INTRODUCTION

Total cessation of self-harm is not necessarily the primary focus of recovery for men who self-harm (Tofthagen et al., 2022). Traditionally, mental health services have been focused on clinical recovery, prioritising the treatment of symptoms of illness and preventing further decline of patients’ mental health and functional status. However, today, the policy priority in many countries worldwide is to transform mental health services to engage with personal and social aspects of recovery (Sofouli et al., 2022). The focus of this paper is men’s subjective experiences of recovery in self-harm.

BACKGROUND

The essence of mental health recovery has been described in terms of individual agency and self-determination, where the person has the autonomy to pursue a life in accordance with their own values and possibilities to actively participate in society despite mental ill-health (Davidson & Roe, 2007). Personal recovery has been conceptualised as complementary to clinical recovery because it is perceived as a non-linear process as opposed to a return to a pre-morbid state or return to normality (van Weeghel et al., 2019). The question of whether recovery always follows an individualised course or if it can also be divided into multiple phases has been
discussed among researchers. According to Davidsson et al. (2010) phase models can be an indirect attempt to make recovery process thinking subordinate to recovery outcome thinking. Perceiving recovery in terms of outcomes is pointless because the only constant outcome of life is death. Focusing on the recovery process is about supporting the person to have a good life, with or without the illness.

The CHIME framework has been used internationally in several studies for diverse populations (Brijnath, 2015; Piat et al., 2017) and was recently described as a comprehensive description of the recovery process (Kanemura et al., 2022). Leamy et al. (2011) introduced the CHIME framework as a conceptual framework for personal recovery in mental illness. This framework was developed through a knowledge synthesis of 97 papers from 13 countries (Leamy et al., 2011). The acronym CHIME stands for five recovery processes: connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. Connectedness refers to individual relations and societal connections, hope refers to the belief by persons with mental illness and by others that they will get better (Leamy et al., 2011; Slade et al., 2012). Identity refers to redefining and rebuilding a positive sense of identity. Meaning is about finding meaning in life, for example, through social goals, spirituality, employment, and also by deriving meaning from the illness experience itself, and empowerment refers to a sense of control over oneself, one's treatment, and feeling like an empowered member of society (Brijnath, 2015).

The CHIME framework has been used in many reviews as an exploratory framework (Jagfeld et al., 2021; van Weeghel et al., 2019; Yung et al., 2021). van Weeghel et al. (2019) conducted a scoping review of systematic reviews and meta-analyses on the conceptualisation of personal recovery, showing clear support for the CHIME conceptual framework. They also recommended that the framework should be adapted to the cultural specifics of the population to which it is applied. Lim et al. (2020) used the CHIME framework to evaluate a personal recovery measure, the Mental Health Recovery measure. In a study by Damsgaard and Jensen (2021), the framework was used as the backdrop for whether music activities contributed to recovery-oriented practice. Some further developments of the framework have been proposed. In 2017, Stuart, Tansey and Quayle proposed an extended framework, CHIME-D, whereby D stands for difficulties. Senneshet et al. (2022) conducted a systematic review and thematic synthesis of the qualitative literature in the context of forensic mental health. Based on the results, they suggested that feeling safe and secure could be added to the CHIME, i.e., CHIME-S.

The focus of this paper is men’s recovery in self-harm. By writing ‘in’ self-harm rather than ‘from’ self-harm, we wish to convey an understanding of recovery as not necessarily related to the presence or absence of illness and symptoms, i.e. if the physical manifestation of self-harm is present does not necessarily determine whether someone considers themselves recovered. For this paper, we also sometimes chose to use the phrase “those who experience self-harm” in order to highlight that self-harm is not an identity or an indistinguishable part of a person, but rather an experience that is highly individual and may vary over time. We also acknowledge that self-harm is a functional behaviour that serves a purpose.

There is no universally accepted definition of self-harm. For this study, we adhered to a definition of non-suicidal self-injury, NSSI, as ‘deliberate self-directed damage of body tissue without suicidal intent, and for purposes not socially or culturally sanctioned’ (American Psychiatric Association, 2013; International Society for the Study of Self-Injury, 2023). NSSI is a complex, multi-faceted phenomenon that serves various functions, such as making life manageable, providing relief and security, and taking control over overwhelming feelings for those who experience self-harm (Lindgren et al., 2022; McManus et al., 2019). In most aspects, NSSI does not differ between men and women (Victor et al., 2018). However, adherence to masculine norms is related with NSSI and may have some influence on choice methods of self-harm in men (Bandel & Anestis, 2020; Green et al., 2018). Also, research on men with severe self-harm suggests that men might be less likely to use self-harm for emotional regulation (Victor et al., 2018).

Geulayov et al. (2018) estimate that only 1:28 young men and 1:18 young women seek hospital care for their self-harming behaviour. The incidence of self-harming behaviour increased among women and men in England from 2000 to 2014. The increase was most significant, from 6.5% in 2000 to 19.7% in 2014, among women aged 16–24 (McManus et al., 2019). A report from the National Board of Health and Welfare (2023) shows that, in Sweden, care for self-harm increased sharply between the years 2015 and 2021. Among girls aged 12–15 years, the proportion (number per 100 000 inhabitants) who were cared for on at least one occasion for an act of self-harm increased by nearly 87% between 2015 and 2021. The increase was particularly pronounced in 2021. An increase was also seen among girls and young women aged 16–19 years, while it remained unchanged in other age groups and among boys and men during the corresponding period. However, about 3% of those who were treated for self-harm during the period died by suicide within 12 months after the end of the treatment period. Men died by suicide more often than women close to discharge from psychiatric inpatient care, with 24 percent of men who died by suicide doing so within 7 days of discharge, compared to 10 percent of women. NSSI might be equally distributed amongst men and women, suggesting that “the long-standing gender gap in NSSI is closing” (Green et al., 2018, p. 36).

While cessation of self-harm is considered a key factor in recovery, recovery is more than cessation and can be described as a subjective experience involving the
absence of NSSI thoughts, increased self-acceptance, psychological recovery and increased coping skills (Lewis et al., 2019). Recovery in self-harm among young people has been described as “a multidimensional and nonlinear process characterised by a “push and pull” between (re-)engagement and cessation/reduction” (Lewin et al., 2023, p.17). Deering and Williams (2018) employed a qualitative meta-synthesis and explored the lived experience of what activities might facilitate personal recovery for adults who continue to experience self-harm. The CHIME framework was used in the interpretation of the results. The majority emphasised the benefits of Internet forums where mutual communication and reciprocity were important keys to promoting personal recovery. This study showed that hope was established by group members accepting that self-harm has a role while congregating with others who did not judge the act. Helping relationships also promoted hope by balancing goals and protection against disappointment. Meaningfulness was promoted by writing online, and empowerment was facilitated by adults controlling the narrative of their self-harm.

To the best of our knowledge, no previous study has focused on men's subjective experiences of recovery in self-harm. In a qualitative study of gender diversity as a decisive factor for recovery, Schön found that gender constructions can influence men's recovery from severe mental illness, both through societal expectations and how men navigate their illness (Schön, 2010). Men strive for control and independence in their recovery and do so by taking an apprentice role and learning strategies from professionals and peers with similar experiences, utilising medication and psychiatric interventions supporting them in understanding and managing illness. Traditional gender roles, such as being the primary breadwinner, can hinder recovery and contribute to feelings of inadequacy (Schön, 2010). A recent review of the literature on men and self-harm concluded that research into this area needs to consider both clinical and personal aspects of recovery and stressed the need for further research exploring recovery from men’s point of view (Toft Hansen et al., 2022). This study aimed to describe men's experiences of recovery in self-harm.

METHODS

To describe men's experiences, we chose a qualitative descriptive design including semi-structured interviews that we analysed using abductive qualitative content analysis (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020). The research group consisted of three women and two men. At the time of the study, three authors worked as university teachers and researchers with a professional background as mental health nurses. Two of the authors were social workers and engaged in the study as representatives of a non-governmental organisation providing support and advocating the rights of people experiencing self-harm or eating disorders. Several authors had lived experience of mental health recovery. This study is reported in accordance with the consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007).

Participants

We used a purposive sampling as we sought to include men who were willing to share experiences of recovery in self-harm. For this study, self-harm was understood as any purposeful self-inflicted physical harm without suicidal intent. Criteria for inclusion were identifying as a man, being 18–60 years old, and having experiences of recovery in non-suicidal self-harm. Persons who had self-harmed during the last 6 months were excluded, both to ensure that participants had some experience of recovery and out of ethical considerations.

We interviewed 11 Swedish-speaking men aged 23–59 years (md 31 years). The length of experience of self-harm ranged between 15 months and 35 years, and the length of time in recovery ranged between 8 months and 30 years. Participants were recruited nationwide and represented both rural and urban areas nationwide.

Procedure

Participants were recruited through postings on home pages and social media. We used homepages and social media accounts specifically targeting people who self-harm or are men but also accounts addressing people interested in mental health issues in general. Presumptive participants were encouraged to visit an online form providing information about the study and allowing them to consent to the study or contact researchers for more information. Researchers contacted men who gave their consent to arrange interviews and were allowed to ask further questions about the study.

Interviews

Individual, qualitative interviews (Kvale & Brinkmann, 2015) were conducted by either the first, second, third, or last author in 2020 by phone or Zoom and audio recorded. Interviews were semi-structured as we used an interview guide that we developed for the study. The interview guide was informed by literature on self-harm and mental health recovery. The participants were asked to describe their experiences of ending self-harm. Further, to describe a situation that fostered/hindered their efforts to end self-harm. To deepen the understanding, clarifying follow-up questions were asked, such as, “Can you tell more about
that?” and “What does that mean?”. The interviews lasted between 18 and 87 min (md 33 min). Researchers had no prior relationship with participants. No repeat interviews were carried out. Transcripts were not returned to participants.

Analysis

Interviews were transcribed verbatim and subjected to abductive qualitative content analysis (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020). In the de-contextualisation phase, we had an inductive approach and divided the texts into meaning units, condensing them when needed, and labelled them with a descriptive code. Then, the re-contextualisation phase started, where we sorted the codes into groups with similar meanings. At this stage, we recognised similarities with the CHIME conceptualisation of recovery. We decided to move on using a deductive approach and sorted our codes into categories based on the CHIME and its core concepts: Connectedness, Hope, Identity, Meaning, and Empowerment. Finally, we abstracted and interpreted the core contents in each CHIME concept and formulated five sub-themes and one main theme, showing men's recovery experiences in self-harm. For example, the code *I'm feeling better because I have left relationships with girls that were focused on sex, drugs, and self-harm* was classified under the content area *Connectedness*. It was then grouped with similar codes, forming the category *Avoiding and ending bad relationships*. This category, along with others in the same content area, laid the foundation for the sub-theme *Finding support in others*. The analysis process is described as a linear process, but it is not. Instead, it is a movement back and forth between an inductive and deductive approach, ending up with the so-called abductive leap (e.g., Chomsky, 1968).

All authors were engaged in the analysis. The first, second, third, and last author transcribed the interviews and identified, condensed, and coded meaning units. To ensure consistency in the degree of abstraction and interpretation, we each began with the same section of an interview and compared meaning units and codes. After agreeing on a common strategy, we divided the interviews between us and completed the de-contextualisation phase of the analysis. In the re-contextualisation phase, codes and themes were subject to repeated critical discussion amongst all authors. Differing interpretations were considered and discussed until consensus was achieved. Participant checking was not applied.

Ethical considerations

This study was carried out in accordance with The Declaration of Helsinki. Ethical approval was granted by the Swedish Ethical Review Authority (2020–03378). Participants gave informed consent for their data to be used in the research.

RESULTS

The analysis identified one main theme: *when the time is right*, and five sub-themes: *finding support in others; trusting that change is possible, getting to know yourself; reaching a new understanding; and developing new strategies to manage life*, which are described below. Each sub-theme relates to a content area encompassing a CHIME component: connectedness, hope, identity, meaning, and empowerment.

When the time is right

The main theme, *when the time is right*, shows that men's recovery in self-harm has a temporal aspect and will only start when favourable inner and outer circumstances align. Recovery may involve reaching a turning point, accepting help, recognising that recovery takes time and involves setbacks and that things can become easier as one ages. Recovery may involve recognising the importance of supportive relationships, seeking and accepting support from healthcare services and peers, learning about oneself, setting goals and making changes in daily life, continuously working to improve and uphold one's well-being, and developing and adopting alternatives to self-harm. The following will explore how the main theme relates to the five sub-themes.

Finding support in others

The sub-theme of *finding support in others* was identified within the content area of *connectedness* and concerns about interpersonal relationships and support issues. Across the interviews, participants described experiences of close relationships as both enabling and hindering recovery in self-harm. Participants perceived close relationships as difficult but crucial for well-being and recovery. The pain of being excluded could trigger self-harm, and fear of abandonment could lead to difficulties connecting with people. Participants described how the support of close friends and relatives had made it possible for them to get through tough times. Concern for one's children could be an important reason not to self-harm, and children wanting to connect was seen as a confirmation of being in recovery. Participants described experiences of ending or avoiding bad relationships as part of their recovery. The ending of bad relationships could be both a consequence and a strategy for feeling better. Participants also described the importance of someone close saying...
enough is enough. Some participants had positive experiences of other people’s reactions, which helped them understand the impact of their behaviour and initiate change. Others described how the lack of reactions from others had enabled them to continue self-harm:

It would have mattered if someone had said something so that I wouldn’t have just continued as I was doing.

(IP 10)

Participants described difficulties in accepting help from others. Many participants shared experiences of “putting on a mask”, not sharing their true feelings with others, and not seeking help for their self-harm. This could be due to feelings of shame and a belief that one should be able to manage things by oneself. Opening up and reaching out was described as a key to recovery. Participants also talked about the value of receiving support from others who had experienced self-harm. One participant shared experiences from group therapy:

We take care of each other. Everyone supports each other when it’s tough and when you're especially vulnerable. After all, we have each other, and we have this in common as well.

(IP 1)

Some participants valued sharing experiences and learning from others as supportive in recovery. However, not all found they could relate their own experiences to others, and there was also concern that meeting others with similar experiences could trigger self-harm.

Participants also described positive experiences of receiving support from mental health professionals. They appreciated being able to reflect on their own behaviour and experiences with a professional who treated them like equals and did not judge them. Notably, one participant had experienced being prioritised for care as a man and believed women had to fight harder to get help. Participants also shared negative experiences of not receiving support from health care. This included experiences of being judged, ignored, and intimidated by mental health professionals. One participant described interacting with mental health professionals:

I have been sitting here next to you all for hours a day, and you’ve never asked me how I’m doing.

(IP 3)

Negative experiences were, in part, also referred to a lack of resources resulting in long waiting times or absence of psychological treatment options, lack of continuity, and staffing issues causing troubles accessing medication.

Trusting that change is possible

Within the content area of hope and optimism, we identified the sub-theme of trusting that change is possible. When talking about recovery in self-harm, participants described experiences of re-evaluating their situation and gaining new insights into what their life could be like without self-harm.

Many participants shared experiences of reaching a turning point where they started questioning what they were doing and decided to change. For some, this had occurred in connection with a specific event, making them reflect on their significance for other people, for example, coming close to taking their own life or the death of a friend in suicide. Others described the importance of being able to relate to others and to be inspired by their progress. Participants talked about how they had realised that help was available. Having experienced mental well-being earlier in life, being offered treatment options, talking to a professional, experiencing progress, and having something to look forward to was perceived as helpful. One participant described how talking to a nurse became a turning point:

Something happened in the emergency psychiatry and clicked in my brain when a nurse said that my children would never stop grieving me. I understood that maybe I am not a burden to my family, and since then, I have not hurt myself.

(IP 11)

Participants acknowledged that recovery could mean different things for different people. Some experienced recovery as returning to who they once were, while others acknowledged that recovery might not necessarily equate to “normalcy”. One participant described recovery as a process that takes time and requires commitment, willpower, and patience, while another described quitting self-harm as “quite easy”.

Getting to know yourself

The third sub-theme, getting to know yourself, was identified within the content area identity. This sub-theme was derived from participants’ descriptions of recovery in self-harm as a process of discovering, accepting, and learning to like who you are.

You see how you develop, and then you feel good about it. So you don't want to screw it up, just a little … and better self-esteem and it's also in turn that you don't want to injure yourself.

(IP 6)
Participants described learning about and accepting who you are as difficult and challenging but crucial for recovery. They had come to realise that self-harm had become their identity and a way of both masking and channelling otherwise unmanageable feelings of anger and fear. Learning to like who you are meant that the need for self-harm was reduced, but also that the absence of self-harm made it easier to like oneself. Some participants described self-harm as an expression of self-hatred.

Participants described being able to be open and talk about experiences of self-harm as important but connected with feelings of shame and vulnerability that had to be overcome. Participants also shared experiences of dealing with stigma related to other people's prejudice and ignorance about self-harm. Participants experienced that other people were taught that people who self-harm were violent and could not be trusted. Participants had been reluctant to seek help as fear of being diagnosed amplified perceptions of being abnormal.

When asked about their views on gender aspects of recovery in self-harm, participants described both similarities and differences between men's and women's experiences. They believed that men's recovery was affected by macho culture and expectations of men to not talk about feelings and to “suffer in silence”, although the primary reasons for self-harm were believed to be the same. A reluctance among men to seek help for self-harm was believed to be amplified by notions of self-harm as a “women's problem”.

Reaching a new understanding

Within the content area meaning, we identified the sub-theme, reaching a new understanding. This sub-theme brings forth changes in participants' understanding of what is important in their lives, what leads them to self-harm, and what it takes to move on from self-harm.

Participants described learning about why they had begun self-harm as an important part of recovery. A part of the recovery process was understanding that recovery would take time and involve backlashes. Self-harm was described as part of a complex process that took time to grasp. For example, participants describe self-harm as a consequence of traumatic childhood events, difficulties experiencing and managing emotions, lack of impulse control, and a negative self-image and low self-esteem. One participant stated:

The realization that the background to the self-harming behaviour was to take care of myself made it impossible to continue.

(IP 7)

Participants described how they gained insight into what was important and what they wanted with their lives. Participants also described how they had learned to appreciate the importance of a well-structured and meaningful everyday life. Recovery involved setting personal goals for their own life, as described by one participant:

The goal for me is that I should be able to live a dignified and functional life. Also relationally and the relationship I have with myself.

(IP 2)

Developing new strategies to manage life

The final sub-theme, developing new strategies to manage life, was identified within the content area empowerment. In the interviews, participants talked about taking action and consciously creating a life that makes it uncomplicated and worthwhile not to self-harm. This involved developing new skills and making use of one's experiences.

Participants explained how understanding the function of self-harm, e.g., feeling high, alleviating anxiety, and letting off steam was essential to develop alternate strategies. Participants also stressed the importance of identifying circumstances that made it difficult to abstain from self-harm. These could involve emotional strain, problems of everyday living, and objects and events that would act as triggers.

I realized that I cut myself to be happy and feel good and that there are many other ways to achieve that.

(IP 7)

Participants described a multitude of activities and strategies to achieve mental well-being by dealing with emotions and avoiding self-harm. These activities involved distraction, work and physical activity, meditation, mindfulness, medication, psychotherapy, self-reflection, reading, handicraft, and engaging with people. Such activities and strategies could be preventive but could also serve as direct alternatives to self-harm. Other alternatives involved snapping a rubber band on the wrist, hitting oneself with an open hand, using cannabis, breathing exercises, and listening to loud music.

Participants described recovery as no longer experiencing a need for self-harm when feeling better. However, they also shared experiences of self-harm, no longer achieving the same purpose as before. Participants experienced that life got more manageable as they got older, making it easier to leave self-harm behind them.

DISCUSSION

The analysis described men's recovery in self-harm in one main theme: when the time is right, and five sub-themes:
finding support in others; trusting that change is possible; getting to know yourself; reaching a new understanding; and developing new strategies to manage life.

Overall, our findings confirm that the CHIME construct is meaningful and helpful in analysing, describing, and understanding recovery processes. In the analysis, we were able to identify content providing insight into the specifics of men's recovery in self-harm relating to each of the five constituents of CHIME. In our analysis, we were able to categorise the content according to the dimensions of recovery suggested in the CHIME framework, and we propose that our findings provide meaningful insights into the specifics of self-harm recovery within each domain. Thus, our study does not suggest a need for additional dimensions of the framework, such as those proposed by Stuart et al. (2017) and Senneseth et al. (2022).

By outlining the complexity of men's recovery in self-harm, our findings confirm previous research suggesting that men's recovery in self-harm does not necessarily focus on stopping self-harm (Tofthagen et al., 2022). Our findings describe how ending self-harm is neither irrelevant to recovery nor its end goal. Instead, recovery is about asking for help, understanding why, finding alternatives, accepting who you are, accepting setbacks, and finding out what it takes not to need to self-harm. Our findings suggest that self-harm fills a purpose when life is without meaning, but becomes meaningless when life becomes meaningful.

Turning points are common in mental health recovery narratives (Llewellyn-Beardsley et al., 2019). Building on Leamy et al. (2011) conceptualisation of recovery as multiple intertwined processes, our findings describe how the initiation of men's recovery in self-harm might require multiple inner and outer preconditions to align. Previous research has shown the importance of mental health professionals engaging with patients, not being judgmental (Cutcliffe & Stevenson, 2008), being supportive, and acknowledging patients as experts (Lindgren, 2011). Within the sub-theme, finding support in others encountering non-judgmental professionals was described as important in men's recovery in self-harm. As explicated in the main theme, when the time is right, our findings highlight the temporal aspects of recovery, suggesting that recovery processes might initiate when certain inner and outer conditions align. Our findings highlight how hope is interconnected with connectedness and meaning and describe opening up and reaching out as a key to recovery. Our findings highlight the importance of hope in recovery, which might be underrecognised in daily psychiatric care (Seelør et al., 2020).

Our findings provide some support to the notion that gender constructions influence men's mental health recovery. Most prominent in our results are men's difficulties opening up and seeking help, which in part was related to expectations of men to be self-sufficient and able to tolerate suffering and self-harm as a female-coded phenomenon. As self-harm is related to masculine norms (Bandel & Anestis, 2020; Green et al., 2018), our findings suggest that an important aspect of men's recovery might be challenging and overcoming such norms. Our findings suggest that men's recovery in self-harm is affected by experiences of stigmatisation and self-stigmatisation and that gender-related stereotypes might amplify these. In line with Schön (2010), in our study, we were mainly positive about the help they had received from mental health professionals and had made use of this in recovery. This included, for example, therapies for increased self-awareness and developing strategies to manage life. However, our findings do not align with Schön's description of the dominating influence of masculine norms of being independent, having a job, and being able to provide for a family. We speculate this might be due to changing societal norms in Sweden during the almost two decades between Schön's data collection and the current study. It is also worth noting that some participants experienced easier access to mental health treatment because of being male. This might indicate an awareness amongst mental healthcare professionals that gender norms prevent men experiencing self-harm from seeking help and that when they do, they might be worse off. If this is the case and if such concerns are well founded, it is beyond the scope of this study. It is worth noting that none of the interviewed men talked about meaning in spiritual or religious terms. This might be explained by Sweden being one of the most secular countries in the world (worldvaluessurvey.org) or by men placing less emphasis than women on meaning-making in mental health recovery (Schön, 2010).

Strengths and limitations

The current study has its strengths and limitations. One strength is that the research group involved people with lived experience of mental health recovery and mental health care. Thus, theoretical and experiential perspectives informed the design, data collection, and interpretation of findings.

The use of qualitative methodology allowed an in-depth exploration of men's experiences of recovery in self-harm. The participants varied in age, experiences of self-harm, as well as how long they had recovered in self-harm. They represented all parts of Sweden and were located in rural and urban areas.

Some limitations also need to be acknowledged. The number of participants in this study was relatively small, which may be seen as a limitation. However, trustworthiness in a qualitative study is gained more by the richness of each interview than by the sample size (Sandelowski, 1995). The interviews were rich in content, and the participants were eager to narrate their experiences.
CONCLUSIONS

This study provides unique findings describing recovery in self-harm from the perspective of men. The study confirms previous research suggesting that while the cessation of self-harm might both be a sign of and contribute to recovery, it is not the defining feature of recovery. The study also confirms the applicability of the CHIME framework in the context of men’s self-harm.

CLINICAL IMPLICATIONS

Our findings provide an incentive for mental health professionals to be persistent in providing person-centred, recovery-oriented care for men who self-harm. They offer hope not only for men who self-harm but also for mental health professionals who engage men who self-harm. The same approach or intervention that might seem futile in the first 99 encounters might prove to be life changing the hundredth time. If the inner and outer preconditions align, a seemingly routine encounter might be a turning point.

AUTHOR CONTRIBUTIONS

All authors meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors and are in agreement with the manuscript. CRediT author statement: Sebastian Gabrielsson: Conceptualization, methodology, formal analysis, investigation, writing – original draft, writing – review and editing, project administration. Nicole Wolpher: Conceptualization, formal analysis, investigation, writing – review and editing. Elias Zammata: Conceptualization, formal analysis, investigation, writing – review and editing. Lisbeth Fagerström: Conceptualization, methodology, formal analysis, investigation, writing – review and editing. Britt-Marie Lindgren: Conceptualization, methodology, formal analysis, investigation, data curation, writing – original draft, writing – review and editing, project administration.

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CONFLICT OF INTEREST STATEMENT

Sebastian Gabrielsson is the Associate Editor of the International Journal of Mental Health Nursing. The other authors report no conflict of interest.

DATA AVAILABILITY STATEMENT

Due to the sensitive nature of the questions asked in this study, participants were assured interview recordings and transcripts would remain confidential and would not be shared.

ETHICS STATEMENT

Ethical approval was granted by the Swedish Ethical Review Authority (2020–03378).

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