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ORIGINAL RESEARCH: EMPIRICAL RESEARCH –  
QUALITATIVE

## Former patients' experiences of recovery from self-harm as an individual, prolonged learning process: a phenomenological hermeneutical study

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Akademi University, Vasa, FinlandTOFTHAGEN R., TALSETH A.G. & FAGERSTRØM L.M. (2017) Former patients' experiences of recovery from self-harm as an individual, prolonged learning process: a phenomenological hermeneutical study. *Journal of Advanced Nursing* 73(10), 2306–2317. doi: 10.1111/jan.13295**Abstract****Aim.** To explore, describe and understand former patients' experiences of recovery from self-harm.**Background.** Previous research shows that a person's development towards a more secure self-image, mastery of their emotions, an understanding of what triggers self-harm and mastery of new ways to cope with problems are central to recovery. Recovery from self-harm is still a relatively new field of research.**Design.** A phenomenological hermeneutical approach.**Methods.** Eight participants were interviewed in 2013. Inclusion criteria were as follows: to have committed no self-harm during the past 2 years, to have experienced recovery and to be 18 or older. We analysed data using a phenomenological hermeneutical method.**Findings.** The findings resulted in three themes with subthemes. The first theme, the turning point, occurred at the start of the recovery process. Participants learned to choose life, verbally express their inner pain and reconcile with their life histories. In the second theme, coping with everyday life, participants learned how to choose alternative actions instead of self-harm and attend to their basic, physical needs. In the third theme, valuing close relationships and relationships with mental health nurses, participants learned to receive support from close relationships with others and mental health nurses. A tentative model illustrates the comprehensive understanding of the recovery process, described as an individual, prolonged learning process.**Conclusion.** To achieve recovery, persons who self-harm need guidance and knowledge of how to realize a personal learning process. More research is needed on how mental health nurses can support individual transition processes and thereby facilitate recovery.**Keywords:** individual, interview, mental health nurse, phenomenological hermeneutic, prolonged learning process, recovery, self-harm

**Why is this research needed?**

- There is limited knowledge of former patients' experiences of recovery from self-harm.
- Patient interventions should be strengthened in clinical practice, focusing on recovery.

**What are the key findings?**

- Choosing life increases one's motivation to learn how to express pain through alternative actions instead of self-harm.
- Balancing basic, physical needs reduces vulnerability and the need to self-harm.
- Self-awareness is needed for recovery, which is an individual learning process.

**How should the findings be used to influence policy/practice/research/education?**

- Mental health nurses who are solution-oriented and understand the individual behind the diagnosis can support individuals choosing life instead of self-harm.
- More research is needed on how mental health nurses can support self-reflection on alternative actions, whereby the recovery process from self-harm can start sooner in clinical practice.
- More research is needed on the role of close relationships in the recovery process and on relatives' experiences of being close to a vulnerable self-harming person.

**Introduction**

Self-harm is a complex and growing phenomenon in the western world (Kerr *et al.* 2010), and the majority who self-harm do not seek professional help. Thus, the actual prevalence could be even higher (Andover 2012). In England, hospital presentation for self-harm exceeds 200,000 episodes annually (National institute for health and clinical excellence 2011). In the USA, adults' lifetime prevalence of non-suicidal self-injury is 5.9%, including 2.7% who had self-injured five or more times (Klonsky 2011). In Norway, about 4% of the adult population self-harms (Hjelmeland & Knizek 2010).

Self-harm is often comorbid with serious pre-existing psychiatric disorders. Of hospital patients who self-harm, 80% were found to suffer from other psychiatric disorders such as depression, anxiety disorders or alcohol misuse (Hawton *et al.* 2013). The term self-harm encompasses a broad scope

of behaviours including acts of self-injury, self-mutilation and deliberate self-harm (Toftthagen *et al.* 2014), and various forms of self-harm are often used concurrently. In this study, we use the term self-harm to mean direct, bodily self-harm.

It is not uncommon that persons who self-harm are ambivalent towards recovery (Klonsky *et al.* 2011) and the absence of an alternative coping strategy can be a barrier (Grunberg & Lewis 2015). Persons who have recovered from self-harm have their own experiences of the different stages in the recovery process (Grunberg & Lewis 2015).

The concept of recovery is relatively new and across the globe policy-makers and others responsible for mental health services alike have incorporated recovery into their services (Roberts & Wolfson 2004). Perkins and Slade (2012) distinguished between 'recovering from an illness,' which they define as being free from symptoms, medication and treatment and 'recovering a life'. When 'recovering a life', a person takes more responsibility for his/her own health and redefines him/herself, returning to basic functions and improving his/her quality of life with good relationships (Andresen *et al.* 2003, 2006, Topor *et al.* 2011).

**Background**

We conducted a systematic literature search, which resulted in several studies on general experiences of recovery from mental illness. Of these, only four qualitative studies were found on experiences of recovery from self-harm and no quantitative studies were found.

Shaw (2006) interviewed six female participants about their experiences of recovery from self-harm. In Shaw's study, the participants took control over their lives in partnership with professionals, who helped them to recognize their resources and understand what triggers them to self-harm. Shaw found that the development of a belief in oneself and a concern for one's physical and psychological well-being promoted recovery. In a study by Kool van Meijel and Bosman (2009), 12 female participants were interviewed about their experiences of starting the recovery process. They found that the participants' self-esteem increased throughout the recovery process and that the participants experienced a further deepening of contact with the self.

Wills and Hons (2012) interviewed six female participants who self-harmed and found that rebuilding a new self and striving for self-management and hope promoted recovery as a central result. Buser *et al.* (2014) interviewed 12 participants and found that the participants experienced

that removing themselves from those specific environments that triggered their self-harm promoted recovery.

The four qualitative studies showed that the process of recovery from self-harm is individual. Persons who self-harm must come to a unique understanding of what triggers their self-harm and develop alternatives that allow them to cope with their problems and relationships without the need for self-harm. This occurs through the development of a secure self-image and the mastering of one's emotions. Still, we agree with Kogstad *et al.* (2011) that research on how persons actually recover from self-harm is limited.

It is important to gain deeper understanding of the recovery process from long-term self-harm. Little research exists on the personal experience perspective. Consequently, there is scarce knowledge about former patients' individual coping methods and the gradual process of recovery from self-harm. It is important that mental health nurses have knowledge about what recovery from self-harm entails to understand the self-harming person and develop further nursing initiatives when supporting persons who self-harm towards recovery.

## The study

### Aim

The aim of the study was to explore, describe and understand former patients' experiences of the process of recovery from self-harm.

### Design

A phenomenological hermeneutical approach influenced by Ricœur's (1976) philosophy and further developed by Lindseth and Norberg (2004) was used. According to Ricœur (1976), one person's experience cannot directly become another person's experience; something (such as meaning) is transferred from one sphere of life to another. We therefore maintain that the experiences of former patients who have experienced the process of recovery from self-harm can be transferred to a deeper common meaning of the phenomena studied here.

### Participants

The participants were recruited through two mental health user organizations. The leaders of the two organizations sent e-mails to their various members, which included information about the study and a request for participants. The inclusion criteria were: to have committed no self-harm

during the past 2 years, to have experienced recovery from self-harm and to be aged 18 or older. We decided that a 2-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 14–20% of adults will repeat a self-harm event while about 1–2% will commit suicide (Haukka *et al.* 2008, Chen *et al.* 2011).

Twelve persons initially accepted to participate in the study. Ten were found through the mental health user organizations, one through the media and one through another researcher's research. Eight of the 12 met the inclusion criteria to participate in the study.

One man and seven women with a mean age of 36 participated in this study. The participants had on average self-harmed for 15 years (8–33 years) and experienced recovery for 5 years (2–8 years). Four worked in mental health care as experience consultants; one was a volunteer in a mental health user organization, one was a care worker, one was a student and one was a writer. Several could not remember the number of times they had been admitted for mental health care and/or somatic care for self-harming. One had only had contact with emergency services and a psychiatrist, while another had been admitted 86 times for mental health care and 50 times for somatic care. All had cut themselves repeatedly from moderately to more seriously over time 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, presented in Table 1.

### Data collection

Interviews were conducted during 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?' and '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 & Norberg 2004). The interviews took place where the participants wished to be interviewed: place of work, residence or hotel conference room.

**Table 1** 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, 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, 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, Eastern Norway	Currently: No diagnosis Previously: Posttraumatic 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, Western Norway	Currently: Depression, disassociation, posttraumatic stress disorder, periodic suicidal thoughts Previously: affective disorder, attempted suicides	Cutting, burning, eating disorders	Many in mental health care and somatic care	33 years (15–48)	Experience consultant in mental health care	2 years
Female, 37, Western Norway	Currently: Holds moods in check through medication Previously: anxiety, depression, posttraumatic stress disorder, manic depressive disorder	Repeated cutting	Went to a psychiatrist and emergency services	10 years (18–29)	Care worker	8 years
Female, 32, Northern Norway	Currently: recurrent depression Previously: Emotionally unstable personality disorder, attempted suicides	Cutting, pills	Psychiatrists, dialectical behaviour therapy group.	8 years (18–26)	Experience consultant in mental health care	6 years
Female, 26, Eastern Norway	Currently: Periodic suicidal thoughts Previously: Emotionally unstable personality disorder, attempted suicides, intoxication, Bulimia	Serious cutting, substance abuse, bulimia	60 in mental health care and 12 in different units and repeated admission to somatic care	12 years (10–22)	Writer	4 years
Female, 30, 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 5 years in total	7 years (18–25)	Student	5 years

### Ethical considerations

The Norwegian Social Science Data Services (NSD) approved the study on 7 November 2011 (project number 28242). The study did not need approval from the Norwegian Regional Committee for Medical and Health Research Ethics (REK) because the study did not include any clinical interventions, and the participants were not considered a particularly vulnerable group.

Prior to each interview, the first author provided the participants with verbal and written information on their right to anonymity, confidentiality and withdrawal from the study at any time. The participants were guaranteed confidentiality and anonymous presentation of the results. They gave informed consent to participate in the study.

### Data analysis

The analysis of the data material consisted of a movement between three steps: naive reading, structural analysis and comprehensive understanding (Lindseth & Norberg 2004).

#### Step 1: Naive reading

In the first step, the research group read, reread and discussed the text with an open mind 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. The first understanding of the text was synthesized into a short narrative.

#### Step 2: Structural analysis

Thematic structural analysis was used to explain what the text expressed. The analysis was characterized by a de-contextualization of the text. The text was divided into meaning units, which were condensed and labelled 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 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. For an example of the structural analysis (Table 2).

#### Step 3: Comprehensive understanding

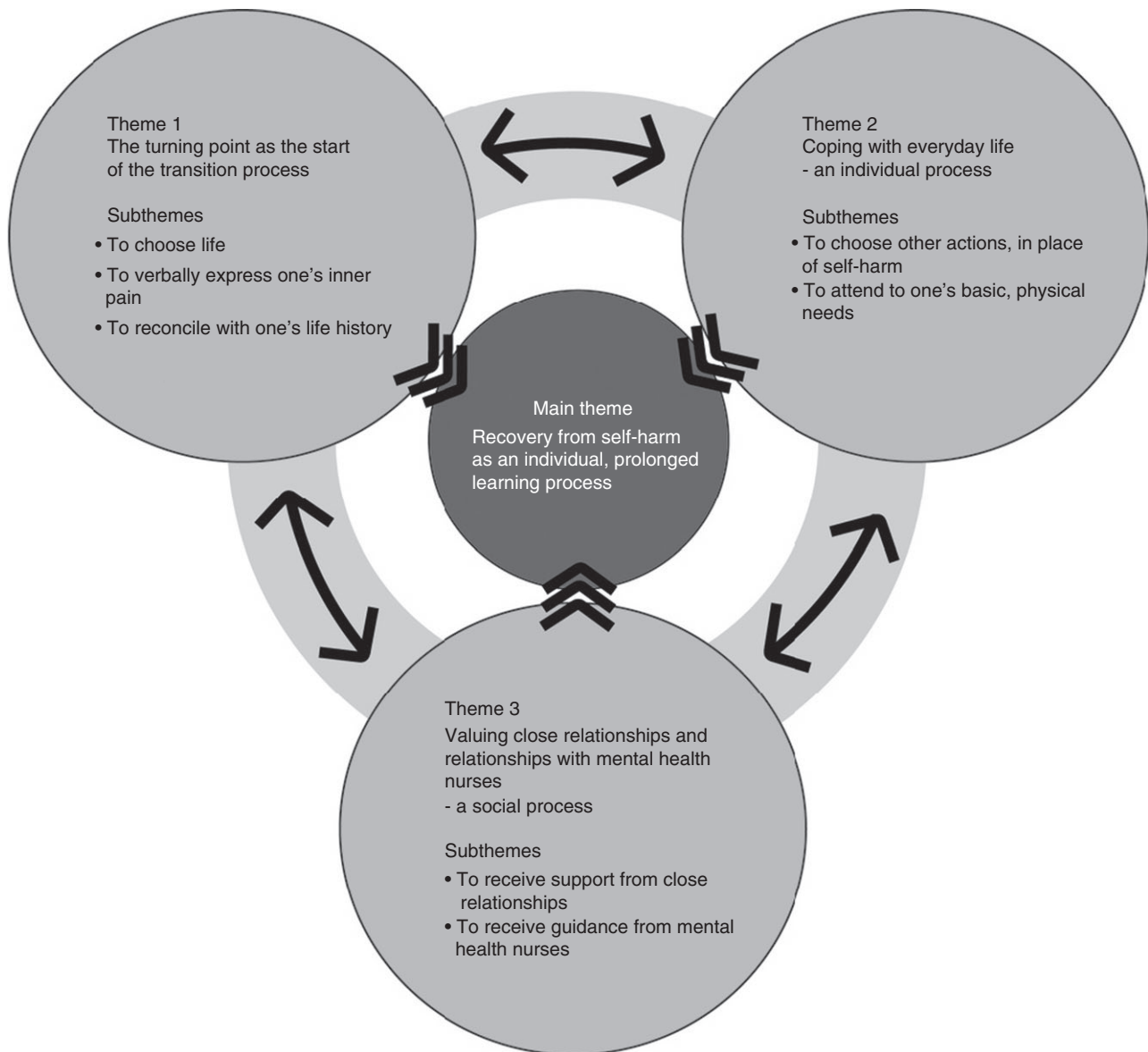
In this last step, the in-depth interpretation was developed from the relevant literature, research questions, naive reading, structural analysis and the research group's pre-understanding. The subthemes and themes were further interpreted into a main theme that described the essential meaning of what recovery from self-harm means for persons who have self-harmed (Figure 1).

### Rigour

The trustworthiness of the findings was based on the following four criteria: credibility, transferability, dependability and confirmation (Guba 1981). During our analysis of the data, the description of the participants was taken into

**Table 2** Example of the structural analysis: from meaning units to themes.

Meaning units	Condensed meaning units	Sub-theme	Theme
Have felt more familiar and at ease with myself really because I have always had a goal all the time. Two years ago I took an educational course. I have never taken a course but I managed it. Two years ago when I took a certificate of completed apprenticeship, that did a lot for me. It was a goal in my life that was actually reached. Yes that I am very proud of. (P5)	To be proud of completing an educational course and reaching a goal in my life. (P5)	To choose life	The turning point as the start of the transition process
What I have that is in any case most important for me is to have it be stable – have a stable life. (P5)	To have a stable life. (P5)		
I quit I suppose actually when I found my husband. Then it was no longer, like, no. (P5)	To find an important person in (one's) life –the end of self-harm. (P5)		



**Figure 1** Main theme: Recovery from self-harm as an individual, prolonged learning process.

account and credibility ensured by variation sampling in the homogenous group (Graneheim & Lundman 2004). During the interviews, the participants were given the opportunity to reflect on their experiences of the recovery process from self-harm (Shenton 2004) and they contributed various nuances on what recovery from self-harm entails (circling-reality) (Dervin 1983, Shenton 2004). Thick description was employed, in the form of themes, to provide credibility. All stages of the research process, including data collection and data analysis, were described to realize transferability. Dependability, as determined by our systematic presentation

of the study sampling process, was considered successful. We elected to describe the study in such a manner so that other researchers can recreate it but not necessarily achieve the same results (Shenton 2004). The first author started the analysis process by composing a first draft of the synthesis of the naive reading and thereafter determining the subthemes and themes. Confirmation occurred when the research group together confirmed the results of each step of the analysis and interpretation processes until we reached a consensus, also ensuring the least possible bias in the interpretation of the material (Shenton 2004).

## Findings

We first present the synthesis of the naive reading, second describe the three themes and seven subthemes that emerged from the structural analysis and last present an interpretation of a main theme – the essential meaning of what recovery means for persons who have self-harmed (Figure 1).

### Synthesis of the naive reading

The participants described self-harm as a shameful, lonely and addictive pattern of behaviour that alternated between moderate self-harm and suicide attempts. They experienced the turning point towards recovery as a choice towards better health and a realization that they no longer wished to continue engaging in serious self-harm. Participants experienced the act of self-harm as a short-lived alleviation of an inner pain they could not verbally express.

Several participants described that being met with good attitudes by mental health nurses helped them to promote opportunities for the recovery process. This is a prolonged process where nurses understand the pain behind the self-harm and do not meet the person who self-harms with anger or condemnation, but instead give him/her the time and allowance to try to stop and fail. The participants gradually learned to recognize the signals or triggers for self-harm, distract themselves from engaging in self-harm and understand the root of their pain and verbally express difficult emotions and events. They experienced that nurses helped them manage their own basic, physical needs.

Many of the participants experienced the support of family or friends. The participants described that they learned step by step to set limits for other persons who triggered their vulnerability. Despite previous traumatic family events, after recovery several wished to remain in contact with their family, with the desire to forgive their family members. Several participants said that they wished to reconcile themselves with their life history.

### Structural analysis

#### *Theme 1: The turning point as the start of the recovery process*

*To choose life.* Prior to the turning point that brought them to the process of recovery, all of the participants repeatedly self-harmed over years. They used several different forms of self-harm simultaneously, or alternated between different forms. Over time, the participants felt it

was necessary to increase the degree of their self-harm to achieve the same feeling of relief. Consequently, their self-harm became an addictive, planned or impulsive behaviour:

It is certainly difficult when it has become an addiction. It was something that followed me, that I must do in a way. (P3)

Several participants related that self-harming was a secret, lonely and shameful action. 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) behaviour and chose to stop or reduce the behaviour:

There was suddenly blood everywhere and it was not planned. It was a little too deep and I realized that I did not have control over it. (P3)

Several related that they reached a turning point when they began a stable or supportive adult relationship, had children, wanted to keep a job and/or did not wish to cause their family pain. The participants' turning points indicate that stable relationships promote recovery: when a person wants a relationship to continue or is affected by experiences such as interdependence, stability, concern or love:

To have it be stable. Have been married for 13 years. We have children and have a normal family life. I might simply have grown out of self-harming. (P5)

*To verbally express one's inner pain.* Self-harm was the only way 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:

There was a lot of guilt and shame with self-harming. Did not know why I did it. What was wrong with me? I knew of no other way I could master the pain inside. (P7)

As participants began to understand their inner pain and become more self-content, their self-respect increased and their need to self-harm decreased. 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 behaviour:

So I began to feel, because I really wanted to write about the self-harm. This entailed that when I read it – I became conscious of some of what I often thought about ahead of [the self-harm] or



what I thought afterwards. To write is to sort [through] – because when the pressure is smaller – then the need is, after all, smaller as well. It is no longer as painful then, or as good – the self-harm loses its function, I think. (P3)

*To reconcile with one's life history.* All participants had had difficult childhoods, where they took on adult responsibilities much too soon, experienced sexual assault and/or were bullied by family or friends:

My mother could, if she touched me, wash her hands or change [her] sweater. Once she hit me and I got sent in to wash myself. I was not allowed to use the same bathroom as the rest of the family for several months. Then you develop a sick attitude to your own body. (P2)

Some of the participants stated that they should have shared their history with others earlier and lived with less guilt and loneliness. Despite serious events, several participants wished to reconcile with their families after they had gained greater self-respect, but on their own terms:

My mother got help and we went many rounds as a family and it was important, so we have talked about almost everything I think and we have a very good relationship today. I am happy about this. (P3)

Physical scars are also part of the life histories of persons who self-harm and even after recovery they carry the past with them through their scars. Some participants experienced that their scars could cause some other persons to label them mentally ill, despite their recovery and that others could comment on the scars in public. This could make it difficult for the participants to reconcile with their life histories:

Today it is difficult to live with the scars because I am unable to identify myself with them, so it becomes very strange sometimes. (P3)

*Theme 2: Coping with everyday life – an individual process To choose other actions, in place of self-harm.* The participants learned to take responsibility for and more actively think about not self-harming. Instead of self-harming they could listen to music, cry, engage in physical activity, breathe heavily, watch television or write. The methods used were individual and stemmed from each person's interests:

For me it is clearly a solution to call someone. To see if some friends want to stay overnight. I think that what I often do is read, daydream maybe and watch television, that and take care of

animals. It [is] to have sound around myself, like, so that it is not completely quiet. (P2)

Learning to distract oneself can be compared with 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:

It has been a very long process to learn other methods of mastering the pain; healthy ways such as crying. It is something that persons should understand, that you do not want to cut yourself if you can do something else instead, but it is a part of the illness as well. I still think that I might cut myself again, but then I must just try to take it from there. (P7)

*To attend to one's basic, physical needs.* The participants described that they were not capable of managing their basic, physical needs or recognizing bodily indicators of stress, which would lead to a physical vulnerability that triggered their need to self-harm. They needed support and help to learn to gradually take responsibility for themselves and their health, learn to continuously master stress and become more solution-oriented in everyday life:

I still have, to be sure, periods where this vulnerability crops up if I am unable to take care of [my] basic needs. (P6)

They realized that attending to their own basic, physical needs balanced everyday life and stabilized them: for example, eating regularly or getting enough sleep:

In the beginning it was stressful and chaotic – but getting enough food, enough rest, socializing and doing activities, I got something positive out of [this] and some security. (P6)

*Theme 3: Valuing close relationships and relationships with mental health nurses – a social process*

*To receive support from close relationships.* The participants described close relationships in various ways. Some had stable relationships with friends or family, some were happy that a relationship had 'persevered' even when they were ill and some had relationships that changed over time. Some did not divulge that they continuously self-harmed; they were scared of burdening others with their pain and therefore did not speak about their self-harm:

I have very good friends and it is actually pretty amazing, because I would not have had the strength if they had not been friends with me when I was really ill. (P2)

The participants explained that their families could experience a sense of helplessness from seeing them ill over the years, during good and bad phases:

The family have reacted in a natural way, they have been angry and sad and resigned. They have shown a lot of support and understanding. But they have tried and wanted to understand. (P7)

*To receive guidance from mental health nurses.* To receive help and guidance, the participants described they needed to be open about their suffering. They 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 the prolonged recovery process. The participants also described that being forcibly put into care was positive in retrospect:

I can remember someone who was good at observing and charting [the patterns]. They noticed and told me that I began to be uneasy and could intervene. I was unable to stop it myself. They said, 'Do you feel uneasy now. Do you want to go for a walk' – in that way they could actually stop it. (P8)

The participants related that the nurses promoted self-respect and helped them develop self-worth when they were well-received and seen and accepted for who they are. It was also beneficial when the nurses helped them understand that they need not be defined by their illness. They 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 pre-understanding. As seen in this study, at a turning point, participants started a prolonged recovery process in which they chose life and stable relationships, learned to verbally express their inner pain and reconciled with their life histories (first theme; see Figure 1). They gradually learned to 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 (second theme). 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 (third theme).

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 lifelong 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. The main theme and results from the structural analysis were compiled and shaped into a tentative model of the recovery process from self-harm (Figure 1).

## **Discussion**

The aim of this study was to explore, describe and understand former patients' experiences of the process of recovery from self-harm. A transition from self-harm to recovery as an individual learning process emerged as the main theme.

An important result was that all of the participants experienced an existential turning point when they began to fear dying or losing a stable relationship. They made the decision to choose life and seek out new ways to cope with their pain. During the recovery process, the participants learned more health-promoting behaviours and thought patterns, which in turn helped them to stop or refrain from using their bodies as the pain-dampening objects of their physical suffering.

To cope with painful emotions, the participants had self-harmed in various and multiple ways for many years and such behaviour becomes an addiction. In a study that included a concept analysis of self-harm, researchers found that physical pain can alleviate mental suffering (Toftthagen *et al.* 2014). The participants described that during the recovery process, their emotions evolved from self-hate and shame to ever more self-contentment and self-worth. Kaufman (1992) found that self-harming is a shame-based syndrome and that a shamed identity is a barrier to health. Moreover, the internalization of a stigma is a barrier to recovery and occurs in social interactions (Yanos *et al.* 2008). In various theories of suffering, the experience of shame can be central to human suffering (Gustin 2014). Through learning to reflect on experiences of feeling shame, the patient can find new and alternative thought patterns (Gustin 2014).

The participants related that, during the recovery process, they learned how to verbally express their inner pain: to control their emotions, thereby experiencing improved self-image and mastery of the impulse to self-harm. Health-promoting behaviours and alternative strategies were particularly used, such as physical activity, writing or direct expression of emotions. Norman and Borrill (2015) found that alexithymia, the inability to identify and describe emotions in the self, is most frequent among women who self-harm.

The participants also reconciled with their life histories; they had all experienced difficult childhoods where they took on, for example, adult responsibilities in their family, were bullied or experienced sexual, mental and/or physical abuse. As seen in Lereya *et al.*'s (2013), experiences of being bullied during childhood increase the risk for self-harm.

The participants gradually learned to cope with everyday life without the need for self-harming. Positive experiences gave participants the energy and ability to attend to their basic, physical needs and made them less likely to self-harm. Persons who self-harm use their body to communicate their experiences of mental suffering. Therefore, in clinical practice, the potential exists to place greater focus on patients' physical injury rather than mental suffering (Rosenbaum 2016).

Participants also learned to value relationships, because they wanted to maintain and develop interdependence, stability, concern or love with others. Positive feelings for certain important persons contributed to a decline in their self-harm. In a study by Latina *et al.* (2015), depressed adolescents were less likely to begin self-harming if a caring, open and communicative dialogue with their parents existed.

In our study, the participants explained that nurses who are solution-oriented and understand the person behind the diagnosis promote recovery. The traditional medical way of solving health problems is not enough for these patients. According to Davidson and Roe (2007), up to 35–75% of patients with mental illness do not experience recovery as defined as a medical cure. Still, most can learn to live with their symptoms. Our study showed that persons who self-harm can learn to find new forms of self-expression and learn to choose life and gain a greater understanding of how they can promote their own well-being, even if they are still struggling and not completely 'cured' of the need to self-harm.

Our study showed that it is possible for persons who self-harm to learn to choose life and cope with everyday life, without the need for self-harm. It is possible to gain a

greater understanding of how one's own well-being can be promoted, even without being completely 'cured' of the illness. The journey to recovery from self-harm is an individual, prolonged learning process.

### Limitations

The sample was limited to eight former patients who had experienced recovery from self-harm. Gender differences cannot be fully explored as only one participant was male. It was difficult to recruit former patients for participation in this study. The organizations' representatives said that talking about self-harm can be emotionally challenging for those who have recovered. However, the participants positively engaged in the interviews and openly shared their experiences, which resulted in a rich data set and strengthened the credibility.

### Conclusion

In this phenomenological hermeneutical study, the participants experienced both recovering from illness and 'recovering a life'. They decided at a certain turning point to stop self-harming, which increased their motivation to learn how to master their everyday life. They learned to clearly take more responsibility for their own health and gradually learned to understand themselves better, thereby improving their self-awareness and self-worth. When mental health nurses and close relatives and/or friends tolerated the participants' mental suffering, they contributed to the recovery processes. Innovative mental health nurses who promote recovery through solution-oriented and person-centred methods can alleviate the suffering of persons who self-harm.

A greater emphasis should be placed on the motivation of patients to balance basic, physical needs, so that their vulnerability can be reduced and on the importance of learning to verbally express inner mental pain. Furthermore, the experience of suffering from self-harm and how health-care professionals can promote a person's individual learning process in partnership with persons who self-harm. More research is also needed on relatives' experiences of supporting the vulnerable, self-harming person during the recovery process.

### Author contributions

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (<http://www.icmje.org/recommendations/>)]:

- substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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## Conflict of interests

The authors declare no conflict of interests with respect to the authorship and/or publication of this paper.

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