) or as a way to master or stop suicidal thoughts (Edmondson, et al., 2016). Consequently, the act of self-harm can be considered a discrepancy: between a person's short-term experience of mastering difficult emotions and thoughts and the more long-term consequences of the action. Suicidal intent does not necessarily underlie repetitive direct self-harm, but the consequence of such may have a greater effect than a person intends and can lead to somatic complications or death. All episodes of self-harm, even without suicidal intent, entail a risk for suicide (Kapur et al., 2006; Bergen et al., 2010; Andover et al., 2012; Muehlenkamp, 2014; Nock et al., 2006; Guan et al. 2012; Klonsky et al., 2013).

In a review of literature that encompassed 15 studies, Norman and Borril (2015) found that persons who self-harm display poor emotional expression. The purpose of their study was to investigate the relationship between self-harm and alexithymia, which is a condition where persons find it difficult to identify and verbalize own emotions. Norman and Borril (2015) saw significantly higher levels of alexithymia in women who self-harm than those who do not, but recommend further research on whether such is evident among men. They noted that poor emotional cognition and poor emotional

expression associated with alexithymia could increase vulnerability to self-harm, especially in women.

Consciousness is closely related to language (Colapietro, 1989). Persons who do not master the ability to give voice to emotions and verbally express themselves (alexithymia) have often experienced trauma. Trauma is difficult to verbalize and, often, those who experience trauma are not encouraged to speak about it (Colapietro, 1989). Consequently, persons can experience intense, internal emotional pain and turmoil without being able to put words to it. Tiffany and Thomas (2013) found that persons who self-harm subjected themselves to physical pain as a diversion from their emotional pain and that it was difficult for them to alter their behavior and use different coping techniques instead of self-harming, such as talking about emotional pain.

When a person's ability to verbalize emotional pain is limited, self-mutilation can stabilize his/her trauma and provide a "voice on the skin" (McLane, 1996). Persons who self-harm may experience that they have not been taught how to verbalize their emotions or else they report that they experienced in their families that emotions were not to be mentioned or talked about (Tiffany & Thomas, 2013).

Ogden and Bennett (2015) found that physical pain was not only used to divert attention from emotional pain but also allowed persons to validate their emotions. In their study, participants were empowered by their self-harm in that it provided a sense of calm, peace and control in relation to difficult emotions, for a limited period of time. It could even cause a sense of self-care or mastery, when verbally expressing emotions was difficult.

2.5 Psycho-social perspective on self-harm

In some cultures, self-harm is considered socially acceptable when the behavior is linked to a religious or ritualistic context (Farber, 2000). Skårderud (2007) stated that,

“Our culture has made the healthy, clean and whole body into a moral good. It is ideal. Self-harm becomes then similarly reprehensible, shocking or sick” (p.300). Persons who self-harm often experience shame, isolation, secretiveness and loneliness in connection with the behavior (Tiffany & Thomas, 2013).

When a person is engaged in an emotional relationship with someone else, it is difficult to argue that they should not intervene in the other’s self-destructive behavior.

Engaging with others can limit a person’s independent actions, and it is important to be open to a sliding scale where human beings are more or less autonomous (Friberg von Sydow, 2011). Hopelessness increased the risk for self-harm among persons who live alone, are homeless or unemployed, have previously received psychiatric treatment and/or have abused alcohol (Steeg et al., 2016). From 2008-2010, both unemployment and the number of persons engaging in self-harm in the UK increased. In those areas where unemployment did not increase, the number of persons self-harming remained unchanged (Hawton et al., 2016).

Research also shows that self-harm is a learned behavior (Øverland, 2006). Hodgson (2004), who interviewed self-reported self-injurers via e-mail, found that persons who self-harm can either discover cutting on their own or learn about it from external sources such as friends or the Internet; such information helps “support” self-harmers in their actions. The participants in Hodgson’s (2004) study learned to hide their self-harm with clothing and cover stories. Several eventually told someone they trusted about their history of self-harm, once they became tired of maintaining secrecy on the matter. Those who learned to self-harm on their own often blame others for the fact that they started self-harming.

Self-harm can represent an expression of both powerlessness over and a rebellion against the expectations that society has of young women in the Western world (Fjelldal - Soelberg, 2013). On the Internet, persons who self-harm are able to find others who do likewise, and this allows the establishment of a culture of self-harm where the experience of social aberration does not exist. When persons self-harm, they feel a sense

of freedom from the pressure to “perform” and look good. In that self-harm is considered to be a mainly female phenomenon, men can feel a greater shame associated with self-harm, and it is possible that they withdraw or hide their behavior more than women (Fjelldal-Soelberg, 2013). Still, not all persons who self-harm fit this stereotype of a negative form of understanding. Self-harm can also be understood in the light of a relationship or as belonging to a community.

3.0 Earlier research on recovery from self-harm

3.1 Recovery - from self-harm from a nursing perspective

3.1.1 Nurses' knowledge and attitudes toward persons who self-harm

Several studies show that some nurses have little knowledge of self-harm and that they therefore relate to persons who self-harm with less empathy (Huband & Tantam, 2000; Warm et al., 2002; McAllister et al., 2002; Pembroke, 2006; McHale & Felton, 2010; Lindgren, 2011; Saunders et al., 2012; Tiffany & Thomas, 2013). Wilstrand and colleagues (2007) found that several nurses who care for persons who self-harm felt burdened with feelings, including fearing for a patient's life-threatening actions and that they were powerless in the nurse-patient relationship. Feeling overwhelmed by frustration could also cause nurses to take sick leave. They could experience some support and debriefing from colleagues and/or management, with the goal of working toward balancing professional boundaries: such as not letting staff allow themselves to be overwhelmed by patients but instead allowing them to express understanding, engagement, hope and possibility, in order to help patients.

In one study investigating nurses' experiences of caring for persons who self-harm, Thompson et al. (2008) described the stress that nurses experience in the nurse-patient relationship with persons who self-harm. This could include how nurses manage the emotional impact of working with persons who self-harm and the balancing of professional responsibilities in relation to risk. The participants in Thompson et al.'s (2008) study used compound experience-based interventions to master their work and articulated that safe, non-judgmental guidance and support from colleagues were not only important in their work but also helped reduce their anxiety.

Research also shows that when nurses have knowledge of self-harm behavior this strengthens their understanding of patients' suffering and approach in a positive manner (McAllister et al., 2009; Saunders et al., 2012; Karman et al., 2015). In their literature

review, McHale et al. (2010) found that a lack of professional knowledge (education) and clinical training hinders therapeutic attitudes in the nurse-patient relationship between mental health nurses and persons who self-harm.

In their study in which an intervention called solution-focused nursing was implemented, McAllister et al. (2008) found that increasing nurses' knowledge of self-harm influenced their capacity to help patients improve their health by motivating patients toward hope and change on the journey to recovery. Nurses became more oriented toward person-centered care with a focus on change. Karman et al. (2015) found that education can positively influence nurses' attitudes in the meeting with persons who self-harm; nurses become more patient-oriented, choose a more empathetic and explanatory approach with fewer restrictive interventions and establish a more autonomous and professional-decision-based working environment.

3.1.2 Meeting persons who self-harm with autonomy and/or paternalism

In inpatient care, a restrictive approach is traditionally used with persons who self-harm, which can increase the number of episodes and severity of self-harm (Harrison, 1998). Several studies describe the use of constant special observation and indicate that no correlation exists between this form of observation, safety and a reduction in self-harm behavior (Bowers et al., 2008; Stewart et al., 2009).

O'Donovan and Gijbels (2006) found that the focus of most intervention strategies lay on interventions such as security and preventing self-harm by removing sharp objects from patients, ensuring that patients had their nightclothes on, special observation, no-harm contracts and/or distraction techniques. Acute mental health care settings were considered to be highly stressful settings, where nurses did not always have the time to therapeutically engage with patients who self-harm, and nurses felt dominated by the medical model of care that contradicted the person-centered approach they wished to provide (O'Donovan & Gijbels, 2006).

In some guidelines for the short-term follow-up of persons who self-harm, an approach that incorporates the idea of harm minimization, by giving patients tools with which to harm themselves while in a certain setting, is recommended (National Institute for Clinical Excellence, 2004; Royal College of Nursing, 2006). In a study by Birch et al. (2011), participants (all female) were not stopped from engaging in self-harm but were instead encouraged to engage in alternative ways of expressing themselves rather than self-harm. For instance, patients could be allowed to write their own care plans and an expectation existed that they would start the process of finding words to express their thoughts and emotions. They were also placed in situations where they had to come into contact with sharp objects. They furthermore were encouraged to seek company from nurses when they experienced insecurity.

Nurses working at the same unit can have different opinions on whether patients should be allowed to harm themselves or not. Rovik (2007) found that mental health nurses and other professional caregivers find it difficult to understand that persons can show such violence toward themselves and that self-harm can spread among patients (social contagion). In Rovik's study (2007), staff were divided as to which interventions should be taken in response to self-harm: whether staff should be present during the act, forbid self-harm or use force to prevent the act. When a zero-tolerance attitude was implemented, patients' need to self-harm developed into situations where violence and physical restraint (belting) were used.

Self-harm and harm minimization were the focus of Holley et al.'s (2012) study, where in interviews nurses related that they were initially divided as to whether patients should be allowed to self-harm while in inpatient care. When inconsistencies in the nursing practice being realized were found, an intervention was put into place. This resulted in a team that possessed knowledge of how to support safe self-injury and that individual measures were introduced in patient relationships. As a result of these changes, the number of self-harm episodes was reduced. In another study, interviews with nurses revealed that they experience both sympathy and antipathy in the meeting with self-

harm behavior (Brodtkorb, 2001). In Brodtkorb's (2001) study, participants described a balancing act in the meeting with patients relevant to whether nurses should take on the responsibility for patients' behavior or whether they should ensure that patients be able to take responsibility for their own behavior, with the goal of promoting maturity and growth in patients.

3.2 Personal experiences of the recovery process from self-harm

Studies show that, as patients, persons who self-harm and their close relatives often do not experience recovery because of poor relationships with professional caregivers who have little knowledge of self-harm.

In her doctoral dissertation, Lindgren (2011) described that in the meeting with professional caregivers, self-harm patients and their families experienced that the patient-caregiver relationship promoted little hope for recovery. In Lindgren's (2011) study, patients' parents initially had confidence in the care being provided but eventually experienced that those providing care were not professionally competent. The patients' parents expressed that professional caregivers seemed to feel frustration, anger and powerlessness in the situation and were not able to instill a hope for recovery in them.

Persons who self-harm seek understanding and acceptance, not rejection, from professional caregivers, and when caregivers correct patients' self-harm through coercive measures, patients' frustration and shame increases (Looi et al., 2015). Patients desire a mutual caregiver-patient relationship instead of distrust from professional caregivers, and the use of punishments and coercive measures with patients does not contribute to establishing a relationship. In another study, female patients related that they found it difficult to trust in others and articulate their experienced stress (Baker et al., 2013). Here the triggers that promoted a need for self-harm were related to the

absence of control over own emotions, and the participants related that physical pain was used as an alternative to emotional pain

3.2.1 Personal experiences of what promotes a recovery process

The building of trust and mutual interaction in a therapeutic relationship is central to the self-maturation and growth of the person who self-harms and his/her recovery from self-harm. The helpless human being behind the cutting or self-harm behavior needs to be recognized as a person and integrate own experiences into the recovery process and create meaning by redefining the self.

The female participants in Hammer et al.'s (2013) study related that their coping strategy included the desire to be admitted to a care unit and stop self-harming through the help of accessible professional caregivers who noted and accepted patients' autonomy and participation. The participants in Ogden and Bennett's study (2015) were motivated to seek help for recovery when the balance between emotional pain and the level of self-harm no longer provided comfort and instead became a barrier to well-being and when a lack of control over the self-harm behavior was experienced. The participants sought relationships with caregivers who listened to and accepted them and were caring and non-judgmental. Several participants related that they had received help from different sources and described that they sought the form of help that was, for them, the most health promotive (Ogden & Bennett, 2015). Hunter et al. (2013) found that individual follow-up, such as having someone to talk to, promoted the recovery of a person's own self-worth, inspired hope in the possibility to change one's life and placed the theme (self-harm) in perspective. If the persons undergoing this process are to find meaning in their suffering and wish to improve their well-being, they must not hold back personal information (Long et al., 2016). Patients sought a recovery process from self-harm that included, as central themes: talking about stress, a desire for protection from self-harm, mastery of what is difficult through the use of a different method, and being treated as a normal person (Baker et al., 2013).

Women who were interviewed about their personal experiences of inpatient mental health care in a study by Lindgren et al. (2004) stressed that being “seen” by professional caregivers strengthened their self and hope for improvement. This included that the caregivers spent time with them and demonstrated friendliness and openness in the patient-caregiver relationship. They experienced a change toward recovery when they felt that professional caregivers understood them and talked about and co-investigated the reasons underlying their self-harm in order to find a health-promotive alternative to self-harm. These women stated that they had been treated with dignity and allowed to participate in, plan and take responsibility for increased self-care (Lindgren et al., 2004).

In one user-led study, researchers found that psychiatric inpatients in acute care experienced that their suffering was taken seriously when they were given the opportunity to spend time and build a relationship with professional caregivers (Walsh and Boyle, 2009). Doing so improved their self-esteem and promoted their recovery process. The participants were also allowed to engage in activities on their own as a form of self-help in learning to distract themselves from the urge to self-harm. Some indicated that they wished to participate in the drawing up of own treatment plans but that this seldomly occurred. Care measures must be individually implemented and emanate from a person’s life history and type of self-harm and caregivers must show understanding and friendliness (Hume & Platt, 2007). In their study, Wills and Hons (2012) showed that in order to recover the self, persons must accept themselves and work toward hope in order to gain control over their self-injury, and that support from mental health services was essential if such was to occur.

Positive factors that can influence a recovery process from self-harm can include: coming to the decision to stop harming oneself, supportive relational ties, empathetic professional care that is person-centered, motivators that stop one’s self-harm, a reduction in the psychological symptoms that trigger self-harm, taking control of one’s life and believing in oneself, engaging in other things rather than self-harm (Shaw, 2006).

4.0 Theoretical perspective in the dissertation

At present, there is no international consensus on how the concept of recovery should be understood or defined within the context of mental health (Davidson et al., 2005a; Casey, 2008; Tiller, 2007; Collier, 2010; Borg & Karlsson, 2017; Barker & Buchanan-Barker, 2011), despite the concept of recovery already having emerged in the field in the 1980s (Coleman, 1999; Casey, 2008).

As seen in relevant literature and research, the concept of recovery includes multiple dimensions: in the natural science paradigm, for example, where human beings are viewed more like objects and subjects than in the humanistic paradigm. Schøn et al. (2009) limits recovery to three perspectives. The first is that recovery can be the consequence of being cured from an illness, that is to say the result of a planned treatment where a person becomes symptom free and is able to master everyday life. The second is that recovery is experienced as personal change and growth. The third is that recovery can be a spontaneous or natural event where a person can become better without treatment. While recovery can occur without medical treatment it is always a process where the suffering human being experiences greater mastery of everyday life. Collier (2010) nonetheless maintains that medical recovery is merely part of a person's recovery of life.

In this dissertation, the various perspectives of recovery are not considered mutually exclusive but are instead viewed from a holistic view of the individual, unique person and his/her life situation. The person has developed illness or disease over time and his/her human resources can, through support and collaboration be activated as part of a recovery process. The perspective taken on recovery here is that it is both an individual process, where a person experiences living with illness and its effects on his/her social life, and a lifelong learning process, where the person lives with the social challenges unique to him/her and experiences a cure from illness. For one person, a cure from illness can be the most important approach toward recovery while for another the social

recovery process is most important. A person-centered perspective in nursing promotes a person's recovery process.

4.1 Recovery from mental illness and suffering

Several researchers in the field of mental health view recovery as a change in the "I" or "self" in a person, yet do not limit what they define the I or self to be (Borg & Topor, 2003). Heggdal (2008) views the recovery of the self as a whole beyond the perspectives of the person's psyche, body, existential and social state.

Ricoeur (1986/1988 p.83) maintains that human beings live in both "explanation" and "understanding". Ricoeur describes two distinct kinds of identity (Ricoeur 1990/1992): the *idem*, the substantial identity in a thing, and the *ipse*, the reflective self, which is that which maintains a person's sameness and is a form of continuous identity over time in an existential perspective: the "who" of a self. Self-knowledge as the hermeneutics of the self is not always given. Ricoeur maintains that the hermeneutics of the self is relevant to how one understands the relationship between the *idem* and the *ipse*, and maintains that it is this which is the complementary in the relationship between the person and the patient. Both paradigms become limited if they do not include the other.

4.1.1 Recovery as curing from illness

From a purely medical perspective, recovery from self-harm entails that a person displays few or no symptoms or deficits associated with a serious mental illness (Davidson et al., 2009; Ferden et al., 2008; Hummelvoll, 2012; Borg & Karlsson 2010) and displays no need to self-harm. If no need to self-harm is seen, then the patient is considered to be in recovery from serious mental illness. In his work, Slade (2009) described a transformational and result-oriented perspective in which results or

conditions are observed and evaluated by professional caregivers who are experts in their field, for example in self-harm.

In the natural science paradigm, it is the objective that facilitates the development of an anonymous and independent observation. Medical recovery focuses on the patient's medical history, not the human being "behind" the patient, and the patient's history is understood emanating from medical context and language (Frank, 2000). Language used thus is more neutrally observant. The "problem" is found, for the most part, to lie within the patient him/herself and the applied clinical approach is to change the patient through treatment and support so that he/she can become "normal" and no longer reliant on mental health services (Slade et al., 2014). Mental illness is the basis upon which evaluations occur, evaluations of whether the patient is capable of taking care of him/herself, because he/she is not "in their right mind" (Davidson et al., 2009).

4.1.2 Recovery as a personal process

Each person has own experiences and understanding (meaning) of what recovery means to them (Davidson et al., 2009; Slade et al., 2012), and what it for him/her entails to live with suffering from a mental illness. Anthony (1993) and Davidson and Roe (2007) defined recovery as a personal process, with Anthony (1993) focusing on the person's, "unique process of changing one's attitudes, values, feelings, goals and/or roles" (p.15), and Davidson and Roe (2007) focusing on the process where the person rediscovers hope and believes in own his/her own possibilities. Recovery is a *non-linear* process that affects the entire person, with a focus on that which is healthy in the person (Topor, 2001; Leamy et al., 2011). The goal of recovery as a personal process is therefore not normalization but instead that the person gradually experiences improved well-being and hope for the future (Borg & Karlsson, 2017).

4.1.3 Recovery as a social process

When the self is defined from what a person considers to be a meaningful life, empowerment and greater control of everyday life is experienced (Leamy, 2011) through a dynamic relationship with that which surrounds the person, for instance work, close environment, friends and family, which can constitute resources (Hummelvoll, 2012; Borg & Karlsson, 2017). This is a personal process toward a worthy life and a positive identity: where there is an absence of stigma or discrimination at one's home, place of work or education (Tew et al., 2012), including the absence of isolation, poverty or unemployment, for example (Topor, 2004; Davidson et al., 2005b; Borg, 2007; Onken et al., 2007; Schøn et al., 2009). When a person is in a recovery process from a mental illness this also entails the establishment of a positive identity finding the meaning in one's own experiences of mental illness, and managing own symptoms and pain.

4.1.4 Recovery as lifelong learning

In instances of physical or mental illness, a person learns new ways of mastering and living with the condition in everyday life. Recovery as an individual process, where own life experiences and redefining one's self from being a patient to holding "citizenship", is a process where lifelong learning is essential on the path to an empowered, own identity (Ryan et al., 2012). Recovery is not possible without a personal empowering process (Boevink, 2012). Helping persons toward empowerment is central if a person's independence and self-confidence are to be supported (Morgan & Yoder, 2012): then the person is the center of his/her own decision-making (McCormack & McCance, 2010) and empowerment becomes a collaborative process with a shared learning approach (Lloyd, 2007; Freire, 1970).

Recovery can be defined as a process of learning a new way of approaching the challenges in everyday life: learning skills, living independently and giving something to the community (Ralp et al., 2000). Central to lifelong learning is the individual

process, where learning is focused on the unique person's own discoveries – only the person him/herself can do this – and the development of the person's own capacity and experiences of making own life choices. Still, recovery does not imply an absence of symptoms or illness. In the therapeutic relationship, a person is invited by a helper to be in a relationship that includes reflection and dialogue and a discussion of various perspectives and approaches (Glover, 2012).

4.2 A person-centered perspective in nursing care

In a person-centered perspective, the patient is a person who is more than his/her illness. Person-centered care is based on a holistic view of the human being. Holistic care is an approach in which the physiological, psychological, sociocultural, developmental and spiritual are integrated (McCormack & McCance, 2017).

Identifying and understanding each patient's care needs and reaching a deeper understanding of the unique person's message of suffering are central elements in each nursing relationship (Fagerström et al., 1998). The person's experience and knowledge form the base for the strengthening of well-being through the nurse-patient relationship, in which the nurse is present, supports the patient, and utilizes practical knowledge (McCormack & McCance, 2017). Working in such a manner, so that the unique person's beliefs and values are taken into consideration, requires a focus on what it is that gives a person meaning in life and an understanding of where said person is in his/her life history. Nurses should also have an understanding of the choices that the person has and support the person's independence by providing personalized informational (McCormack & McCance, 2017). Nurses act in a sympathetic manner when, in their meeting with a patient, they demonstrate respect and acceptance and value the person's uniqueness and support the person in improving his/her coping resources. Authentic engagement is a connectedness between the nurse and patient, where each care situation is a unique, real interaction (McCormack & McCance, 2017).

In person-centered care, nurses work together with the person to establish good routines, personal independence, well-being and reduce the stigma felt by the patient (Gabrielsson et al., 2015). A person-centered approach entails allowing the patient to explore thoughts and emotions, discover a more accepting self (Ruddick, 2010) and express dreams, resources and interests and what can be done to overcome the limitations experienced in everyday life due to mental illness (Borg et al., 2009).

The educational conversations intrinsic to the method are important in person-centered care, where a patient's personal understanding of what it is to be a human being in various situations is shared with caregivers and the patient's learning is stimulated (Forsberg, 2016). Person-centered care can be described using both biomedical and personal parameters (Forsberg, 2016).

It is essential that nurses see the person in their care, confirm his/her experiences and include the person in all aspects of care, which should change over time in accordance with the person's situation, wants and needs (Foss, 2011; Jensen et al., 2013). Nurses must be able to understand which emotional, social, cognitive and contextual conditions influence the nurse-patient relationship (Atkins, 2006). Nurses facilitate the patient's participation in care and provide information that can improve self-determination. This does not, however, entail that the will of the patient is always followed (Bowen & Mason, 2012). Nurses must see the person's needs, illness and suffering yet still set the limits that the person in their care needs (Gustin, 2014).

In innovative practice, nurses and a care organization's leadership work together to provide patients with a sense of well-being and that it is possible for them to participate and be active in their own care. According to Edvardsson et al. (2009), care should be organized according to patients' personal needs and preferences instead of institutional standards or routines. Research shows that the implementation of person-centered care in care facilities contributes to recovery from mental ill health (Chen et al., 2013) and helps patients lead a meaningful life (Farkas et al., 2005). Meeting each patient with an individual approach is central to the realization of a fundamental nurse-patient ethical

attitude (Edvardsson, 2012), and understanding each patient's health processes is crucial for helping the patient in his/her recovery process. Borg and Karlsson (2017) maintain that a person-centered approach and recovery helps a patient take back control and meaning in his/her life back and facilitates hope for recovery and ambitions for the future.

5.0 Rationale and aims

5.1 Rationale for the dissertation

The motivation for the rationale for this dissertation has been presented through a dissemination of earlier research in Chapters 2-3. Upon reviewing the actual research literature on recovery from direct self-harm, one sees that the knowledge that currently exists is still limited in regard to recovery from self-harm from both adult patient and nursing perspectives.

Study 1. To clarify the content of the concept of self-harm.

The concept of self-harm has several synonymous concepts (cf. Chapters 1-2), which are currently used to delineate the content of the phenomenon self-harm. Consequently, a clear need exists to further investigate the content of the concept of self-harm, and to generate a first draft of a theoretical model that can be used as a basis for the further investigation and development of the self-harm concept (Rodgers, 2000). In this study, concept analysis is used to increase understanding of what is meant by the concept of self-harm in the disciplines of medicine and nursing science.

Study 2. To explore mental health nurses' experiences of caring for adult inpatients who self-harm during an acute phase.

In several studies, researchers have found that some mental health nurses lack empathy in the meeting with persons who self-harm and that their knowledge of self-harm is limited (cf. Chapter 3). Studies have shown that mental health nurses try to ease the suffering of persons who self-harm and promote their recovery, for example, by showing that they are understood and acknowledged and motivating and giving them hope for recovery. However, this should be further explored as more evidence is needed. One conclusion is that there is still limited research on how mental health nurses promote recovery for adult patients who self-harm.

Study 3. To explore, describe and understand adult former patients' experiences of their personal recovery.

Currently, self-harm is understood to be a complex phenomenon that affects the entire human being, and many persons who engage in self-harm also suffer from other forms of mental illness (cf. Chapter 2). One common perspective is that self-harm is done with conscious intent and driven by a person's need to regulate own emotions (cf. Chapter 2). The risk for suicide seems to simultaneously increase when a person self-harms. Some who self-harm have difficulties verbalizing their inner pain, and emotions seem to have an effect on self-harm (cf. Chapter 2). Self-harm is still considered "taboo", and many of those who self-harm do not seek professional help (cf. Chapter 2).

In this dissertation, various studies on patients' experiences of what promotes recovery from self-harm have been presented (cf. Chapter 3). Nevertheless, few previous studies have included an analysis and investigation of the experiences of adult former patients who have self-harmed, especially those who have experienced at least two years of recovery. By deepening knowledge of how former patients have experienced the recovery process from self-harm, new and valuable knowledge is gained. It is possible to gain better understanding of how persons who have suffered from self-harm have learned to cope with their illness and suffering, what and/or who has promoted their recovery process, what could be learned from their experiences, and when, how and in what context they received help and support. These aspects should be further researched and explored in greater detail.

5.2 The aim of this dissertation

The overall aim of this dissertation was to expand understanding of recovery from self-harm, in other words a true clarification of the content of the concept self-harm, through interviews with mental health nurses and former patients.

The specific aims for the studies

In study 1, the specific aim was to clarify the content of the concept self-harm and the consequences of improved understanding for the disciplines of medicine and nursing science through the application of a theoretical concept analysis.

In study 2, the specific aim was to explore mental health nurses' experiences of caring for inpatients who self-harm during an acute phase.

In study 3, the specific aim was to explore, describe and understand former patients' experiences of their personal recovery from self-harm.

6.0 Design and methods

6.1 The overall design

The research project described in this dissertation has, overall, a qualitative exploratory research design. In a qualitative research approach, the aim is to describe and analyze the characteristics or qualities of the phenomenon being studied. The purpose is to understand human actions and meaning as well as the social systems and praxis they are included in (Malterud, 2011). An exploratory approach allows researchers to explore an area for which there is little prior knowledge (Polit & Beck, 2017). Such an approach is suitable in that there is limited knowledge on recovery from self-harm, especially in regard to research that synthesizes mental health nurses' and former patients' experiences of recovery from external self-harm.

Table 1. Overview of the realization of the qualitative exploratory research design, including data sources and the methods used for data collection and analysis in studies I-III.

MAIN DESIGN Qualitative exploratory research design	SPECIFIC DESIGN	DATA SOURCES	METHODS USED FOR DATA COLLECTION	METHODS USED FOR ANALYSIS
Study I Clarifying self-harm through evolutionary concept analysis	An inductive theoretic approach	Total of 48 research papers: 25 articles from medicine and 23 articles from nursing science	Systematic literature search with additional manual search	Evolutionary concept analysis
Study II Mental health nurses' experiences of caring for patients suffering from self-harm	A qualitative, exploratory and descriptive design	15 mental health nurses	Qualitative interviews	Content analysis
Study III Former patients' experiences of recovery from self-harm as an individual, prolonged learning process.	A phenomenological hermeneutical approach	8 former patients who had suffered from self-harm	Qualitative interviews	Phenomenological hermeneutical method

6.2 Study I

6.2.1 The design of the study

This study has an inductive theoretic approach.

6.2.2 Data collection: Literature review

A systematic database search of the Medline, PubMed, Cinahl, and PsychINFO databases for articles published between 1997 to 2007 in the English language using the keywords self-harm, self-harming, and psychiatric care occurred. All texts were evaluated based on the clarity of their presentation of research method. Rodgers (2000) recommends that each discipline included in a study should be represented by approximately 30 studies and suggests supplementing a database search with a manual search if necessary in order to obtain this number. Accordingly, 9 additional studies, 4 within medicine and 5 within nursing science, were manually chosen through a systematic search of the references of the articles selected from the database search. This resulted in the inclusion of 25 medicine and 23 nursing science articles (Toftthagen & Fagerström, 2010a, p 12-13).

6.2.3 Data analysis: Rodgers' evolutionary concept analysis

In study I, an evolutionary concept analysis was used to clarify the concept of self-harm (Rodgers, 2000). The data analysis began with a reading of all the articles chosen for inclusion. For the purposes of this study, articles whose first listed author was a physician were considered to be medicine articles while studies whose first listed author was a nurse were considered to be nursing science articles. The articles were then coded according to name of first author, category of context/sample and research method. Each article was read in its entirety and then the concept's context, surrogate terms, antecedents, attributes, examples and consequences (cf. Table 2, Toftthagen & Fagerström, 2010b), as specified in Rodgers' evolutionary method (a structure for the inductive analysis of articles as themes), were identified and written down on separate papers (Rodgers, 2000).

Table 2. Questions used during the core analysis phase.

Surrogate terms	Do other words say the same thing as the chosen concept? Do other words have something in common with the concept?
Antecedents	Which events or phenomena have been associated with the concept in the past?
Attributes	What are the characteristics of the concept?
Examples	Are concrete examples of the concept described in the data material?
Consequences	What happens after or as a result of the concept?

(Toftthagen & Fagerström, 2010b)

Data for each dimension were examined for agreement and disagreement across disciplines and for change over time. After initial analysis by the first author, key ideas were discussed in the research group until agreement was reached and themes were identified. Concepts change over time and are influenced by the contexts in which they are used (Rodgers, 2000).

6.3 Study II

6.3.1 The design of the study

This study has a qualitative, exploratory and descriptive design.

6.3.2 Recruitment of mental health nurses

Mental health nurses at five adult acute care units at four psychiatric clinics in Norway were asked if they would consent to be interviewed and thereby participate in the study. Inclusion criteria were that participants were employed 100 % at an acute inpatient psychiatric unit for more than three years and either were specialized in mental health nursing or were registered nurses with extensive work experience in caring for self-harm patients. Nurse leaders and specialist nurses with responsibility for development and quality assurance were excluded.

The top managers at the four participating clinics gave written permission for the study, and study participants were recruited by their employers, who asked those who met the inclusion criteria whether they wished to participate in the study. The participants were interviewed at their place of work during working hours. A total of fifteen participants were interviewed, 12 mental health nurses and three registered nurses. Of these, 13 were women and 2 were men and they had worked in acute psychiatric care contexts for a mean of 5,1 years (Toftthagen, Talseth & Fagerström, 2014)

6.3.3 Data collection: Interviews

Semi -structured interviews were conducted between autumn 2010 and spring 2011. The interviews lasted from 45 to 90 minutes, and the participants were interviewed at their place of work during working hours. The interviews started with an open-ended question about participants' experiences of caring for patients who self-harm. An interview guide was used during the interviews and included the following themes: mental health nurses' experiences of caring for persons who self-harm, patients' expressions of self-harm, the use of force, what inhibits or promotes self-harm patients' coping abilities (mastery) in relation to self-harm and how self-harm affects nurses'

own feelings. The interviews were audio-recorded and transcribed verbatim into text. The transcribed interviews were coded with a number and the audio files locked (Toftthagen, Talseth & Fagerström, 2014).

6.3.4 Data analysis: Manifest and latent content analyses

The study of the experiences of mental health nurses was based on qualitative content analysis inspired by Graneheim and Lundman (2004). Qualitative content analysis is a method of analyzing verbal and written data in a systematic way and making replicable and valid inferences from texts (Krippendorff, 2013) and is an interpretive process that focuses on context, subjects and text similarities and differences (Graneheim and Lundman, 2004).

The transcribed interviews were analyzed using qualitative *manifest content analysis*, which includes seven steps (Graneheim and Lundman, 2004). In the **first** step, the researchers read and re-read the transcribed interview material to obtain an overall understanding of the content of the interviews: that is, participants' experiences of caring for patients who self-harm in an acute mental health care context. In the **second** step the focus lay on the text, which was divided into meaning units. A meaning unit can be one or several words, sentences, or paragraphs that are related to one another through aspects relevant to the aim of the study with regard to content or context. In the **third** step, the meaning units were condensed, and in the **fourth** step the condensed meaning units were compared, discussed and labeled with codes. In the **fifth** step, the codes were abstracted, compared and sorted into subcategories. In the **sixth** step, ten categories were created from the similarities and differences seen between the subcategories. In the **seventh** step, ten categories were formulated into two main categories: challenging and collaborative nurse-patient relationship and promoting well-being thorough nursing interventions.

In the **last phase** of the analytic process, the *latent theme* was created from a deeper interpretation of the underlying meaning of the subcategories and categories and

formulated as follows: promoting person-centered nursing to inpatients suffering from self-harm. Throughout the entire analytic process, categories, subthemes and themes were compared with the interview texts. Together, the researchers of the study engaged in a discursive reflective process and dialogue about the interpretations and abstractions of the subthemes and themes, continuing until consensus was reached (Toftthagen, Talseth & Fagerström, 2014).

6.4 Study III

6.4.1 The design of the study

This study has a phenomenological hermeneutical approach.

6.4.2 Recruitment of former patients who have experienced recovery from self-harm

Several different approaches were used to recruit former patients who have experienced recovery from self-harm; six participants were recruited through two mental health user organizations, one through the media and one through another researcher's research, for a total of eight participants. Those who were interested in being interviewed were asked to send an e-mail to the main researcher and confirm their interest in participation. The inclusion criteria were that a person had experienced recovery from self-harm, had not engaged in self-harm during the past two years and was 18 years of age or older. The research group determined that a two-year period of no self-harm was appropriate as an inclusion criterion because during the first year following a hospital-treated self-harm event about 14 to 20 % of adults will repeat a self-harm event while about 1-2 % will commit suicide (Haukka et al., 2008).

The participants included one man and seven women with a mean age of 36. All had cut themselves repeatedly from moderately to more seriously over a period of years, and seven had attempted suicide once or more. Seven had engaged in other forms of self-

harm, such as overdosing, sticking sharp objects into the body, swallowing sharp objects, substance abuse, eating disorders and/or burning the skin (Toftagen, Talseth & Fagerström, 2017).

Table 3. Description of participants

An overview of participants' gender, age, geographical location, self-reported diagnoses, type of self-harm, number of admissions into care, number of years experienced self-harming, employment and time elapsed since recovery.

GENDER AGE GEOGRAPHICAL LOCATION	SELF- REPORTED DIAGNOSES	TYPE OF SELF- HARM	NUMBER OF ADMISSIONS INTO CARE	NUMBER OF YEARS EXPERIENCED SELF-HARMING	EMPLOYMENT	TIME ELAPSED SINCE RECOVERY
Male 49 years old Eastern Norway	Currently: Periodic suicidal thoughts. Previously: Suicidal, Psychotic breaks, Several attempted suicides.	Deep cutting. Tools used: knives, needles, knitting needles, syringes, swallowed sewing needles, scalpels.	Many in mental health care and somatic care. Does not remember	29 years (16-45)	Volunteer in a mental health user organization	5 years
Female 35 years old Southern Norway	Currently: No diagnosis. Previously: Emotionally unstable personality disorder, Attempted suicides.	Swallowed sharp objects, Difficulties eating, Cutting.	86 in mental health care and 50 in somatic care	14 years (20-34)	Experience consultant in mental health care	About 2 years
Female 27 years old Eastern Norway	Currently: No diagnosis Previously: Post-traumatic stress disorder, Repeated episodes of depression, Attempted suicides.	Cutting, Burning, Pills.	Many in mental health care and somatic care	8 years (14-22)	Experience consultant in mental health care	5 years
Female 50 years old Western Norway	Currently: Depression, Disassociation, Post-traumatic stress disorder, Periodic suicidal thoughts. Previously:	Cutting, Burning, Eating disorders.	Many in mental health care and somatic care	33 years (15-48)	Experience consultant in mental health care	2 years

	Affective disorder, Attempted suicides.					
Female 37 years old Western Norway	Currently: Holds moods in check through medication. Previously: Anxiety, Depression, Post-traumatic stress disorder, Manic depressive disorder.	Repeated cutting.	Went to a psychiatrist and emergency services	10 years (18-29)	Care worker	8 years
Female 32 years old Northern Norway	Currently: Recurrent Depression. Previously: Emotionally unstable personality disorder, Attempted suicides.	Cutting, Pills.	Psychiatrists, Dialectical behavior therapy group.	8 years (18-26)	Experience consultant in mental health care	6 years
Female 26 years old Eastern Norway	Currently: Periodic suicidal thoughts. Previously: Emotionally unstable personality disorder, Bulimia. Attempted suicides, Intoxication,	Serious cutting, Substance abuse, Bulimia.	60 in mental health care and at 12 different units and repeated admission to somatic care.	12 years (10-22)	Writer	4 years
Female 30 years old Eastern Norway	Currently: Emotionally unstable personality disorder. Previously: Anorexia, Bulimia, Attempted suicides.	Cutting, Burning, Hitting, Pills, Anorexia, Bulimia.	Admitted to mental health care units for about five years in total.	7 years (18-25)	Student	5 years

(Toftthagen, Talseth & Fagerström, 2017)

6.4.3 Data collection: Interviews

The interviews were completed autumn 2013 by the first author. The data consisted of eight transcribed and anonymized interviews (240 pages in total) with an interview time of 50-120 minutes per interview. The first question asked during the interview was “Can you tell us about your experiences of gradual recovery from self-harm?”, followed by: “What motivated you to start recovery?”, “How have mental health nurses promoted a hope for recovery for you?”, “How have you learned to cope with your self-harm?” Further questions were asked to encourage participants’ reflections on what they thought and did during the recovery process from self-harm and to increase the interviewer’s understanding of the participants’ histories (Lindseth and Norberg, 2004).

A great deal of thought was given to deciding on the context of the interviews, that is to say where they should be conducted. Should the interviews be conducted in the participants’ homes, in their private sphere - would it be difficult for the participants to interrupt an interview in this context and ask the researcher to leave? Would it be problematic for the interviews to be conducted in a meeting room at a psychiatric clinic given that the participants have experienced recovery – would this create an unnatural framework? A café is perhaps a neutral location – but conversations can be overheard and individuals observed? A library in the participants’ local area - perhaps associated with the lifestyle of a healthy person? The decision was made that the participants themselves would decide the context.

One participant chose to be interviewed at home, with two friends in the same room during the interview. Another wanted to be interviewed on the premises of a user organization. One was interviewed in a conference room at a hotel and brought along a relative for support during the interview. Two participants chose to be interviewed at the first researcher’s place of work. One chose to be interviewed through the use of a video conference tool, Skype, considering it to be a neutral setting. One participant chose to be interviewed in a meeting room at the psychiatric hospital where she worked. Regardless of setting, after each interview all participants were sent an e-mail in which I asked participants how they felt the day after the interview. All of the participants expressed that the interviews had gone well (Toftthagen, Talseth & Fagerström, 2017).

6.4.4 Data analysis: Phenomenological hermeneutical analysis

A phenomenological hermeneutical approach inspired by Ricoeur's (1976, 1988) philosophy and further developed by Lindseth and Nordberg (2004) was used.

Phenomenology uncovers, describes, and explains the essence of the lived experience of a phenomenon through structures of meaning (Husserl, 1970). Hermeneutics is both the philosophy of understanding and the science of textual interpretation (Geanellos, 1998). According to Ricoeur (1976), interpretation theory is the hinge between language and live experience, preunderstanding-interpretation-understanding (subjective hermeneutics) and the whole and parts (objective hermeneutics) (Ricoeur, 1993, 1995). Ricoeur (1993, 1995) emphasized the dialectic between understanding and explanation.

The analysis of the data material consisted of a movement between three steps: naive reading, structural analysis and comprehensive understanding, which involves a dialectical process between decontextualization and recontextualization of the text, between understanding and explanation and between focusing on what the text says and what understanding the text is pointing to (Ricoeur, 1976; Lindseth & Norberg, 2004).

Step 1. Naive reading.

In the first step, the research group read, reread and discussed the transcribed interviews with an open mind in order to gain an overall grasp of the meaning of the text as a whole. The naive reading generated ideas for the further structural analysis and gave the *first understanding* of the text as a whole material. The first understanding of the text was synthesized into a short narrative (Lindseth & Norberg, 2004).

Step 2. Structural analysis.

Thematic structural analysis was used in order to *explain* what the text expressed. The analysis was characterized by a decontextualization of the text. The text was divided into meaning units, which were condensed and labeled with codes. These codes were compared and discussed, and a decision was made as to how the codes could be sorted into meaningful content as subthemes. The structural analysis was not a linear process but instead moved back and forth between the whole and the structures of the text. Those subthemes with similar content were sorted into themes. The subthemes and

themes were found to be consistent with the naive reading, which strengthened the validity of the structural analysis (Lindseth & Norberg, 2004).

Step 3. Comprehensive understanding.

In this last step, the in-depth interpretation was developed from the relevant literature, research questions, naive reading, structural analysis and the research group's preunderstanding, and the aim of this step was to gain a deeper understanding of the interviews as a whole: to recontextualize the text (Ricoeur, 1976; Lindseth & Norberg, 2004). The subthemes and themes were further interpreted into a *main theme* that described the essential meaning of what recovery from self-harm means for persons who have suffered from self-harm. Together, the research group discussed each of these steps until consensus was reached (Toftthagen, Talseth & Fagerström, 2017).

6.5 Methodological considerations

There is currently no consensus among researchers regarding what sort of quality criteria should be included in qualitative research (Morse et al., 2008; Polit & Beck, 2017). Polit & Beck (2017) noted that the two most commonly used quality criteria in qualitative research today are guided by Guba (1981), Lincoln & Guba (1985) and Whittmore et al. (2001). In this research, the starting point has been Lincoln & Guba's (1985) understanding of trustworthiness, which has been used to determine the overall quality criteria for the methodological consideration: credibility, transferability, dependability and confirmability. The substance of the various criteria overlaps somewhat. The standards for trustworthiness in qualitative research are comparable to the standards for reliability, external validity, objectivity and internal validity applied in quantitative research (Lincoln & Guba, 1985).

6.5.1 Credibility

According to Lincoln & Guba (1985), credibility is when a researcher investigates that which was the intention of the research using the methods selected. Prolonged engagement as a criterion of credibility entails that the researcher is familiar with the

context/culture and distortion and builds trust with the participants (Lincoln & Guba, 1985).

Over time I discovered that the way in which understanding of the surrogate terms related to the phenomenon of self-harm was used and which term was applied was country-relevant and that this affects the comparison of international studies. For example, in the United States and Canada the term non-suicidal self-injury is primarily used. In Europe and Australia, the term deliberate self-harm is more common (Wester and Trepal, 2017). The term suicidal behavior is also often used as an umbrella term that encompasses the various definitions of self-harm (Silverman, 2011), even if self-harm is often defined as not including suicidal intent (cf. Chapter 2). In Europe, the term self-harm is currently most commonly used (Silverman, 2011). That such differences existed was not part of my preunderstanding of the phenomenon, despite my experience working in an acute psychiatric context and in the world of academia.

The building of trust in us as a research team occurred when the implementation of the various studies written and oral information was provided to the various clinic leaders and participants voluntarily participating in studies II and III. Information that was professionally valid yet simultaneously easily understood was used to recruit participants. Trust was also built during the interview situations when the interviewer listened to the participants' experiences and through themes described their own words and gave them time to do so (Mishler, 1986). During these interviews, I asked active follow-up questions in order to elicit nuances in the participants' understanding and to prevent the interpretation of my own understanding of such work in the same context into the participant's experiences.

For the nurses' interviews, the context was conference rooms at their places of work. For the former patients' interviews, the context was chosen by each former patient; they were allowed to decide themselves where they would like to be interviewed so that they would feel as safe as possible. The interviewer travelled to several different cities throughout Norway to complete the interviews.

The participants in study III were considered to be “former patients”, which can contribute to an association between “patient” and “ill” for persons who have experienced recovery. The research team had an understanding of an occasional reduced self-determination (decisional capacity) in persons who self-harm, because that previous suffering can involve better and more acute phases (Rhodes, 2005). Consequently, a time limit was set; the participants in study III were not to have engaged in self-harm during the past two years prior to participation in the study.

At the start of the project, the researcher wanted to interview the participants in study III about their experiences of recovery from an acute psychiatric context. The participants however did not wish to limit their perspectives on personal recovery to this context, but instead wished to include the overall context of their lives. It would appear here that the researcher was too close to her own perspective of the research subject, and that it would have been beneficial to have undertaken a pilot study in which former patients were interviewed in order to gain more understanding of their experiences of the personal recovery process.

After having experienced recovery for at least two years, six of the eight former patients worked in the field of mental health: four as experience consultants at a mental health care clinic, one at a user organization and one as a professional care worker. The participants can in these contexts have developed an understanding of a professional perspective on the follow-up of persons who self-harm, and this can have influenced how they understood and expressed their own experiences of recovery.

Cultures are not static and can change over time. By supplementing the interview studies seen in study II with an observation study in a clinical setting, I could have gained newer understanding of the culture. At the same time, it is possible that participants in

an observation study change their behavior because they are being observed (Masone, 2017).

In studies II and III, mental health nurses and former patients were interviewed about their experiences. Interview saturation (cf. Malterud et al., 2016) entails that the more relevant information there is during data collection, the fewer participants are needed. If we compare with Kvale and Brinkmann (2015), the fifteen participants included in study II and eight participants included in study III constitute a sufficiently representative number of participants. There were only two male participants in study II and only one in study III. The gender differences seen here in the light of an individual recovery process cannot be explained and it is unclear why there were so few male participants in studies II and II. Still, the participants demonstrated deep knowledge of the phenomenon being researched, even if the findings cannot be generalized (Sandelowski, 1993).

Gullieimin and Heggen (2009) referred to Løgstrup's zone of inertia as the individual's private sphere in light of integrity, where the relationship between participant and researcher safeguards human vulnerability, which is not viewed as a weakness but instead as a part of human nature. During the interviews, I as interviewer strove to demonstrate sensitivity to the individual participants by balancing closeness and distance to them during the interviews (Kvale & Brinkmann, 2015). In that the basis for experience is considered a meaningful phenomenon in qualitative research, and it is important to reveal the variation and diversity that characterizes social and human lives, it was important for me to arrange a predictable, receptive, safe and non-dominant atmosphere during the interviews so as to elicit the most honest and spontaneous answers from the participants about their experiences (Kvale & Brinkmann, 2015). During the interviews, I immediately asked whether I had understood a participant's statements correctly, in order to prevent the participants feeling the indignity of having been misinterpreted (Norwegian National Research Ethics Committees, 2009). One

important element of scientific inquiry is that I as a researcher should not assume what participants' intentions are (Tranøy, 1986).

Guba (1981) and Lincoln & Guba (1985) considered member-checking to be a particularly important technique for establishing the credibility of qualitative data. In a member-check, researchers provide participants with feedback about emerging interpretations and obtain participants' reactions to these. Member-check can occur in an on-going manner while data are being collected in the form of probing to ensure that participants' meanings are understood. In the interviews of the mental health nurses and former patients, I sought to include the interviewees as partners in the formation of the data material (Maxwell, 2005). A data collection guide was used during the interviews for studies II and III (see appendices 6 and 7) to provide structure to the interviews, but the follow-up questions were individual in order to elicit answers and reveal the participants' individual perspectives. Sandelowski (1993) advises against member-checking after interviews are completed, advice I have followed; member-checking is not advised because participants have problems recognizing their own experiences and the meaning of the interpretation when the material is synthesized, abstracted and removed from its context. Sandelowski (1993) maintains that interpretation is subjective.

Triangulation (cf. Denzin et al., 2011) involves a variety of data methods, different theories and different investigators. All of the studies part of this research project include different research methods and there were 2-3 researchers working on each study. I worked with my two supervisors who are both mental health nurses and professors of nursing during the analysis of the data in order to prevent the occurrence of premature closure, that is to say reaching a conclusion too soon (Lincoln & Guba, 1985). Parts of the analysis were also discussed during research meetings with my colleagues at Lovisenberg Diaconal University College and during PhD meetings with fellow doctoral students at University of Tromsø - The Arctic University of Norway, where the analysis of the data in study II was commented on and retrospectively re-

done. All three studies have been published in internationally recognized level I-II research journals and have been peer review. In the research, theories of recovery and person-centered nursing are used as well as research articles, interviews with mental health nurses and former patients, and three different analysis methods: evolutionary concept analysis, content analysis and a phenomenological hermeneutical method. The overall aim of this dissertation was to expand understanding of recovery from self-harm, and the project's various studies are compiled here with main findings presented.

6.5.2 Transferability

Lincoln & Guba (1985) maintained that a researcher's responsibility is to promote sustainable research, where a reader can evaluate its applicability to other contexts. "Thus the naturalist cannot specify the external validity of an inquiry: he or she only can provide a thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility" (Lincoln & Guba, 1985, p.316).

In study I, the specific aim was to clarify the content of the concept self-harm and the consequences of improved understanding for the disciplines of medicine and nursing through the application of a theoretical concept analysis. Prior to starting this study, I asked myself the following question: What is the most durable data material for a concept analysis, with regard to the transferability of study I's findings to a clinic for persons who self-harm? Rodgers' (2000) evolutionary concept analysis includes various different sources of data such as: newspapers and/or professional publication, interviews or other forms of expressed language or art. While various sources of data can be combined, the most commonly used source is research papers (Toftthagen & Fagerström, 2010b). Rodgers' evolutionary concept analysis (2000) was chosen as the method for study I because at the start of this research project there was a need for a review of all previous research on the concept of self-harm. A limited literature search occurred (cf. Chapter 6.2) with both qualitative and quantitative studies being included; for the time period investigated the discipline of medicine used more quantitative methods than studies from the discipline of nursing (Toftthagen & Fagerström, 2010b). Similarities and differences between the disciplines of medicine and nursing were in

this manner described relevant to the research team's understanding of self-harm. The context at the start of the research project was acute psychiatric care, and for the time period investigated in this project these two disciplines represented the two largest professional groups in a Norwegian context.

Other forms of concept analysis are also used in nursing science in the Nordic countries, such as Peep Koort's hermeneutic semantic analysis (Sivonen et al., 2010). One might ask why this method was not chosen for the study. In Koort's qualitative hermeneutic semantic analysis method, an analysis of core concepts and theoretical constructs helps elicit deeper understanding of essential meaning content (Sivonen et al., 2010).

According to Koort, data material for concept analysis can consist of texts by linguistic researchers such as dictionaries, encyclopedias and thesauruses, in order to find the meaning a concept has been given in a certain language during different periods of time. Dictionaries do not describe how a concept is used in a tangible context (Nåden & Eriksson, 2003). In regard to transferability, it is important to provide a clear description of the culture and context that data are part of so that a reader can evaluate whether the research findings are transferable to another context (Graneheim & Lundman, 2004). The aim of Koort's qualitative hermeneutic semantic analysis method is to create a context-free definition of a concept and a hermeneutic understanding of the meaningful content of the concept (Nåden & Eriksson, 2003). A concept analysis where a general understanding of language is used as data material is less transferable, and consequently such a method was not chosen for study I. Concept analysis is the first step in the development of a theory and theoretical models (Meleis, 2018). Which concepts are used reveal to other professions what nursing is and what knowledge is considered to be central to nursing. This research project has nursing as a clinical approach.

Thick descriptions emerged from the interviews. Detail-rich data repeated in the interviews in studies II and III after 3-4 interviews were completed, but as previously mentioned few males wished to participate in the study and a gender perspective of the individual recovery process was not possible due to insufficient data. The participants

were described in such a way in studies II and III that readers can evaluate whether the findings of these studies can be transferred to persons in other contexts. The researcher has during the collection of data striven to document the collection of data in a detailed and satisfactory manner. The researcher has furthermore sought to provide sufficient information about the studies' contexts (Polit & Beck, 2017).

6.5.3 Dependability

Dependability pertains to the stability of data over time and whether data can be repeated after a study has been completed (Lincoln & Guba, 1985). Dependability focuses both on the process of the inquiry and the inquirer's responsibility for ensuring that the whole research process is logical, traceable and documented (Lincoln & Guba, 1985).

Theories are continuously developing and changing, and today there is no consensus on a single model for person-centered nursing or recovery but instead several different theories exist. In this research project, the use of established theory consisted of a *person-centered* approach in study II and a *recovery* and person-centered nursing approach in study III. Persons who self-harm are unique individuals. Against this background, the focus of this research has been to view recovery as an individual process where the unique human being's needs are assessed relevant to various ways to approach recovery that can hold a different meaning for each person (cf. Chapter 4). For some, a cure can help reduce the symptoms of their mental disorder/illness/disease and thus their need to self-harm, while for others it is the establishment of safe social relationships that is important for personal recovery. In that the recovery process is experienced individually, person-centered nursing constitutes a central approach to each unique person's recovery process.

If we look to Chapter 4 in this dissertation, the recovery approach is limited to the inner and external resources that can promote recovery. In a study by Jacobsen & Greenley (2001), one central finding was that personal knowledge of one's mental disorder, transformation of the sense of self, reconciliation with the health care system and the

development of interpersonal relationships are central conditions for the realization of recovery. In this research, I have to a lesser extent investigated the organization of mental health care services but have instead placed a greater focus on mental health nurses' interventions and the experiences that former patients have of their own recovery process. Close relatives to persons who self-harm also have experience of the recovery process and understanding for the situation, despite eventual conflicts and/or interruptions/ruptures in the relationship with the person who self-harms, something that this research touches upon. Remembering that theories develop and change, one can question whether data are stable when a study is replicated.

Two different interview guides were created, one for mental health nurses specific to their work in an acute psychiatric context and one for former patients specific to their personal experiences of the recovery process (see appendices 6 and 7). An interview guide should be dynamic in order to create a good interview situation, but it should also simultaneously preserve a research project's theoretical perspective (Kvale & Brinkmann, 2015). Here an attempt was made to include questions in the interview guide that were formulated so broadly that the participants could freely express themselves about their experiences, at the same time that the interview guide took into account the essence of the theoretical perspective.

The data analyses of studies I, II and III were described in detail in the relevant papers in order to create the most transparent explanation of the methodology underlying them for the reader. The first author prepared a draft of the analysis that was then read by the research team and adjusted until consensus was reached. When the data material was considered rich, the research team reflected on the course of the analysis process related to various interpretations of the findings. The analysis was realized by two to three researchers through triangulation, who asked questions about the text and challenged the analysis.

6.5.4 Confirmability

Confirmability refers to objectivity: the potential for congruency between two or more independent persons about data in relation to its accuracy, relevance or meaning (Lincoln & Guba, 1985).

The structural analysis part of the phenomenological hermeneutical analysis is an objective part of the interpretation (Lindseth & Nordberg, 2004), and in conjunction with a naive reading the structural analysis becomes the first step to see whether the analysis is trustworthy. Here the researchers did not seek the participants' individual opinions about the analysis, as they were given the chance to provide their opinions during the interviews and the analysis is based on several participants' experiences. An analysis can be open to several different interpretations, the same number as the number of participants in a study (Lindseth & Nordberg, 2004).

The steps used in all of the studies I-III are described in their relevant papers so that a reader can easily follow them: description of the research context, exemplification of the analysis process as well as justification of the choice of method. The various phases of the research process are also described in these papers and in Chapter 4 (the "Method" section) of this dissertation, alongside the researchers' thoughts during the process (Lincoln & Guba, 1995).

The research team has substantiated all assertions with participant statements to strengthen the findings in the research papers and to include the participants' "message" in the text while also simultaneously protecting the participants' anonymity. The analysis of data can be judged based on how open a researcher is about the various steps involved in the process. Evolutionary concept analysis (Rodgers, 2000) in study I, manifest and latent content analysis (Graneheim & Lundman, 2004) in study II and phenomenological hermeneutical analysis (Lindseth & Norberg, 2004) in study III break the data material down into smaller, content-filled units to facilitate the material's description and interpretation.

6.6 Ethical considerations

Approval for this research project was given by the Norwegian Social Science Data Services (NSD). Data for project number 2441 on August 30, 2009 (“*Selvskade – det stumme språket*”¹), and for project number 2824 on November 7, 2011 (“*Selvskade – det stumme språket. Fra en ensom kamp med lidelsen – till felleskap og dialog?*”²). Permission for the project was granted up to April 1, 2018. In accordance with article 13 of the Declaration of Helsinki (World Medical Association, 2013a), a research protocol for a project should be submitted for approval to a research ethics committee prior to the start of the project. On October 25, 2011, the Regional Committee for Medical and Health Research in South East Norway (REC South East) determined that this project, No. 2824, was an evaluation of complemented treatment for participants who had achieved recovery from direct self-harm. As an evaluation study, the study could therefore be undertaken without the need for further approval from the Regional Committee for Medical and Health Research in South East Norway.

Ruyter (2003, p.112) described informed voluntary consent as that a person: a. has a procedural competence that entails being able to voluntarily communicate his/her decision; b. is competent and able to evaluate his/her own personal situation, including making independent and voluntary decisions about whether to participate based on the information provided and own preferences and values; and c. has a personal competence that entails being competent and understanding the purpose of the project and the consequences of participation (Ruyter, 2003). All of the participants in studies II and III met these criteria during the period of time that I, in the capacity of researcher, was in contact with them. All of the participants voluntarily sought inclusion in the research project and agreed to participate in the applicable study and relate their experiences (Belmont Report, 1978).

¹ Translation, author’s own: “Self-harm – the silent language”.

² Translation, author’s own: “Self-harm – the silent language. From a lonely struggle with suffering – to fellowship and dialogue?”.

All of the study participants (mental health nurses and former patients) were given clear, concise, written information about the study they were participating in (without the use of overtly professional terminology), listing the main points of the study as approved by the Norwegian Social Science Data Services (NSD) including declaration of consent and, as an attachment, a description of the project. This information was reiterated during various phases of the study, prior to a researcher-participant meeting for example, and could take the form of written information or project descriptions sent via e-mail or written or verbal introductions prior to interviews or even, as needed, following an interview. Together the main letter and attachment provided an overview of the study's purpose and detailed the researchers' use of audio files, participants' right to withdraw from the study at any time and participants' right to anonymity and confidentiality.

During the early stages of the project, the research group as a whole discussed whether the theme of the research, self-harm, could trigger those who have experienced recovery from self-harm to start self-harming once more. While asking participants to focus on their recovery allowed us as researchers to explore associations with that which was difficult for the participants during the recovery process, it was understood that this could promote a sense of discomfort among the participants during the interview. I have personally thought a lot about this matter. Even though the participants themselves defined themselves as recovered or "healthy" (a view shared by the Norwegian Social Science Data Services) and neither self-harmed nor received inpatient care for the two years prior to the research interviews, their fundamental illness (post-traumatic stress syndrome, psychosis, borderline personality disorder, and so on) can be complex and manifest in phases.

A fundamental principle in ethical research is that vulnerable groups and vulnerable individuals in particular should be protected during research to ensure that they are not caused harm (World Medical Association, 1964/2013b; Council for International Organizations of Medical Sciences, 2002; Belmont Report, 1979). A participant group consists of unique persons, for whom the research project leader bears a duty during the entire course of a research project to not cause discomfort. It is the research project

leader's duty to ensure that participants understand what it entails to participate in a research project, as per Article 22 of the Declaration of Helsinki (World Medical Association, 1964/2013b). Ruyter (2003) maintains that the purpose of providing information about a study is to not merely reproduce the information but instead to ensure that participants are able to determine whether they wish to participate or not. Due to this concern, all of the participants in this research project received a follow-up e-mail the day after their interviews, in which they were thanked for their participation in the project and asked about their perceptions of the interview. The participants' responses to this follow-up were overwhelmingly positive and focused on the fact that they wanted to participate so as to contribute their personal stories and experiences. Even post follow-up, participants were encouraged to contact me via e-mail or telephone if they felt the need to talk about their subsequent reactions to the interview experience. None of the participants did so.

My responsibility as a researcher is to continuously weigh participants' voluntary participation against their need for protection (Ruyter, 2003). According to Article 15 of the Declaration of Helsinki (World Medical Association, 1964/2013b), medical research involving human subjects should only be conducted under the supervision of a clinically competent medical person. The research subjects themselves must never bear the responsibility, even though they as participants have given their consent. Informed consent should rest upon a researcher-participant trust relationship (Alver & Øyen, 1997).

Even if participants experience that a researcher is maintaining their confidentiality during an interview situation they may nonetheless be less than forthright about their experiences and instead present a "façade" (Gibson et al., 2012). In that I myself am a mental health nurse, during my contact with the participants in the interview situations I was sensitive to their reactions to my questions, for instance whether they displayed mental defense mechanisms. The participants freely spoke about their experiences during their interviews. In a review of 46 relevant studies of psychiatric patients, Jorm et al. (2007) found that the most common method used to investigate distress was to question participants about their emotional reactions to a study. Any eventual negative

effect displayed during an interview should be considered separate and distinct from the participant's original mental distress, because of its short duration and limited effect on the participant's functional ability. Research shows that few participants experience actual distress during clinical and non-clinical psychiatric research. While some participants may experience a form of distress, they nonetheless experience their participation as being positive. Permanent harm was not seen during the course of this project; instead participants overwhelmingly stated that they had positive experiences of their participation.

The mental health nurses participating in study II were not considered to belong to a vulnerable or underprivileged group and as such special consideration for them as a group was not required. Still, I as researcher always demonstrated concern for them during the interview situation so as not to leave them with a negative experience of participating in a research project. Concern was demonstrated by myself during the interview situation in the form of, for example, striving for equality, showing understanding for their actions and professional perspective and the absence of the use of negative comments.

Numbers were assigned to identifiable persons to keep the data transcribed from studies II and III separate, and the code linking data to persons was securely stored in a safe. To further protect the participants' confidentiality, the first author from studies I, II and III, who completed the interviews and transcribed the data from all studies, did not discuss participants in such a way that they could be identified by others.

6.7 Findings

Initially presented in original papers (I-III), the findings from each study are here presented under separate sections, including more detailed information about the studies. For full details, please refer to the original papers (I-III) (Toftthagen & Fagerström, 2010a; Toftthagen, Talseth & Fagerström, 2014; Toftthagen, Talseth & Fagerström, 2017).

Main findings in study I; Toftthagen, R. & Fagerström, L (2010a). Clarifying self-harm through evolutionary concept analysis. *Scandinavian Journal of Caring Sciences*, V 24, 3, pp 610-619.

Five surrogate terms for self-harm were found: self-injury, self-mutilation, para-suicide, suicide attempts and suicide. These terms illustrate a mounting risk for self-harm, such as mild/low risk of death, moderate risk of death and serious injury with risk for suicide.

Antecedents to self-harm may include: gender, mental pain, substance abuse, and relational problems. There is consensus among researchers in the disciplines of medicine and nursing science that over the past decade females have been overrepresented as regards persons who self-harm. There is a link between mental illness and self-harm. Some researchers also perceive self-harm as a flight from stress and mental pain or as an absence of illness. Even substance abuse and drugs may lead to self-harm. Regardless of discipline, researchers agree that relational problems may lead to self-harming behavior.

Attributes of self-harm in this study were shown to have five characteristics: repetitive patterns, harm by mouth, harm to exterior body, physical pain to relieve mental pain and time. In all but one article, self-harm was unambiguously described as physical pain. The authors of both the medicine and nursing science articles agree that self-harm is a pattern repeated over time. Physical self-harm is perceived as an action taken to

alleviate mental pain (it is easier to handle than mental pain) and a way to express and control mental pain. As regards time, self-harm often seems to occur most frequently between afternoon and midnight.

Consequences of self-harm encompass the effects of the self-harm act as well as the person who self-harm's reactions to treatments and care and include: surgical corrections of physical harm, medications, nurses' antipathy and the need for individualized treatment, more knowledge, interventions and inter-professional collaboration.

In this study, persons who self-harm were found to express mental pain. It is important to prevent mental pain from becoming a repetitive, self-harming pattern of behavior with an inherent risk for suicide, and it is therefore essential that nurses promote trust and acceptance in the nurse-patient relationship. Persons who self-harm appear to alleviate their various form of inner mental pain through the repeat infliction of physical pain. Substance abuse, relational problems and/or being female are all related to an increased risk for the need to self-harm. Study I resulted in a theoretical model of self-harm (cf. Figure 1, Tofthagen & Fagerström, 2010a).

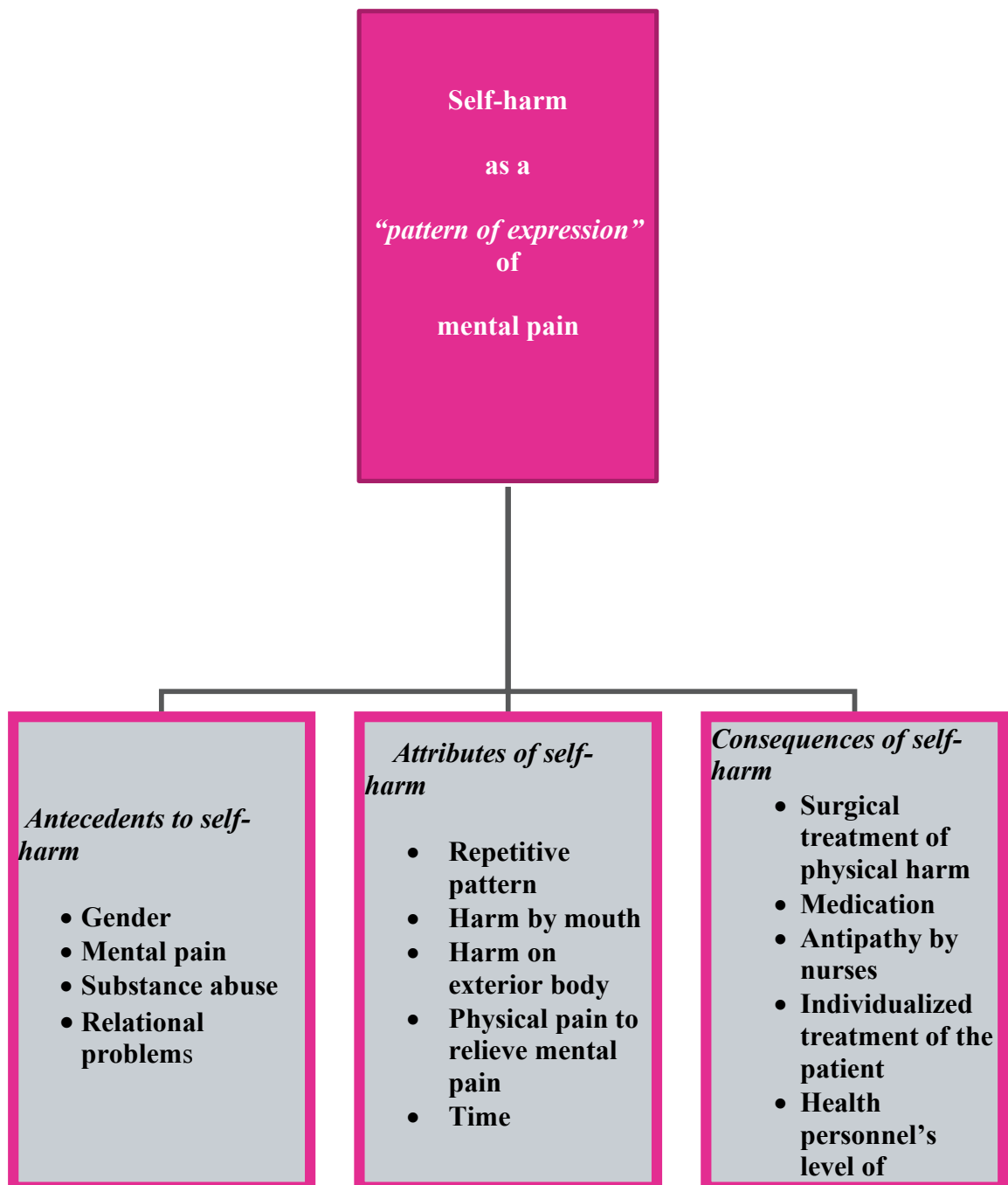


Figure 1. A theoretical model of self-harm

Main findings in study II; Tofthagen, R., Talseth, A-G. & Fagerström, L. Mental Health Nurses' Experiences of Caring for Patients Suffering from Self-Harm. *Nursing Research and Practice*. Volume 2014, Article ID 905741, 10 pages

Two main categories emerged: *challenging and collaborative nurse-patient relationship* and *promoting well-being through nursing interventions*. The underlying meaning of the main categories was interpreted and formulated as a latent theme: *promoting person-centered care to patients suffering from self-harm*.

In the **first main category**, challenging and collaborative nurse-patient relationship, nurses expressed that they used caring attitudes in the meeting with patients who self-harm, which allowed patients to be acknowledged as persons alongside their self-harm behavior. The nurses were thus bearing hope for recovery for the persons who self-harmed, despite their knowledge that the patients had previously undergone traumatic experiences that made them more vulnerable in interpersonal relationships.

The nurses did not wish to appear judgmental in their relationships with patients who self-harm but instead sought to listen and understand the person behind the behavior. This could include focusing on patients' capabilities and rational sides. The nurses sought to be friendly, perseverant and respectful in the meeting with patients, despite patients' projections, which could challenge nurses' attitudes/behavior. Medication was also used to prevent patients' self-harm or "knock-out" patients so that they became calm or sleepy.

The nurses worked with regulating closeness and boundaries in the nurse-patient relationship, in order to maintain a professional relationship. Applying their knowledge of psychological defense mechanisms was one way in which they sought to understand patients. The nurses were aware of patients' various forms of communication and worked toward getting the patients to talk about their emotions in lieu of self-harming. The nurses engaged patients in a reflective dialogue to promote patients' verbal expressions, both prior to and following an act of self-harm.

In **the second main category**, promoting well-being through nursing interventions, the purpose was to identify what it is that triggers a person to self-harm, such as various situations, thoughts or emotions, and ascertain how patients experienced and evaluated these situations. The nurses sought prevention activities with which to avert patients' self-harm and create a psychological "distance" between patients and the need to self-harm. The nurses described this as a learning situation for patients, where patients could learn to recognize the situations that trigger their self-harm and learn to divert themselves instead of engaging in self-harm by listening to music, et cetera. The nurses also helped patients learn to verbalize their actions and emotions.

The nurses at the various clinics experienced diverse attitudes toward whether patients were allowed to self-harm while in care and/or the prevention of all external self-harm. Still, all serious self-harm that could lead to suicide was stopped. The care of wounds following an act of self-harm was considered a form of communication itself, yet the nurses disagreed as to whether they should speak to patients during such about the patient's actual self-harm behavior.

The underlying meaning of the main categories was interpreted and formulated as a **latent theme**: promoting person-centered care to patients suffering from self-harm. How mental health nurses promote care for self-harm patients can be described as a person-centered nursing process. Study II resulted in a table (cf. Table 4, Tofthagen, Talseth & Fagerström, 2014).

Table 4. Mental health nurses' experiences of caring for inpatients suffering from self-harm.

The latent theme

Promoting person-centered nursing to inpatients suffering from self-harm

<p>Main category 1 Challenging and collaborative nurse-patient relationship</p> <p>Categories</p> <ul style="list-style-type: none"> • Evaluating and following-up of triggers • Observing signs of risk for self-harm • Searching for prevention activities • Allowing and/or preventing external self-harm • Taking responsibility for patients' wounds and injuries • Evaluating need for medication 	<p>Main category 2 Promoting well-being through nursing interventions</p> <p>Categories</p> <ul style="list-style-type: none"> • Caring attitude toward the patient • Bearing hope for recovery • Being in a reflective dialogue to promote the patient's verbal expressions • Being emotionally affected by self-harm patients
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(Toftthagen, Talseth & Fagerström, 2014)

Main findings study III; Toftthagen R., Talseth A-G. & Fagerström L. (2017). Former patients' experiences of recovery from self-harm as an individual, prolonged learning process. A phenomenological hermeneutical study. *Journal of Advanced Nursing*. Accepted 24.01.2017.DOI: 10.1111/jan.13295.

Before recovery, the participants used several different types of self-harm simultaneously or alternated between different forms. Over time, the participants felt it necessary to increase the degree of their self-harm in order to achieve the same feeling of relief. Consequently, their self-harm became an addictive, planned or impulsive behavior.

Several participants related that self-harming was a secret, lonely and shameful act. The participants experienced that physical pain was easier to deal with than mental pain. Several described self-harm and suicide attempts as the same phenomenon – but on a sliding scale. They also mentioned that, after having experienced that they could not control their self-harm, they became scared of their (self-harming) behavior and chose to stop or reduce the behavior.

The structural analysis resulted in three themes and subthemes.

In the first theme, *the turning point*, participants started a prolonged recovery process in which they choose life and stable relationships, learn to verbally express their inner pain and reconcile with their life histories. Previously, self-harm was the only method the participants knew of whereby they could endure their inner pain, which could stem from not being affirmed or seen in relationships, feeling alone, having low self-worth or having symptoms of mental illness. Over time, they gradually began to find the words with which to express their inner pain, describe what they felt and understand the processes underlying their behavior.

In theme two, *coping with everyday life – an individual process*, the participants learned to choose other actions rather than self-harm and to attend to their basic physical needs. They learned to gradually master their everyday life in an individual way by learning to engage in alternative actions to self-harm, taking care of their basic, physical needs and

recognizing the individual signals or triggers for self-harm and the indicators of their improvement. Learning to distract oneself can be compared to learning new thoughts that enable new actions. The participants also perceived the process of learning to cope with everyday life as being prolonged. For some, it was difficult to assert that they would never self-harm again. They also considered self-harm to be an illness and not a voluntary action.

In theme three, *valuing close relationships and relationships with mental health nurses*, participants experienced a social process, and this theme's subthemes included receiving support from close relationships and receiving guidance from nurses. The participants explained that their relatives could experience a sense of helplessness from seeing them ill over the years, during good and bad phases. Some of the participants had stable relationships with friends or relatives, some were happy that a relationship had "persevered" even when they were ill, some had relationships that changed over time and some did not divulge that they continuously self-harmed because they were scared of burdening others with their pain, and therefore did not speak about their self-harm.

The participants found it helpful that nurses could observe and chart their suffering and patterns of self-harm and distract them from self-harming when they were unable to do so themselves. Some participants explained that they would be dead if they had not been forcibly put into care during their prolonged recovery process. The participants also described that being forcibly put into care was positive in retrospect. They furthermore described the need to be open about their suffering with nurses in order to receive help. The participants related that when they were well-received and seen and accepted for who they are by nurses, the nurses promoted self-respect and helped them develop self-worth. It was also considered beneficial when nurses helped them understand that they need not be defined by their illness. The participants experienced that flexible, solution-oriented nurses, who wanted to understand and were sincere, transcended the professional nursing role.

Main theme: Recovery from self-harm as an individual, prolonged learning process

In the last phase of the analysis process, the synthesis of the naive reading and the structural analysis were further interpreted together with the research group's preunderstanding. As seen in this study, at a turning point participants started a prolonged recovery process. When life stabilizes, the act of self-harm diminishes in effect. After receiving support from close relationships and guidance from mental health nurses, the study participants started to value such relationships.

The recovery process advanced when the participants gradually learned to understand themselves better and experienced improved self-worth. They understood that recovery takes time and is a life-long learning process with different phases, where the desire to get better is central and decisive. A new understanding of the meaningful content of the participants' experiences was reached, expressed in this study in terms of a main theme: recovery from self-harm as an individual, prolonged learning process. Study III resulted in a figure (cf. Figure 2, Tofthagen, Talseth & Fagerström, 2017).



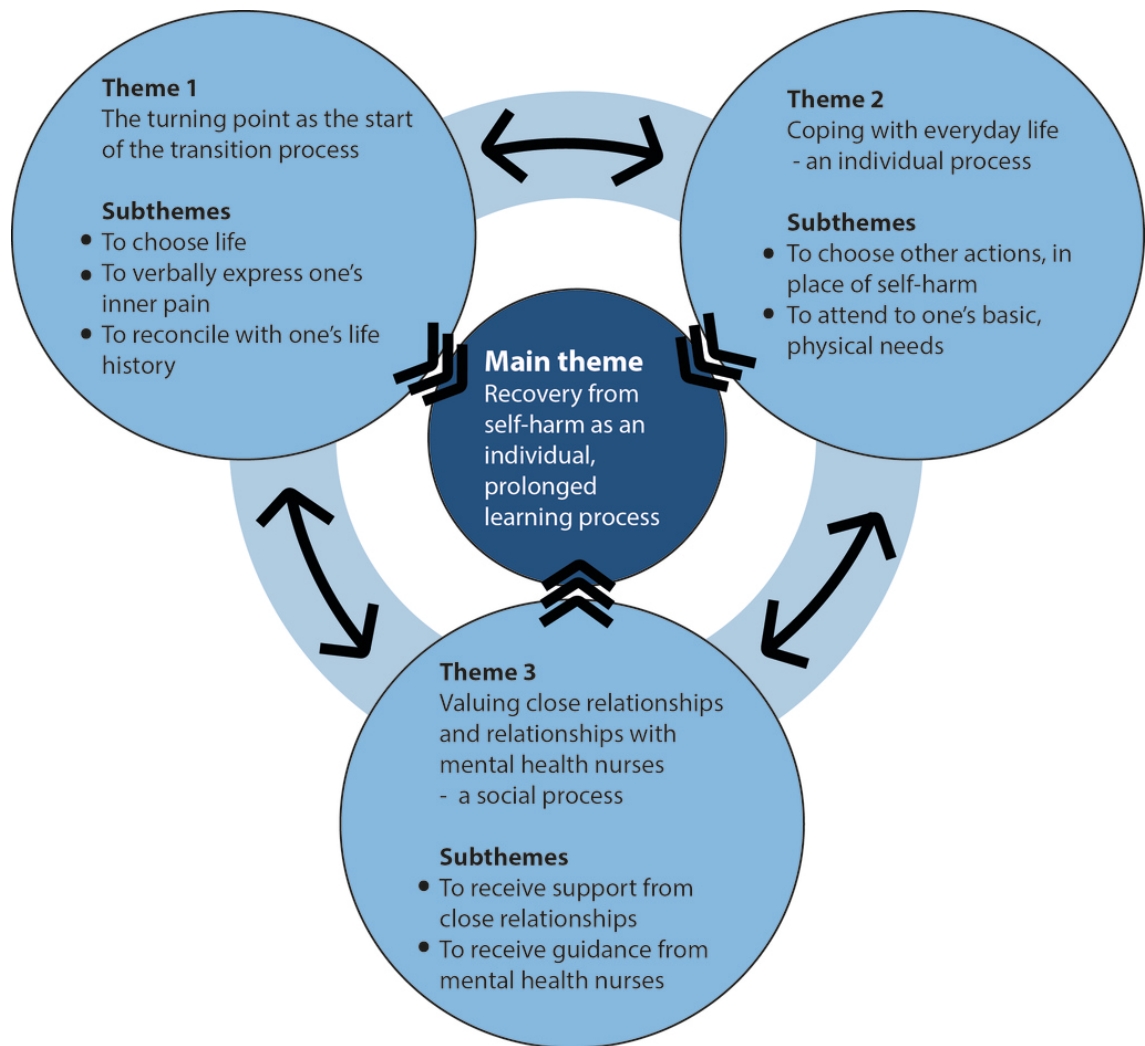


Figure 2. Data analysis findings

Main theme: Recovery from self-harm as an individual, prolonged learning process

7.0 Discussion

The overall aim of this dissertation is to expand understanding of recovery from self-harm. The main research findings from studies I-III have been compiled into three themes: 1. Personal patterns of self-harm; 2. Recovery as an individual learning process, from former patients' perspectives; 3. Recovery - from a nursing science perspective. The three themes encompass a concept analysis of self-harm (study I), interviews with mental health nurses about their experiences of caring for patients suffering from self-harm (study II) and interviews with former patients about their experiences of recovery from self-harm (study III). The discussion of the three themes here is based on the findings of studies I-III (cf. Table 5), considered to be part of a whole comprised of the author's preunderstanding, earlier research and relevant theory.

Table 5. A description of the main findings in studies I–III

Study I	1.1	1.2	1.3	1.4
<i>Interpretation:</i> Self-harm as a pattern of expression of mental pain	Surrogate terms for self-harm	Antecedents to self-harm	Attributes of self-harm	Consequences of self-harm
Study II <i>The latent theme:</i> Promoting person-centered nursing to inpatients suffering from self-harm	2.1 Challenging and collaborative nurse-patient relationship	2.2 Promoting well-being through nursing interventions		
Study III <i>Main theme:</i> Recovery from self-harm as an individual, prolonged learning process	3.1 The turning point as the start of the recovery process	3.2 Coping with everyday life – an individual process	3.3 Valuing close relationships and relationships with mental health nurses - a social process	

7.1 Personal patterns of self-harm

7.1.1 Self-harm - from an illness perspective

From the findings in studies I and III (See Table 5: 1.2,1.3, 3.1), one sees that in the self-harm situation physical pain is experienced as being easier to relate to than mental pain for the person who self-harms. At the same time, earlier research shows that many who self-harm do not feel physical pain as a result of their self-injury (Jacobsen & Gould, 2007; Hicks & Hink, 2008). Self-harm can be experienced as a way to regulate negative emotions such as tension, anxiety, anger and/or feelings of not being real or lacking identity (Crough & Wright, 2004). Chandler (2013) demonstrated that physical pain was not the most essential part of the act of self-harm. In her study, participants found physical pain to be irrelevant or non-existent; self-harm was instead experienced as being a pleasure. Descriptions of self-harm as physical or mental pain and/or pleasure can indicate a divergence between a person's physical body and psyche, where physical pain alleviates mental pain and can provide a sense of pleasure.

In this research, the participants self-harm in different ways over time: it could be planned but also an impulsive and/or addictive action (3.1). The participants experienced that they needed to increase the extent of their self-harm over time in order to maintain the same self-experienced reduction in tension (3.1) and that they then could misinterpret the degree of seriousness of their self-harm, with the consequence that they hurt themselves more than intended (2.1). When a person who self-harms injures him/herself repeatedly over a period of years, the degree of the severity of the repetitive self-harm can increase as well as the frequency of attempted suicide (Brown & Kimball, 2013). One barrier to recovery from self-harm is when the degree of severity of the self-harm is increased in order to achieve the same experience of reduction in tension (alleviation of mental pain) (Gelinas & Wright, 2013). A person can experience that harming the body gives an emotional relief, which can lead to an addiction to self-harm over time, with the associated risk for increased degree of damage.

From the findings in studies I, II and III, one sees that the type of self-harm that a person uses can change either in the short or long term, because each person has an own

“tempo” with different intervals between episodes and degree of severity (1.1, 1.3, 3.1) or can use one method to self-harm (2.1). A personal pattern of self-harm can be described as a fluid pattern between the extremes of light, moderate or severe self-harm, such as parasuicide/attempted suicide (1.1, 1.4, 2.1, 3.1.). Earlier research shows that a person’s pattern of self-harm is unpredictable and changeable (Owens et al. 2015; Andrews et al. 2013) and that persons who continue to self-harm increase the methods they use and the frequency and severity, leading to an increased risk for suicide. This implies that a person’s personal pattern of self-harm can be defined as consisting of several different types of self-harm over time, from mild/moderate self-harm to attempted suicide and suicide.

In this dissertation, the participants experienced self-harm as an illness and an expression of suffering and not a voluntary act, because engaging in self-harm was the only way they knew to achieve short-term, continued alleviation of own suffering (1.2, 3.1). Some of the definitions of self-harm presented in this dissertation (cf. Chapter 2) indicate that self-harm occurs with the conscious intention of the person engaging in the self-harm.

In study III, the participants have and have been diagnosed with different various psychiatric diagnoses in addition to their self-harm. Self-harm can be linked to various diagnoses (Klonsky & Muehlenkamp, 2007) such as: addiction, where the person misuses or is addicted to various substances (Hilt et al., 2008), various personality disorders (Dahl & Grov, 2014), depression (Hankin & Abela, 2011), various forms of psychosis (Beckman et al., 2016) and eating disorders (Svirko & Hawton, 2007).

7.1.2 Self-harm as pain and suffering

Direct self-harm is an action that a person inflicts on his/her own body. In study I, self-harm is understood as a pattern of expression of mental pain, in study II the focus is on the suffering human being and in study III self-harm is described as a mental pain and a suffering from self-harm. In the various studies, repetitive direct self-harm is described by the participants as an expression of pain, suffering and an existential suffering

emanating from one or several traumatic events experienced such as: physical and/or psychological abuse (1.2, 2.1), being bullied (1.2, 3.3) and/or a childhood where they took on adult responsibilities at too young an age (3.1).

Several participants experienced self-harm as a secretive and shameful pattern (2.1, 3.1). The participants could be afraid of bothering others with their pain and suffering (3.2, 3.3). The findings from these studies indicate that persons who self-harm are often lonely bearers of the shame of their own life histories and patterns of self-harm and that they experience that self-harm is an expression of pain and/or suffering as a deep existential pain.

Self-harm can be experienced as an existential suffering, where a person is vulnerable and the act of self-harm is the only way known whereby own suffering is alleviated. Starck et al. (1992) understood suffering through the supposition that suffering is severe pain and that some persons will suffer because of this pain while others will not. Suffering may also be present even when there is no pain. Thus it would appear that pain can be an indicator for suffering, but that this is not necessarily so, and that suffering can occur without the presence of pain.

Tillich (1952) described the existential struggle that human beings experience as a person's struggle to live in harmony and in his/her own distinctive character where one is aware of the threat of nonbeing, that is to say one's own mortality. Human beings wage a continuous struggle against meaninglessness, lovelessness and mortality.

According to Cooper et al. (2011) and Klineberg et al. (2013), keeping one's self-harm a secret is a barrier to support and help toward recovery. Skårderud (2006) refers to "body shame", when trauma manifests as shame in a person's body. Shame as an emotion is thus made physical for the person as a human being in a world where the psyche and physical body are one. In this way, shame can influence a person's self-esteem and become suffering.

Wiklund (2000) investigated suffering in two contexts: among persons with drug addiction-related problems and persons who have undergone heart surgery. She further developed Eriksson's (1994) theory on suffering, which includes three different forms of suffering: suffering related to Illness, to Care and to Life (Lindström et al., 2014). Wiklund (2000) describes suffering as a struggle between dignity and shame and between desire and disinclination, which are a condition for the other. The suffering that a person experiences isolates him/her from others and characterizes the interpretation of the self, values and experiences (Wiklund, 2000).

The person who is suffering attempts to maintain dignity and master shame and therefore struggles with protecting him/herself from losing control over these. In this research, the participants in study III described the act of self-harm as an alleviation of inner pain, where they experienced an increased inner peace after self-harming and mastery of their inner pain/suffering. Self-harm thus became a personal struggle between dignity and shame in the fight against suffering.

Emanating from Wiklund (2000), one can understand self-harm as suffering as a struggle, where a person's suffering is both a fight and a respite from the struggle. In this struggle, a person can withdraw from suffering as a respite from the struggle of suffering, where he/she retreats a little to gather strength. The person can then be surprised by an unexpected impulse, where the need to self-harm becomes strong. Self-harm as suffering can then assume the nature of an isolated event. The person in suffering is revealed and shame is experienced when his/her unique protections from suffering become reduced and control is lost.

Self-harm can also be understood as a self-destructive circle, where the act of self-harm is the only instrument whereby a person can alleviate suffering. The act of self-harming can be seen as providing short-term relief for an inner anxiety: a mere diversion from suffering, not an action that contributes to a reduction in suffering or improved long-term health. Once again taking a starting point in Wiklund (2000), self-harm as suffering can be understood as a tiring struggle where a person perceives the future as devoid of communion and life. The personal experience of self-harm is unique and

complex, at the same time that the person who self-harms desires a life in communion with others (3.3).

The movement between illness and suffering can also be described as the process of becoming. In Eriksson's (1996) theory of health, health is described as a movement in doing, being and becoming. It is a struggle where a person who self-harms can overcome suffering when the consequences of self-harm are realized - that it can lead to death and/or that a person loses contact with his/her closest relatives (See Chapter 7.2.1) – and the person consequently seeks to gain control over his/her life. Illness and suffering can contribute to personal development, such as becoming in suffering, after a turning point where the person is motivated to move toward change, recovery and greater personal well-being. When the person who is suffering from self-harm chooses a different behavior, such as diversion, this is a doing that contributes to health. When a communion where relationships are prioritized over self-harm is sought, this is health as becoming in communion. Deep down, the person longs for a reconciliation with his/her suffering as a tiring struggle and longs to overcome the fear of being rejected by the other (Fagerström, 1999, 2016). This desire gives the person a sense of vitality (Wiklund, 2000; Söderbacka et al., 2017). Communion can also give a sense of vitality that promotes a person's becoming, that is to say that the person can become who he/she really is (Fagerström, 1999, 2016).

Cassel (2004) maintained that suffering is a personal experience that can be expressed as depression, grief, helplessness, physical ailments or a sense of powerlessness. Suffering can also be experienced as shame, stigma or separation from others (Bowlby, 1973). When a person who self-harms experiences a deep existential suffering, the intensity of that person's inner anxiety increases alongside the severity of his/her self-harm and risk for suicide. In light of this, the hope for a greater personal well-being and better everyday life in the future is important for a person's recovery process (Leamy et al., 2011), and a loss of hope can lead to a person giving up and withdrawing, which can influence his/her perception of the possibility for personal recovery (Chen et al., 2013).

7.2 Recovery as a personal learning process – from former patients’ perspectives

7.2.1 A person’s learning process before and after the turning point

Before experiencing a turning point, persons who self-harm live with a self-destructive self-harm pattern where a gradual, non-linear recovery process is not a personal goal. In this research, the participants demonstrated low self-esteem and found it difficult to (re)build a worthy life and a positive identity and find hope and believe in own possibilities as steps toward recovery from self-harm, because several had become addicted to self-harm (3.2). Working toward finding the meaning in own experiences of mental illness and suffering is for many who self-harm not a specific goal. For many who are not yet recovered, self-harm is experienced as alleviating their suffering. The World Health organization (2013b) defines mental health as, “A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (p.38). Consequently, one can say that persons who self-harm have impaired mental health.

In study III, several of the participants were not able to recall the number of times they had been admitted for mental health and/or somatic care for self-harming, while one had only had contact with emergency services and a psychiatrist and another had been admitted 86 times for mental health care and 50 times for somatic care (study III). Persons who have experienced being objectified or made passive by the help that they receive can lose their sense of being a valuable and valued person (Davidson and Johnsen, 2013). Many who self-harm also often live in a context where they are not open about their suffering and self-harm behavior. They may lack safe surroundings related to their close environment, friends and family, for example, because they no longer have contact with them due to previous difficult experiences. Often such persons are not employed and/or do not contribute to the workforce because of their reduced capacity to take care of themselves, self-stigma or societal discrimination (Livingston et al., 2010; Lasalvia et al., 2013; Thornicroft et al., 2005).

One central finding in study III is that former patients experienced the recovery process as consisting of two phases: before the turning point and after the turning point. Becoming in relation to the turning point was experienced as a personal existential realization that change was necessary in order to learn how to improve own well-being. This becoming entails the person acknowledging that, in order to maintain close relationships, there is a need for recovery from the self-harm behavior and suffering. The turning point entails that the person has an existential realization that he/she must choose between life or death and, when in danger of losing contact choose communion with persons close to them (3.1). The participants in study III also related that the experience of losing control over their self-harm frightened them (3.2).

After the turning point, persons who self-harm became motivated to receive professional help as a start to their individual learning processes toward recovery from self-harm. They allowed themselves a new opportunity for improved everyday life and health (3.1). Furthermore, they took increasingly independent choices in their work toward recovery from self-harm.

Earlier research showed that the experience of a turning point can become the start of a prolonged recovery process. In one study, persons who self-harm were found to be able to experience a turning point in relation to addiction and suicidality (Biong, 2008). Biong (2008) maintained that persons experience hope at different turning points, and noted that when a person suffering from addiction is saved from death this can be experienced as a turning point. Sellin et al. (2017) interviewed 14 suicidal patients and found, among other things, that the meaning of recovery is to experience the ability to manage one's own life and reconnect with oneself while struggling between life and death. In another studies, Talseth et al. (1999/2001) showed that persons who have survived a suicide attempt are often relieved that they are still alive and seek help to regain the desire to continue living.

Recovery is a complex personal learning process that takes time, where persons learn new strategies for mastering cognitive, affective and behavioral challenges. Before patients have experienced a turning point, recovery values such as making own choices, becoming empowered and user involvement - while undertaken with the best intentions by nurses – can be experienced as increasing suffering if patients are not ready to embrace such values (Pembroke, 1994). It is therefore essential that nursing should be organized according to patients’ personal needs and preferences and that, instead of implementing institutional routines; each patient’s unique history and personality should be integrated into a person-centered approach (Edvardsson et al., 2009).

In this research, the participants expressed that they desired help from professional, solution-oriented mental health nurses and from other healthcare professionals who could understand, support and be with them during the personal learning process toward recovery, especially after the turning point (1.4, 2.1, 3.2). The participants indicated that one concern was that nurses should be able to collaborate with them and support them in the personal recovery process. In the recovery process, it is essential that nurses contribute to the patient’s hope for a better future and establish trusting relationships. One study showed that women who self-harm value caregivers who listen to them and value and confirm them as human beings. It was also important that they be valued as human beings and not solely evaluated and observed based on the fluctuating nature of their symptoms (Lindgren, 2011). In another study, Looi et al. (2015) found in self-reports from patients who self-harm that a clear desire for collaboration with caregivers and the establishment of a mutual, trustful relationship was expressed. Recovery includes both being observed and evaluated in relation to one’s symptoms and being confirmed as a human being, where mutual trust is important for the establishment of a cooperative nurse-patient relationship in the journey toward recovery.

The participants in study III, former patients, did not wish to limit the context of their experiences of recovery to an acute psychiatric context during their interviews; they clearly related that they experienced the recovery process as encompassing all of the contexts they lived in and that for this reason it was impossible to demarcate a single

context. One can maintain that the participants in study III focused on what a non-linear holistic recovery process entails. These former patients' wishes to not limit the contextual focus of their interviews was taken into account once I understood that, for them, all contexts were merged into one entity in their non-linear recovery processes.

Several of the participants in study III indicated that they sought control of their self-harm behavior in order to master stress, but when their behavior became unpredictable and the realization that they could die or become even more lonely occurred, a turning point emerged as the motivation they needed to become active in the recovery process (3.1). Once the person had acknowledged that his/her self-harm was serious and that death could occur, he/she experienced a true existential anxiety that was more important than using self-harm to reduce tension. This can be interpreted as an existential acknowledgment that change was necessary in their lives: change toward learning to live with suffering and toward greater personal well-being.

A recovery approach does not focus on the elimination of illness and suffering but instead focuses on a greater mastery of life through use of a person's "healthy" aspects, including readiness for recovery as a personal learning process. During the recovery process, it is vital that a person be supported through the confirmation of their worth as a valuable human being (Davidson & Johnsen, 2013).

7.2.2 Learning to master everyday life

In study III, several participants expressed that believed themselves to be vulnerable and that this was why it was difficult for them to master everyday life. The participants experienced that they learned to recognize personal *stress*, what it was that triggered their self-harm and own vulnerability and more about mastering their own basic, everyday needs (3.2). They were preoccupied with learning to balance their physical needs, such as ensuring that they slept enough, ate properly and were physically active. This provided them with an experience of becoming stronger and being able to create more structure in their everyday life and recovery.

The participants also acknowledged that their self-harm did not lead to the mastery of their mental illness and suffering and instead sought to learn new cognitive, affective and behavioral coping strategies with which to prevent feeling vulnerable and as though they need to self-harm and to learn to recognize what caused them stress. In Shaw's (2006) study, female participants expressed that taking control of their lives was essential to the recovery process and stopping their self-harm. Skårderud (2006) found that the experience of physical or mental abuse affected the human body as a subject. In an investigation of adverse childhood experience in which several studies were reviewed, researchers found a link between a person's experience of traumatic life experiences and risk factors for disease/early mortality associated with cardiovascular disease, stroke, various forms of cancer, chronic respiratory tract infections, diabetes and hepatitis (Fellitti et al., 1998). A person who self-harms must be understood from a holistic perspective, and this should be taken into consideration during the personal recovery process because personal stress also has an effect on the physical body and in a person's ability to balance basic needs.

A medical approach to recovery includes that a professional caregiver is defined as an expert and a patient as a passive recipient of treatment (Hummelvoll, 2012). A medical expert approach and its associated reduction in symptoms can provide support to persons who self-harm, especially for those who have not yet experienced a turning point, where the person to a lesser extent is focused on the personal recovery process.

Persons who self-harm often conceal their vulnerability and personal stress in relation to what triggers their emotions and often isolate themselves from other people. They then acknowledge the necessity of working toward a personal recovery process, where painful experiences of mental illness and suffering are a condition for greater mastery of own triggers for self-harm and an identity that allows them to experience greater well-being in everyday life. Recovery from self-harm is a complex learning process that takes time and involves the entire human being. As seen in this research project, the participants took greater responsibility for their self-harm behavior by distracting themselves by listening to music, taking a walk, crying, et cetera (3.2). Balancing one's

need for self-harm with the demands of everyday life requires that a person gains a new understanding of the self and requires that he/she learns a personal change, which occurs through the help of reflection and dialogue that focus on the person's experiences and own understanding of the self.

Learning to balance the demands of everyday life with new patterns of thought and taking responsibility for one's self-harm can require, among other things, learning how to distract oneself instead of self-harming. Persons who self-harm must learn how to adapt and respond differently to the challenges and demands of everyday life and learn new skills, for example peaceful conflict resolution, and discover other persons and cultures, which will influence their development physically, mentally, culturally, spiritually and esthetically (Delors, 1996).

Improving relationships with family, friends and other relatives is part of mastering one's everyday life. In this research, the participants experienced different versions of such relationships: for instance, some experienced stable relationships while some experienced relationships that fluctuated. Several of the participants noted that they did not want to talk about their self-harm with their relatives, for fear of burdening these persons with their pain (3.3). In one study, Sælør and Biong (2017) looked at the various forms of hope that relatives of persons with mental ill health perceive that they have experienced. One type of hope expressed in their study was "everyday hope", and they found that this could be changed to each unique situation, place and time or various different forms of collaboration or relationships. Everyday hope was also found to be associated with the relationship with professional caregivers who provide patients' relatives with confirmation, seeing them as unique persons, and who engage relatives in discussing any possible feelings of guilt related to the patient's situation.

Earlier research showed that social arenas, for instance family, friends, work or school, are important for a person's recovery process (Topor, 2011). A poor relationship with one's family, friends or work colleagues can trigger self-harm. It is important that a

person learn to master triggers for self-harm, so that he/she can become aware of them and learn how to prevent re-traumatization in personal relationships. A re-traumatization as an experience of powerlessness can manifest as an inability to express words and thoughts and is primarily recalled as a sensory experience that can be reawakened by perceptual likeness (Kirkengen, 2005).

7.2.3 From a person's difficulties in verbally expressing the need to self-harm to the expression of the self

The participants in this research project described that at the beginning of their illness they had difficulties expressing in words why they needed to self-harm. For several of the participants, this absence of a verbal language with which to express their own illness and suffering lasted for several years and was a part of their prolonged recovery process (1.2, 2.1, 3.2). Earlier research showed that when a person is suffering, his/her expression of self-harm can be silent (alexithymia) and the person can find it difficult to describe emotions (Polk & Liss, 2007). The person can then employ emotionally focused coping and avoidance more than rational or detached coping (Hawton & Rodham, 2006).

Persons who find it difficult to describe or verbally express their emotions have a reduced ability to tolerate stress, and it is therefore necessary that they learn alternative methods whereby to master stress. An affective activation occurs before such persons are able to describe their emotions in words. Emotions are thoughts in the sense that they are an experience where an affective activation occurs in a person (Damasio, 1999). If a person's perceptions are not affirmed, his/her language cannot express these impressions (Martinsen, 2003).

The participants in this research project valued mental health nurses who observed and evaluated their suffering and patterns of self-harm, helped them acknowledge that they were more than their self-harm behavior, contributed to strengthening their self-respect and accepted them as unique persons (3.3). Earlier research exists on attitudes as communication between nurses and other professional caregivers and patients who self-

harm (cf. Chapter 2). Holm and Severinson (2011) found in their study that women who self-harm are capable of changing their behavior when they feel confirmed, safe and trusted. Experiencing a sense of security and being understood in the nurse-patient relationship motivates patients to work with their self-harm behavior toward greater personal well-being and recovery. In a study by Long et al. (2016), seeing a person, human contact and an integrating experience promoted a positive change in a person's reconnection to him/herself and others. Looi et al. (2015) found that a gap exists between patients' hopes of being understood, confirmed and met with an open and mutual dialogue and what they experienced in their meetings with professional caregivers, where they experienced a feeling of powerlessness after being ignored and not listened to.

The use of everyday language is central to the development of personal relationships and the promotion of community integration (Borg et al., 2009). Helping a patient find his/her unique language for expressing stress and establishing a trusting relationship takes time and requires continuity in the nurse-patient relationship, because cognitive change occurs as a process over time (2.1). When the participants in this research project began to understand and express their inner pain and suffering, their self-esteem and self-respect increased and they found, over time, the words that better expressed what they felt and understood to a greater extent their own personal history (3.1). The participants learned over time new thoughts, established new health promotive patterns of thought and took more responsibility for themselves (3.1).

7.3 Recovery - from a nursing perspective

7.3.1 Cutting as the alleviation of suffering before the turning point

Mental health nurses have different approaches to whether patients, who have little awareness of the dangers of self-harm and a strong desire to self-harm, should be allowed to self-harm or not while in care (2.2). One approach is to meet the person who wishes to self-harm with shielding, belting and/or other forms of limit setting. Another approach is to allow patients the possibility to self-harm while in care by giving them tools with which to self-harm (1.4, 2.2). In such an approach, nurses should take responsibility for the care of patients' wounds after self-harm and administer medication that can alleviate the patient's illness and suffering (1.4, 2.2).

Facilitating self-harm can constitute an ethical dilemma for mental health nurses, relative to their duty to ensure the well-being of their patients; nurses have an ethical responsibility to realize a care practice that promotes patients' health and prevents illness (Norwegian Nurses Organisation, 2016). Still, admissions to acute psychiatric care include relatively short stays and patients will continue to self-harm after discharge if they experience that self-harm can help them alleviate or control their emotional pain (McAllister & Estafan, 2002). Self-harm can constitute a way for persons to take control over their lives (Brown & Kimball, 2013).

The participants in study II agreed that serious self-harm that could result in suicide should always be stopped (2.2). Persons who self-harm can also be remitted into care if they are considered a danger to themselves or to others on the provision and implementation of mental health care (the Mental Health Care Act) (Lovdata.no., 2017). One sees in Chapter 2 of this dissertation that a person's self-harm varies in its degree of severity over time and that there is an increased risk of suicide among those who self-harm.

Lindgren et al. (2011) described a dominant approach to persons who self-harm as a "fostering repertoire", where professional caregivers motivated patients by setting down

rules that must be followed while in care. In person-centered care, focus is placed on each unique patient's perception of his/her situation and nurses' professional evaluation of the situation. Meeting persons who self-harm with a person-centered approach entails that caregivers understand the unique human being's perception of the situation more than the predetermined routines that define nursing interventions. Person-centered nursing entails contributing to giving patients control over their lives once more and giving them hope and aspirations for the future (Ekman et al., 2011; McCormack and McCance, 2010).

It is essential that nurses and patients engage in a dialogue on the various aspects of self-harm. Instead of discussing whether patients are allowed to self-harm while in care, caregivers can guide patients away from self-harm by introducing them to the use of diversionary activities, such as listening to music, running, et cetera (2.2). In this manner nurses contribute to patients' establishment of inner reflection, which contributes to patients' autonomy even after discharge through the strengthening of their problem-solving abilities in relation to self-harm. Nurses must in such instances evaluate where patients are (which stage they are in) in their recovery process and prerequisites for learning.

Facilitating patients' self-destructive behavior by allowing them to self-harm while in care can constitute an ethical dilemma related to nurses' duty to promote patients' well-being. In a person-centered approach, patients' subjective experience before the turning point can be that, at the moment that self-harm occurs, it provides them with real time alleviation for their suffering. Some of the participants in study III described that after the turning point they recognized that their self-harm did not originate in their free will but that they instead were mentally ill. Several of the participants in study II, who were mental health nurses, described self-harm as a form of mastery over mental pain. From the findings of study III, one sees that when persons are in a more acute phase of self-harm they perceive that they use self-harm to alleviate their mental pain but that after the turning point they perceive self-harm to be more of an illness.

In earlier research, patients experienced that caregivers' primary goal was to keep patients under control while in care in a context that patients experienced as being chaotic and which instilled fear, and patients experienced that caregivers often used physical coercive means and medication. Some patients even experienced that they lost all hope of receiving support through the healthcare system and thus their hope for personal recovery. These patients related that they wished that they had not come into contact with the healthcare system, even though they experienced that they needed acute care (Looi et al., 2015).

James et al. (2017) investigated the use of harm reduction as a nursing approach to support persons who self-harm while in care. In the research presented in James et al.'s study, caregivers were worried about the practical risks of severe self-harm if patients were allowed to self-harm while in care. The caregivers expressed that it was an ethical concern whether it was part of their role as caregivers to allow patients to self-harm while in care, that they strove to protect patients from self-harm and that it was part of their duty to distract patients from self-harm. In James et al.'s study (2017), no guidelines were found regarding how a harm reduction approach should be implemented or whether the professional caregivers tasked with implementing this approach wished to be held responsible for patients seriously harming themselves while in their care (James et al., 2017). The caregivers also questioned whether patients' self-harm should be organized so that it occurred in the presence of caregivers. In another study, Shaw (2006) found that, for females, the greater a length of time that had passed since one's last self-harm event, the more likely one was able to resist the urge to self-harm.

In person-centered care, nurses work with the person in the establishment of good daily routines, independence and well-being and the reduction of stigma (Gabrielsson et al., 2015). Cleary et al. (2013) interviewed 21 mental health nurses working in acute inpatient mental health units about various recovery-related topics. The participants in this study described that positive attitudes, person-centered care, hope, education and an individual pattern of recovery were necessary to prevent readmission and that these are central to a better life for persons who are living with mental illness. Still, the

participants related that the knowledge that mental health nurses possessed was not fully implemented into care.

A person-centered approach entails that nurses sees each unique human being in their care, affirms this person's experiences and includes the person in all aspects of care. This involves nurses guiding patients based on patients' prerequisites and informing them about the consequences of self-harm (Anderson et al., 2015). In Norway, all persons in need of help, including those in need of comprehensive and prolonged help, have the right to an individual plan that includes goals for long-term, coordinated and coherent follow-up (Ministry of Health and Care Services, 2011). It is required that each individual plan be drawn up in conjunction with the person who will receive the care. The use of an individual plan can allow a patient to retake control of his/her life and participate in own care. Nurses are responsible for ensuring the patient's participation in this process by guiding each patient in regard to experiences of illness and suffering, what the patient perceives to be own resources that can be used in the recovery process, the patient's goals or hopes, et cetera.

7.3.2 Understanding the person's prerequisites for learning

Mental health nurses use different professional skills in their meeting with patients in order to understand and help patients. Knowledge of various psychological defense mechanisms is one type of knowledge that is used to understand how patients unconsciously protect themselves during illness and suffering (2.1). As seen in this dissertation, nurses were conscious of bearing the affective projections that are part of the nurse-patient relationship, which for mental health nurses can be experienced as being unpleasant, provocative and demanding (2.1). It is important that nurses understand a patient's sense of loneliness and worry and bear hope for greater well-being for the patient when the patient is unable to do so him/herself (2.1). In this dissertation, the nurses were certain that negative attitudes in the nurse-patient relationship could promote a patient's self-harm and that it was therefore important to maintain a certain professional behavior (2.1). At the same time, these participants believed in their patients' capacities and rational sides and worked toward strengthening

patients' resources so that each patient could realize an individual recovery process, with a focus on learning new strategies whereby to master illness and suffering (2.1).

Earlier research shows that caregivers for persons who self-harm can experience frustration and helplessness in the caregiver-patient relationship (Rayner et al., 2005; Wilstrand et al., 2007). The manner in which patients cope with their emotions can unconsciously be transferred to their caregivers (Rayner et al., 2005). Defense mechanisms such as projection can unconsciously be used by patients to protect their "I", through the transference of their own unacceptable emotions to others (Hummelvoll, 2012). Patients' feelings of hopelessness can also be experienced by caregivers, and it is therefore crucial that caregivers understand each patient's mental defense mechanisms as a part of the patient's prerequisites in order to learn how to guide patients on their own terms. Earlier research showed that persons who self-harm can feel misunderstood and dissatisfied with the way that nurses approach patients' experiences of self-harm (McHale & Felton, 2010). It is important that nurses do not reflect the patients' projections back (retransference) as a projective identification and that caregivers recognize patients' experiences (Lindgren et al., 2004; Dickinson et al., 2009, Holm & Severinsson, 2011). Other studies showed that persons who self-harm value attitudes such as being listened to and not being judged for their self-harm (Huband & Tantam, 2004; McAndrew & Warne, 2014; Long et al., 2016).

In her work, Martinsen (2003) investigated the untouchable zone, where professional respect for others' personal boundaries is central. Persons who self-harm have often kept their behavior secret and are vulnerable when talking openly about their behavior. Through their sensitivity in the closeness-distance relationship to the person who self-harms in his/her suffering and vulnerable identity, nurses can create an attitude that contributes to the shaping of a therapeutic relationship. If one compares with Martinsen (2000), one can conclude that an ethical demand exists to protect the vulnerable human being.

In this research, the participants in study II were aware of how to bear patients' suffering and not retransfer. Helplessness is often a risk factor for repetitive direct self-

harm (Steege et al., 2016). Creating hope in patients is therefore part of promoting recovery. Anderson et al. (2015) maintained that when nurses change their approach to supporting learning in the nurse-patient relationship this results in caregivers becoming more supportive than controlling and that they focused less on disease, illness and treatment and instead established more dialogues with their patients, thereby strengthening and supporting patients in taking responsibility and accepting personal goals. Person-centered care is a flexible and individual-oriented approach in which nurses strive to see the whole human being and his/her life history.

As seen in this research, mental health nurses work toward strengthening patients' self-image (2.1) by bearing and sustaining hope for recovery when patients are not capable of doing so themselves (2.1). The goal of such is to promote self-respect and self-worth in the patient (2.1). It is therefore important for nurses to get to know their patients before starting any interventions as not doing can cause harm (2.1, 3.2).

Earlier research shows that emotional dysfunction is linked to self-harm (see Chapter 2). A medical perspective on recovery includes focusing on and reducing patients' symptoms of depression, borderline personality disorder and other similar diagnoses so that a reduction in the patients' anxiety can be brought about: through the therapeutic use of medication, for example. In a study of all female participants, Shaw (2006) found that, even before the participants had decided to stop their self-harm, self-harm was stopped when the psychological symptoms that triggered the self-harm were reduced in frequency and intensity. For some of the participants in Shaw's (2006) study, such an intervention resulted in more adaptive coping skills or a sense of "feeling better". For all of the participants, taking control of their lives was central to stopping their self-harm.

7.3.3 Using collaboration so that a person learns distraction instead of self-harm

As seen in this research, mental health nurses believe in patients' resources and work toward patients learning new strategies whereby to master their behavior without the need to self-harm. The participants spent time with each patient and motivated the patient to engage in dialogue about his/her situation and the signals that arise that

indicate a need to self-harm (2.2). The mental health nurses sought to teach patients how to distract themselves with alternative activities when the need to self-harm arose, in order to create a distance between the patients and their suffering (1.4, 2.2). In study II, the participants encouraged patients to verbalize their need to self-harm by working toward the establishment of a reflective dialogue with each patient, in order to promote verbal expression (2.2). The participants observed and evaluated patients' triggers and strove to establish a therapeutic relationship and dialogue with each patient (2.2).

All of the participants in study II sought to engage patients in dialogue in order to establish collaboration in the nurse-patient relationship in regard to what triggers patients to self-harm and to work toward distracting patients from engaging in self-harm by organizing various activities together with the patients. As mental health nurses, the participants bore the patients' hope for recovery from self-harm when the patients themselves could not. The recovery goals for persons who self-harm change over time in conjunction with their recovery process. Nurses can support this process and the transitions between the various stages. Nurses are perceived as being sympathetic when they create a "being" with the patient, meet the patient with respect and acceptance, value the patient's uniqueness and support the patient in improving his/her coping resources. Authentic engagement is connectedness between a nurse and patient, where each care situation is a unique, tangible interaction (McCormack & McCance, 2017).

The participants in study II sought to know each patient as a whole person because they sought to ensure that each patient received the correct follow-up. They worked toward establishing a reflective dialogue together with the patient about his/her triggers and experiences of suffering, with a focus on person-centered care. Sharing decision-making entails allowing the patient to participate in care and giving him/her the information needed to increase self-determination. The patient's experiences and knowledge are used as the basis for strengthening his/her well-being through the nurse-patient relationship, where nurses are present, supportive and use their professional knowledge (McCormack & McCance, 2017). Heggdal (2008) emphasized using the patient's own experiences as a starting point for the learning process and maintained that learning cannot be seen as being separate from a person's life context. Mental health care units

today encompass different contexts where patients can be met during the different stages of their recovery process. The non-linear recovery process is spread over time for persons who self-harm, and this influences the focus of the guidance that is given. The participants in study II worked toward establishing a reflective dialogue together with patients about their triggers and experiences of suffering, with a focus on person-centered care. Among other things, the nurses sought to teach persons who self-harm how to distract themselves from engaging in self-harm.

8.0 Conclusions, implications for nursing and health care practice and further research

8.1 Conclusions

The main aim of this dissertation was to expand understanding of recovery from self-harm. Following an evolutionary concept analysis, interviews with mental health nurses and former patients and a compilation of the findings, the conclusions to be drawn from a nursing perspective are that:

- Self-harm is experienced as an illness and expression of existential suffering. A person's self-harm can change over time, with varying intervals, methods and degree of severity. Several former patients experienced the physical act of self-harm as a way whereby to regulate tension stemming from negative emotions. The act of self-harm was the only way known to the former patients to achieve the short-term alleviation of their suffering.
- Increasing the extent of their self-harm was the only way for many former patients to sustain their self-experienced reduction in tension, with increased risk for suicide. Increased self-harm over time was for many addictive and can constitute a barrier to recovery from self-harm.
- Persons who self-harm struggle to: maintain their dignity, master shame of their own life history and not lose self-control. Several former patients experienced the act of self-harm to be secretive.
- Each person undergoes a unique learning process toward recovery. Prior to a turning point, the person lives with the self-harm behavior and addiction to self-harm and is not focused on an individual non-linear recovery process. Reaching a turning point was experienced by many former patients to be a personal existential acknowledgement that change was necessary to strengthen their personal well-being after losing control of their self-harming behavior. The former patients experienced a sense of having to choose between life or death and/or communion with close

relatives or loss of contact with them. After the turning point, the former patients were motivated to receive professional help as a start to the personal recovery process toward a better everyday life. The recovery process is an individual learning process over time, where the person who self-harms to an ever-greater extent makes independent choices in his/her life.

- Mental health nurses promote person-centered care for patients suffering from self-harm when they seek to understand the unique patient and establish a collaborative nurse-patient relationship and realize person-centered interventions.
- The former patients learned to recognize what is that triggered their vulnerability and stress and learned new strategies whereby to master their self-harm behavior. The former patients took more responsibility for their own self-harm behavior and for distracting themselves from engaging in such behavior. The mental health nurses sought to collaborate with patients when teaching patients how to distract themselves instead of engaging in self-harm.
- Difficulties in verbally expressing why they needed to self-harm could promote a prolonged recovery process for the former patients. Helping persons who self-harm find their own individual language and understand more of their life history takes time, conversations, continuity and the establishment of a trusting nurse-patient relationship.
- Persons who wish to self-harm while in care can be met with shielding, belting or other forms of boundary setting or else be allowed to self-harm.
- Mental health nurses take responsibility for patients' wounds and administer medication that can alleviate patients' illness/suffering.
- Mental health nurses seek to understand the conditions for learning that the person who self-harms has in order to help him/her. The mental health nurses were cognizant of the importance of having a professional understanding of the countertransference between themselves and their patients and that it could affect the nurse-patient relationship. This included understanding patients' experiences of loneliness and worry and bearing hope for patients' well-being when the patients themselves were unable to do so.

8.2 Implications for nursing and health care practice

- A person's self-harm "rhythm" can change over time, with different intervals methods and degree of severity. It is essential to chart the scope of a person's self-harm over time, because for many who self-harm feel that it is necessary to necessary to increase their self-harm in order to sustain the self-experienced reduction in tension, despite increased risk for suicide and the danger of becoming addicted to self-harm, which creates barriers to recovery from self-harm.
- Some persons keep their self-harm secret and are the sole barer of the shame of their experienced trauma and existential suffering. It is essential to have the knowledge that persons who self-harm may be struggling to maintain dignity and prevent themselves from losing control of their self-harm behavior.
- Reaching a turning point is experienced as a personal existential acknowledgement that change is necessary and that one is motivated to receive professional help as the start of the personal recovery process toward a better everyday life, where the person to a greater extent makes independent choices in life. Clinical practice must facilitate the individual guidance of the person toward recovery, because the person may or may not have acknowledged a turning point or may or may not view the act of self-harm as a strategy whereby to master behavior.
- Teaching persons who self-harm how to distract themselves instead of engaging in self-harm and facilitating dialogue about the different aspects of engaging in self-harm over time is essential. Clinical practice must teach persons who self-harm how to recognize that which triggers their stress and new, individual cognitive, affective and mastery strategies.
- Helping persons who self-harm find their "language" and understand more of their life history requires time, conversations, continuity and the establishment of a trusting nurse-patient relationship. Clinical practice must help persons who self-harm verbalize their suffering in conversations, strengthen their self-respect and recognize them as unique human beings.

8.3 Implications for research

- Further research on recovery from self-harm is needed in order to gain a deeper and more systematic understanding of the individual recovery process as seen from the perspective of time, person, gender, substance and context and should occur as part of a collaboration between user researchers, mental health nurses and other care givers.
- Further research is needed on how persons who self-harm wish to be met during the various phases of the recovery process: for instance, prior to and following an acknowledged turning point.
- New concept analyses of synonyms for self-harm and meta-analyses of earlier research should occur in order to reveal the starting point for the creation of a theory on the similarities and differences between the various understandings of self-harm.
- Systematic research should be undertaken into how nurses can support persons who self-harm in their individual development of language so as to help them learn how to express difficult emotions and trauma.
- Knowledge in clinical practice should be systemized regarding how to teach persons who self-harm what triggers their stress, what can distract them from engaging in self-harm and new, individual cognitive, affective and mastery strategies with which to master their self-harm behavior.
- A new, knowledge-based mobile phone application should be developed, where persons who self-harm can log into a virtual reality when they have the impulse to self-harm and be distracted through questions about what has triggered their need to self-harm; there should also be suggestions for how persons can distract themselves. Such a mobile phone application can also strengthen the ability of persons who self-harm in verbalizing why they feel a need to continue their self-harm and can promote an inner reflection on alternative actions.

9.0 References

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Appendices

Appendix 1: Approval the from the Regional Committee for Medical and Health Research in South East Norway (REC South East) for project: No. 2824 (Selvskade - det stumme språket. Fra en ensom kamp med lidelsen – till fellesskap og dialog?).

Region: Saksbehandler: Telefon:
REK sør-øst A Jørgen Hardang 22845516

Vår dato: Vår referanse:
25.10.2011 2011/1390a
Deres dato: Deres referanse:

Randi Tofthagen
Lovisenbergt 15 B

2011/1390a Selvskade det stumme språket. Fra en ensom kamp med lidelsen - til fellesskap og dialog

Vi viser til e-post av 10.10.2011 med svar på komiteens merknader og til e-post av 23.9.2011.

Komiteen ba om en klargjøring av om prosjektet er å forstå som "en form for evaluering av gitt behandling". I så fall trenger ikke studien forhåndsgodkjenning av REK for å kunne gjennomføres.

I tilbakemeldingen til komiteen sies det: "Studien er en evalueringsstudie av gitt behandling. Metoden er intervju på cirka en time med mennesker som har oppnådd recovery av ytre selvskade og ikke lenger har kontakt med helsevesenet. Det er informantenes erfaringer med hva de har opplevd fremmet og hemmet recovery av ytre selvskade som er i fokus."

Komiteen forstår dette slik at prosjektet er å forstå som en evaluering av gitt behandling. Det faller derfor utenfor helseforskningslovens virkeområde og kan gjennomføres uten godkjenning av REK.

Vedtak:

Etter søknaden og tilbakemelding på komiteens spørsmål fremstår prosjektet som en form for evaluering av et etablert behandlingstilbud, og faller derfor utenfor helseforskningslovens virkeområde, jf. § 2. Prosjektet kan gjennomføres uten godkjenning av REK.

Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jfr. helseforskningsloven § 10, 3 ledd og forvaltningsloven § 28. En eventuell klage sendes til REK Sørøst A. Klagefristen er tre uker fra mottak av dette brevet, jfr. forvaltningsloven § 29.

Med vennlig hilsen

Gunnar Nicolaysen
professor dr. med.
leder

Jørgen Hardang
seniorrådgiver

Kopi: lisbet.fagerstrom@hib.no ; Høgskolen i Buskerud ved øverste administrative ledelse
postmottak@hibu.no

Appendix 2: Approval from the Norwegian Social Science Data Services (NSD) for project: No. 2824 (Selvskade – det stumme språket. Fra en ensom kamp med lidelsen – till fellesskap og dialog?).



Randi Toftagen
Lovisenberg diakonale høgskole
Lovisenberggaten 15 B
0456 OSLO

Vår dato: 07.11.2011

Vår ref: 28242 / 3 / SSA

Deres dato:

Deres ref:

TILRÅDING AV BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 03.10.2011. All nødvendig informasjon om prosjektet forelå i sin helhet 04.11.2011. Meldingen gjelder prosjektet:

28242	<i>Selvskade - det stumme språk. Fra en ensom kamp med lidelsen - til fellesskap og dialog?</i>
Behandlingsansvarlig	<i>Lovisenberg diakonale høgskole, ved institusjonens overste leder</i>
Daglig ansvarlig	<i>Randi Toftagen</i>

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven/helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://www.nsd.uib.no/personvern/prosjektoversikt.jsp>.

Personvernombudet vil ved prosjektets avslutning, 01.07.2015, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim


Sondre S. Arnesen

Kontaktperson: Sondre S. Arnesen tlf: 55 58 25 83
Vedlegg: Prosjektvurdering



Delstudie 3 i tidligere innmeldt prosjekt 22441.

Utvalget består av ca. 15 personer som tidligere har blitt behandlet for selvskading, og som ikke har vært i kontakt med helsevesenet på minst to år. Personene i utvalget anser seg selv som friske og er ferdige med sin behandling. Formålet med prosjektet er å undersøke hvordan brukerne har erfart recovery av ytre selvskade ved å undersøke deres erfaringer med hva som fremmer og hemmer recovery i samarbeid med psykiatriske sykepleiere. Data samles inn ved hjelp av personlig intervju.

Førstegangskontakt opprettes av brukerorganisasjonen Mental helse som vil kontakte tidligere pasienter via deres medlemssider på internett med forespørsel om å delta i prosjektet. Personer som ønsker å delta tar direkte kontakt med forsker.

Viser til mottatt kopi av brev fra REK den 26.10.2011. REK vurderer prosjektet som å være en form for evaluering av et etablert behandlingstilbud, og faller derfor utenfor helseforskningslovens virkeområde.

Personvernombudet finner at behandlingen av personopplysninger i prosjektet kan hjemles i personopplysningsloven §§ 8 første alternativ og 9 a) (samtykke). Det vil i prosjektet bli registrert sensitive personopplysninger om helseforhold, jf. personopplysningsloven § 2 nr. 8 c).

Det gis skriftlig informasjon og innhentes skriftlig samtykke. Personvernombudet finner skrivene mottatt 03.10.2011 godt utformet.

De direkte personidentifiserbare opplysningene er erstattet med et referansenummer som viser til en navneliste som oppbevares atskilt fra det øvrige datamaterialet.

Prosjektet skal avsluttes 01.07.2015 og innsamlede opplysninger skal da anonymiseres og lydopptak slettes. Anonymisering innebærer at direkte personidentifiserende opplysninger som navn/koblingsnøkkel slettes, og at indirekte personidentifiserende opplysninger (sammenstilling av bakgrunnsopplysninger som f.eks. yrke, alder, kjønn) fjernes eller endres.

Appendix 3: Approval from the Norwegian Social Science Data Services (NSD)
for project number 2441 (Selvskade – det stumme språket).



Randi Tofthagen
Lovisenberg diakonale høyskole
Lovisenberggaten 15 B
0456 OSLO

Vår dato: 31.08.2009

Vår ref: 22441 / 2 / IBH

Deres dato:

Deres ref:

KVITTERING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 20.08.2009. All nødvendig informasjon om prosjektet forelå i sin helhet 28.08.2009. Meldingen gjelder prosjektet:

22441

Behandlingsansvarlig
Daglig ansvarlig

Selskade - det stumme språket

*Lovisenberg diakonale høyskole, ved institusjonens overste leder
Randi Tofthagen*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.


Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, vedlagte prosjektvurdering - kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://www.nsd.uib.no/personvern/prosjektoversikt.jsp>.

Personvernombudet vil ved prosjektets avslutning, 30.06.2010, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen


Bjørn Henriksen


Ingvild Bergan Hordvik

Kontaktperson: Ingvild Bergan Hordvik tlf: 55 58 32 32
Vedlegg: Prosjektvurdering



Utvalget består av 10-14 psykiatriske sykepleiere. Det gis skriftlig informasjon til utvalget, og innhentes skriftlig samtykke. Personvernombudet finner informasjonsskrivet tilfredsstillende, slik det foreligger per 28. august 2009.

Behandlingen av personopplysninger kan hjemles i personopplysningsloven § 8 første alternativ (samtykke).

Innen prosjektslutt 30. juni 2010 anonymiseres datamaterialet. Ombudet minner om at med anonyme opplysninger forstås opplysninger som ikke på noe vis kan identifisere enkeltpersoner i et datamateriale, verken direkte, indirekte gjennom bakgrunnsvariabler eller gjennom navneliste/koblingsnøkkel eller kode. Lydopptak slettes.

Emne: Prosjektnr: 22441. Selvskade - det stumme språket
Dato: mandag 8. mai 2017 10.02.01 sentraleuropeisk sommertid
Fra: Hildur Thorarensen
Til: Randi Toftagen

BEKREFTELSE PÅ STATUS

Hei, viser til epost registrert hos personvernombudet 03.05.2017.

Personvernombudet har nå registrert 01.04.2018 som ny dato for prosjektslutt.

I tilfelle det skulle bli aktuelt med ytterligere forlengelse av prosjektslutt, vil vi gjøre oppmerksom på at forlengelse på mer enn ett år utover den sluttdatoen utvalget er informert om (01.04.2017) ikke kan påregnes uten at det vurderes å gi informasjon til utvalget.

Ved ny prosjektslutt vil personvernombudet rette en henvendelse angående status for behandlingen av personopplysninger.

--

Med vennlig hilsen

Hildur Thorarensen
Seniorrådgiver | Senior Adviser
Seksjon for personverntjenester | Data Protection Services
T: (+47) 55 58 26 54

NSD – Norsk senter for forskningsdata AS | NSD – Norwegian Centre for Research Data
Harald Hårfagres gate 29, NO-5007 Bergen
T: (+47) 55 58 21 17
postmottak@nsd.no www.nsd.no

Appendix 4: Information folder to mental health nurses

Oslo,dato....

Hei.

Jeg søker med dette å kunne benytte akutt psykiatrisk avdeling som forskningsfelt for en intervjustudie av sykepleiere med problemstillingen: ”Hvordan erfarer sykepleiere å fremme en terapeutisk relasjon til brukere som har behov for å gjøre ytre repeterende selvskade?”

Den empiriske studien forutsetter at jeg kan få intervjuer inntil fire sykepleiere som har sitt arbeid ved akutt psykiatrisk avdeling. Sykepleierne må ha arbeidet minst 3 år i akuttpsykiatrien i 100 prosent stilling ,og har videreutdanning i psykisk helsearbeid. Studien har til hensikt å beskrive: *hvilke erfaringer sykepleierne har når det gjelder å skape en terapeutisk relasjon i møte med menneske som gjør ytre selvskade.* Vedlagt er veiledende intervjuguide for studien om mulig ønsker jeg å intervjuer sykepleierne i september/oktober 2009.

Hvis du finner å kunne innvilge denne søknaden, vil jeg be om at avdelingsleder ved akuttpostene spør fire aktuelle sykepleiere om de er villig til å la seg intervjuer. Hvis det er flere akuttpsykiatriske poster er det ok at respondentene kommer fra ulike poster. Når jeg får oppgitt navn og telefonnummer til de aktuelle sykepleierne, vil jeg ta kontakt med dem for ytterligere informasjon og avtale tid og sted for intervju. Det er ønskelig om intervjuet kan foretas på arbeidssstedet og innenfor arbeidstiden til den enkelte sykepleier. Intervjutiden vil vare i seksti minutter.

Vedlagte informerte samtykkeerklæring skrives under av sykepleier før intervjuets start.

De signerte samtykkeerklæringene vil bli oppbevart nedlåst inntil studien er publisert, for deretter makuleres. Studien er godkjent av NSD ((Norsk samfunnsvitenskapelige datatjeneste). Jeg har av mitt arbeidssted, Lovisenberg diakonale høgskole, gitt Fou tid høst 2009 og vår 2010 for å gjennomføre studien.

Ønskes det mer informasjon om studien, kan jeg kontaktes på telefon 22 35 83 64 , 95 00 01 96 og e-post: Randi.Tofthagen@ldh.no

Vennlig hilsen

Høgskolelektor / Psykiatrisk sykepleier

INFORMERT SAMTYKKE

Jeg har blitt spurt om å delta i en intervjustudie om selvskade.

Høgskolelektor / psykiatrisk sykepleier Randi Tofthagen har fra sitt arbeidssted Lovisenberg diakonale høgskole fått fou tid til å gjøre en intervjustudie om selvskade. I den forbindelse har jeg sagt meg villig til å la meg intervjuet av henne. Intervjuene skal dreie seg om min erfaring med hvordan jeg som sykepleier skaper en terapeutisk relasjon i møte med mennesker som gjør repeterende ytre selvskade.

Intervjuet vil bli tatt opp på lydbånd. Lydbåndet vil få et foreløpig nummer som ikke vil bli knyttet til mitt navn annet enn ved en kodeliste, som oppbevares utilgjengelig for andre enn Randi Tofthagen. Lydbåndene vill bli oppbevart nedlåst i bankboks og vil bli slettet når artikkelen er antatt for publisering, og senest innen 30.06.10. Jeg forstår at intervjuet er frivillig, og at jeg når som helst kan trekke meg fra undersøkelsen. De opplysninger som jeg har gitt., skal ikke kunne føres tilbake til meg som person fra publikasjoner.

Hvis jeg etter intervjuet har kommentarer eller spørsmål kan Randi Tofthagen nås via telefonnummer 22358364 eller 95000196.Eventuelt e - post:: Randi.Tofthagen@ldh.no.

Min underskrift her, viser at jeg har sagt meg villig til å bli intervjuet på overnevnte vilkår.

Dato:.....

Respondentens navn:.....

Arbeidssted:.....

Telefonnummer:.....

Randi Tofthagen::.....

Appendix 5. Information folder to former patients

Forespørsel om deltakelse i forskningsprosjektet

Selvskade det stumme språket

Fra en ensom kamp med lidelsen – til felleskap og dialog?

Jeg har fra mitt arbeidssted Lovisenberg diakonale høgskole fått forskningstid til å gjøre en studie om ytre selvskade. I den forbindelse er dette et spørsmål til deg om du ønsker å delta med dine erfaringer i et intervju?

Intervjuet er på maks en time. Intervjuet vil foregå på et brukerstyrt senter i ditt nærmiljø.

Fokus er dine erfaringer med hvordan du som bruker av psykisk helsevern har erfart bedring av ytre selvskade. Det innebærer at du i dag ikke skader deg selv, og ikke har vært i kontakt med helsevesenet de siste to år.

Intervjuet er frivillig, og du kan når som helst trekke deg fra studien. De opplysninger du gir skal ikke kunne føres tilbake til deg som person fra publikasjoner eller på annen måte.

Intervjuet vil bli tatt opp på lydfil. Lydfilen vil få et foreløpig nummer som ikke vil bli knyttet til ditt navn annet enn ved en kodeliste som oppbevares i min bankboks. Lydfilene og samtykkeerklæringen vill bli oppbevart nedlåst i bankboks, og vil bli slettet når avhandlingen er ferdig i 2015.

Jeg er psykiatrisk sykepleier og har arbeidet mange år i akuttpsykiatrien og som høgskolelektor i psykisk helsearbeid. I tillegg forsker jeg nå på hva som fremmer bedring av ytre selvskade som en del av en doktorgrad.

Dersom du ønsker å delta, undertegner du samtykkeerklæringen nederst på dette arket før intervjuets start.

Hvis du etter intervjuet har kommentarer eller spørsmål, kan Randi Tofthagen nås via telefonnummer 22358364 eller 95000196. Eventuelt epost::
Randi.Tofthagen@ldh.no.

Min underskrift nedenfor, viser at jeg har sagt meg villig til å bli intervjuet på overnevnte vilkår.

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien

Navn:

Telefon:

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, intervjuer, dato)

Appendix 6: Semi-structured interview guide for mental health nurses

Intervjuguide med tema selvskade

Hva er dine tanker om hvorfor et menneske skader seg selv?

På hvilke måte veileder du pasienten til selv å ta ansvar for ulike faser av sin selvskadeatferd?

Har du erfaringer med at pasienten lærer alternative uttrykksmåter for psykisk smerte (tegne, skrive dagbok, etc.) i stedet for at pasienten skader seg selv?

Hvordan opplever du emosjonelt å være i relasjon til mennesker som skader seg selv?

Hvilke erfaringer har du med hva som hemmer og fremmer å skape en relasjon med mennesket som gjør selvskade?

Hvilke tanker og erfaringer har du om hva som kan fremme mestring av sykdommen hos mennesket som skader seg selv?

Hvilke nedskrevne prosedyrer i posten eller teoretiske referanserammer arbeider du ut i fra i møte med mennesker som gjør selvskade?

Beskriv hvordan du vurderer bruk av tvang i møtet med mennesket som gjør selvskade.

Hvilke ulike ord har du hørt benyttet for å beskrive ytre selvskade?

Appendix 7: Semi-structured interview guide for former patients

INTERVJUGUIDE

- Kan du fortelle om tiden du skadet deg selv?
- Hva er selvskade for deg?
- Hva innebærer bedring av ytre selvskade for deg?
- Hvorfor har du sluttet å selvskade?
- Kan du beskrive hva sykepleier har bidratt med?
- Hvilke holdninger hos sykepleieren har du erfart fremmer bedring av ytre selvskade?
- Hvilke holdninger hos sykepleieren har du erfart hemmer bedring av ytre selvskade?
- Har du mottatt veiledning av sykepleier om hvordan du skal unngå å gjøre selvskade?
- Når du selvskadet hva gjorde sykepleier da?
- Var det kontinuitet i oppfølging av sykepleier under og ved gjentatte innleggelser i sykehuset?
- Opplevde du at sykepleier var tilgjengelig for dialog etter innleggelsen?
- Opplevde du å være medvirkende i din egen behandling på sykehuset?
- Er det noe ved oppfølgingen fra helsevesenet du ønsker hadde vært på en annen måte?
- Har du noen erfaringer om hva man konkret kan gjøre for å unngå selvskade hvis man får tanker om det?
- Tenker du at selvskadeatferden kan komme tilbake?
- Hvorfor hadde du behov for å skade deg selv?
- Har du nettverk utenfor sykehuset som har støttet deg i bedringsprosessen?
- Er det andre erfaringer med å gjøre ytre selvskade du ønsker å fortelle om?

Hvor lenge er det siden du skadet deg selv?

Hvordan skadet du deg?

- en gang?
- gjentatt?
- en type handling?
- Flere ulike former?
- Endret handlingene seg over tid?

Hvor mange ganger var du innlagt i sykehus på grunn av selvskade?

Hvor lenge har du opplevd bedring?

Går du til behandling nå?

- Har du en diagnose?