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MARJA-LIISA RISSANEN

Helping Adolescents Who Self-Mutilate

A Practice Theory

UNIVERSITY OF KUOPIO

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A Practice Theory

Doctoral dissertation

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ABSTRACT

The purpose of this study was twofold: to describe self-mutilation among Finnish adolescents and help for it, and to develop a practice theory of helping adolescents who self-mutilate. The study sought answers to the following questions: What are the concepts, their definitions and associations between them when describing self-mutilation among adolescents and help for it in Finland? How is the concept of self-mutilation defined? What concepts are associated with self-mutilation? How is the concept of an adolescent who self-mutilates defined? How is the concept of help defined?

The research approach in the original studies included qualitative description and inductive content analysis. The data in the original studies were collected using data and methodological triangulation from adolescents who self-mutilate (n=80), from their parents (n=4) and from nurses who had experience of caring for adolescents who self-mutilate (n=10). Metasynthesis was applied in synthesizing the findings of the original studies into a practice theory of helping adolescents who self-mutilate.

The practice theory of helping adolescents who self-mutilate consisted of three main elements, being the concepts of self-mutilation, of an adolescent who self-mutilates, and of help to adolescent self-mutilation, including helping and nursing care.

Conclusions. Self-mutilation includes all kinds of destructive acts towards one's own skin such as scratching, cutting, burning or self-injuring, either alone or together with someone else, covering all parts of one's body excluding the head and back, and using any tool that happens to be available and that makes a mark or causes a bleeding wound or wounds. Self-mutilation can also be used as way to commit suicide. Self-mutilation is a multifaceted phenomenon possessing a huge range of characteristics.

The factors contributing to self-mutilation, the purposes of self-mutilation and the sequels of self-mutilation are associated with the act. An adolescent who self-mutilates looks external good and is conscientious and takes care of her significant others, especially if they are in trouble or in any kind of difficulty. However, internally she is very sensitive, having a low self-esteem: she considers herself inferior to others. She feels lonely and is ashamed of her self-mutilation. In addition, she is the one who will become mistreated by others because of her self-mutilation.

Help for an adolescent who self-mutilates includes all kinds of help as well as nursing care provided by the adolescent herself and by other people. Anyone who knows about self-mutilation can be of help. Help consists of knowing, caring and interfering. Knowing means knowing of self-mutilation as a phenomenon, while caring and interfering include a caring attitude, asking adolescents how they are, and realizing and recognizing if something is not well, as well as guiding an adolescent to professional help if needed.

Medical Subject Headings (MeSH): Adolescent; Self-Mutilation; Self-Injurious Behavior; Therapy;Nursing

Rissanen, Marja-Liisa. Itseään viiltävien nuorten auttaminen: käytännön teoria.
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TIIVISTELMÄ

Tämän tutkimuksen tarkoituksena oli kuvata suomalaisten nuorten itsensä viiltämistä ja heidän auttamistaan sekä kehittää käytännön teoria nuorten itsensä viiltämisestä sekä heidän auttamisestaan. Tutkimuksessa etsittiin vastauksia seuraaviin kysymyksiin: mitä ovat käsitteet, jotka liittyvät suomalaisten nuorten itsensä viiltelyyn ja siihen saatavilla olevaan apuun? Mitkä ovat näiden käsitteiden määritelmät ja miten ne ovat yhteydessä toisiinsa? Miten itsensä viiltäminen on määritelty? Miten nuori, joka viiltää itseään, on määritelty? Miten auttaminen on määritelty?

Tutkimuksessa käytettiin laadullista lähestymistapaa. Tutkimusaineisto muodostui alkuperäistutkimuksiin osallistuneiden itseään viiltäneiden nuorten (n=80), itseään viiltäneiden nuorten vanhempien (n=4) ja itseään viiltäneitä nuoria hoitaneiden hoitajien (n=10) nuoren viiltelyä ja siihen saatua apua koskevista kuvauksista, jotka analysoitiin induktiivisella sisällönanalyysillä. Alkuperäistutkimusaineiston keräämisessä käytettiin sekä aineisto- että menetelmätriangulaatiota. Saadut tulokset yhdistettiin metasynteesilla käytännön teoriaksi itseään viiltävän nuoren auttamisesta.

Käytännön teoria- itseään viiltävän nuoren auttaminen muodostuu kolmesta pääelementistä; käsitteistä itsensä viiltely, itseään viiltävä nuori ja itseään viiltävän nuoren auttaminen sisältäen sekä avun että hoidon. Tulosten mukaan itsensä viiltäminen on kaikenlaista oman ihon vahingoittamista kuten kynsimistä, viiltämistä tai polttamista yksin tai yhdessä jonkun kanssa kaikkialle muualle kehoon paitsi päähän ja selkään. Kaikki saatavilla olevat välineet, joilla on mahdollista aiheuttaa jälki tai verta vuotava haava tai haavoja, ovat käyttökelpoisia. Itsensä viiltämistä voidaan myös käyttää keinona tappaa itsensä. Itsensä viiltäminen on monimuotoinen ilmiö monine ominaispiirteineen.

Itsensä viiltämiseen yhteydessä olevat tekijät voidaan jakaa viiltelyä edeltäviin, itse tapahtumaan myötävaikuttaviin tekijöihin, viiltelyn tarkoituksiin sekä viiltelyn seurauksiin. Nuori, joka viiltää itseään näyttää ulkoisesti voivan hyvin, on tunnollinen ja läheisistään huolehtiva, etenkin jos näillä on ongelmia. Sisäisesti hän on hyvin herkkä, hänellä on heikko itsetunto, ja hän pitää itseään muita huonompana. Hän kokee itsensä yksinäiseksi ja häpeää viiltämistään. Muut kohtelevat häntä hänen viiltelynsä vuoksi huonosti.

Itseään viiltävän nuoren auttaminen sisältää kaikenlaisen avun hoidon lisäksi. Jokainen, joka tietää viiltelystä voi auttaa. Myös itseään viiltävä nuori itse on itsensä auttaja. Auttaminen on tietämistä viiltelystä ilmiönä, välittämistä ja puuttumista siten, että nuorelta kysytään kuulumisia ja jos jokin on tavallisuudesta poikkeavasti, se havaitaan ja tunnistetaan ja nuori ohjataan tarvittaessa ammattiavun piiriin.

Yleinen suomalainen asiasanasto (YSA): nuoret; itsetuho; auttaminen; hoitotyö

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Finally, my dearest thanks I owe to you Jouni, my beloved husband. Your love and care have been the most invaluable resources for me during these years, in addition to the practical help with the computer. When I felt I might give up because of all kinds of difficulties, you supported me and pushed me gently forward, believing in me. Thank you for that.

Vuorela, October 2009

Marja-Liisa Rissanen

PROLOGUE

"Many of those who are in extreme distress do not ask for help, but if we watched and listened better we would understand that they ask more than others. They ask for help with their body language, their looks, their self-destructive acts." 19-year-old female

To children and adolescents

LIST OF THE ORIGINAL PUBLICATIONS

This dissertation is based on the following original publications, referred to in the text by their Roman numerals I-VI

I Rissanen M-L., Kylmä J & Laukkanen E. 2008. Descriptions of self-mutilation among Finnish adolescents: a qualitative descriptive inquiry. Issues in Mental Health Nursing 29, 145-163.

II Rissanen M-L., Kylmä J & Laukkanen E. 2008. Parental conceptions of self-mutilation among Finnish adolescents. Journal of Psychiatric and Mental Health Nursing 15, 212- 218.

III Rissanen M-L., Kylmä J & Laukkanen E. 2009. Descriptions of help by Finnish adolescents who self-mutilate. Journal of Child and Adolescent Psychiatric Nursing 22, 7-15.

IV Rissanen M-L., Kylmä J & Laukkanen E. 2009. Helping adolescents who self-mutilate: parental descriptions. Journal of Clinical Nursing 18, 1711-1721.

V Rissanen M-L., Kylmä J & Laukkanen E. 2009. Self-mutilation among Finnish adolescents: nurses' conceptions. International Journal of Nursing Practice (submitted).

VI Rissanen M-L., Kylmä J & Laukkanen E. 2009. Helping and caring for adolescents who self-mutilate: nurses' conceptions and experiences. Scandinavian Journal of Caring Sciences (resubmitted).

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Appendix 6. Parents' informed consent to participate in the study.

Appendix 7. The advertisement about the study aimed at nurses caring for adolescents who self-mutilate.

Appendix 8. Nurses' informed consent to participate in the study focusing on nurses caring for adolescents who self-mutilate.

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1 PURPOSE OF AND BACKGROUND TO THE STUDY

1.1 Purpose of the study

The study was twofold: to describe self-mutilation among Finnish adolescents and help for it, and to develop a practice theory of helping adolescents who self-mutilate. In this study, the phenomenon of self-mutilation and help for it is approached from different viewpoints using data and methodological triangulation to derive as complete a description as possible of the phenomenon (Tobin & Begley 2004). The viewpoints were those of nonclinical adolescents who self-mutilate, the parents of adolescents who self-mutilate and nurses who have experience of caring for adolescents who self-mutilate. All the informants were given an opportunity to openly describe self-mutilation and help for it. By synthesizing these different viewpoints it is possible to develop a practice theory for helping adolescents who self-mutilate (Im 2005).

1.2 Adolescence as a context of the study

Adolescence includes the years between 11/12 to 22 (Marttunen & Rantanen 2000). The course of adolescent development depends on biological, sociocultural and emotional factors that are interlaced, meaning that an adolescent has little control over them. The influence of social environments, such as family, peers and school on an individual's development and especially on cognitive and psychological development needs both cognitively stimulating interaction and emotional support. (Blos 1962, Havighurst 1972, Erikson 1982, Sroufe et al.1996).

The developmental phases and life tasks during adolescence have been defined by several authors, including Blos (1962), Havighurst (1972) and Erikson (1982). Havighurst (1972) suggested that the tasks of life are related to certain periods, and that if a process remains incomplete at that time, it will never been achieved properly, having effects in the next developmental task (Havighurst 1972). According to Havighurst (1972), the developmental tasks of

adolescence arise from biological, psychological and cultural bases (see also Blos 1962). These tasks are 1) achieving new and more mature relations with age-mates of both sexes, 2) achieving a masculine or feminine social role, 3) accepting one's physique and using the body effectively, 4) achieving emotional independence from parents and other adults, 5) preparing for marriage and family life, 6) preparing for an economic career, 7) acquiring a set of values and an ethical system as a guide to behaviour, and 8) desiring and achieving socially responsible behaviour (Havighurst 1972).

In practices, this means that during adolescence an adolescent undergoes rapid physiological, psychological and social changes and set, for example, his or her educational goals. It is a period of maturing and acquiring of new cognitive skills. Physiological changes are welcome, but on the other hand they might confuse an adolescent and evoke ambiguous emotions that she or he will actively externalize. Most 12- to 14-year-old girls have reached puberty, but their physical maturation is faster than their psychological maturation. Boys develop more slowly and by the age of 12 half of boys have reached puberty. In addition, in well-developed countries, the onset of puberty in boys nowadays occurs later than previously. Developmental regression is deeper among boys than among girls, and boys might therefore look like men but they might behave in a very childish way. (Aalberg & Siimes 2007.) Experiences of oneself vary rapidly, as do adolescents' moods. The characteristics of normal adolescence vary considerably from storms to calmness. This might include external storms and quarrels, but an adolescent who seems to be calm might also be going through storms in her or his mind. (Rantanen 2000, Korhonen & Marttunen 2006.)

Adolescence is a vulnerable period during which the first signs of developmental problems and mental disorders may appear (McGee et al. 1995). There are differences between younger and older adolescents in the prevalence of various developmental problems and in how they express their difficulties, e.g. through self-harming, including unhealthy behaviour (Singleton 2007).

Unhealthy behaviour in adolescence might be more evident than other forms of self-harm, for example the use of intoxicants such as tobacco and alcohol. In the European School Survey Project on Alcohol and Other Drugs (ESPAD) published 2009, 77% of Finnish 15- to 16-year-old students had been drinking alcohol during the previous 12 months, while in some other European countries the proportion of students who had been drinking was higher, for example 91% in Germany and 88% in the United Kingdom (Hibell et al. 2009). In the same study, the percentage of students who had ever smoked was 60% in Finland, being nearly the same as the average among other participating countries (58%). However, 69% of students in Germany and 52% in the United Kingdom had smoked at some time (Hibell et al. 2009).

International epidemiological studies have shown that 10-20% of adolescents have mental disorders (Kim et al. 2007, McGee et al. 1995), and approximately 10% of adolescents attempt to commit suicide (Evans et al. 2005). Different psychosomatic symptoms and/or attacks against one's own body can be signs of mental problems, or they may reflect short-term developmental problems. It has been suggested that self-harm may also in some way be part of adolescent development (Lönnqvist 1985). Investigations focused particularly on adolescents and their care are important, because different developmental phases need phase-specific interventions (Singleton 2007).

1.3 Generation of a practice theory in this study

According to Burns and Grove (2001, p11), "A theory consists of a set of concepts that are defined and interrelated to present a view of a phenomenon." Thus, a theory is a description of reality. In nursing science, theory development has preceded from the grand theories of the 1950s to today's situation-specific theories that have their roots in practise (Im 2005). Theories in nursing science can be categorized into different categories, for example based on their level of abstraction. Grand theories developed in the 1950s are very abstract ones, being systematic constructions of the nature, mission and goal of nursing. They were not useful in guiding clinical nursing, education or research. In the 1990s,

the progress in theory development was considerable, producing a large number of middle-range theories. (Meleis 1997.) These theories were based on the changes and progress that had occurred on the metatheoretical level between the 1980s and 1990s, meaning that in nursing science, as across other disciplines, there was a change towards epistemic pluralism on theoretical and philosophical level. (Im 2005).

Middle-range theories are theories having a more limited scope and lower level of abstraction than grand theories. They have also been addressed to specific phenomena or concepts reflecting practice in general and on a universal level. However, middle-range theories rarely consider, for example, cultural or socio-political contexts that are important in nursing practice between the nurse and patient. (Meleis 1997.) Thus, there was a need for theories that were more "ready to wear" in practices, as Kirkevold (1993 p.37) wrote: "The practise theory is proposed as a useful tool to systematize, communicate, reflect upon, refine, and extend the clinical practise of experienced nurses caring for this group of patients (meaning patients with chronic skin disease)."

According to Kirkevold (1993), the structure of practice theory includes four components: 1) the underlying model of the considered phenomenon among nurses, 2) the basic values that can affect the structure of care, i.e. what are the decisions and priorities nurses make when providing care, 3) the strategies of action nurses choose for reaching the goals and 4) the context of the actions. In this particular study these components were described from the viewpoint of nurses and in addition from the viewpoint of adolescents and their parents. Furthermore, these viewpoints were synthesized.

A practice theory, also referred to as a situation-specific theory, can be developed from a middle-range theory (Im & Meleis 1999) or from nursing practise by using a qualitative inductive approach (Im 2005). A situation-specific theory can also be tested depending on its philosophical basis and, if the aim is to test hypotheses in real settings (Riegel & Dickson 2008). Despite this, a

situation-specific theory cannot be generalized and used in other situations (Im & Meleis 1999), but it can explain a specific health or illness experience or phenomenon in a unique population (Im 2006). A practise theory might include several situation-specific theories (Im 2005), or these terms can be used as synonyms (Tolley 1995), as I have done in this study.

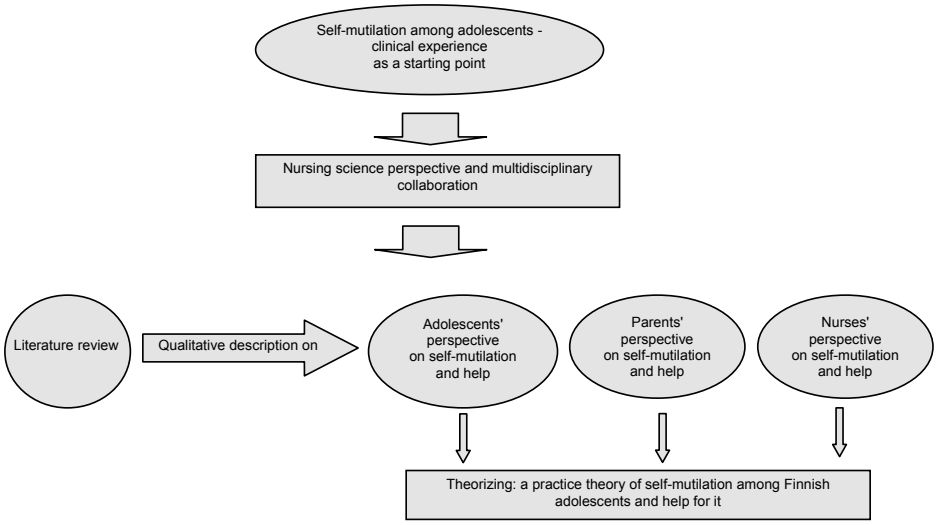

Figure 1.Generation of a practice theory of self-mutilation among Finnish adolescents and help for it

Figure 1 illustrates the generation of the practice theory in this study. My clinical experiences served as the starting point, followed by nursing science perspective (Im 2005). The multidisciplinary collaboration began when I was planning my Master's thesis in 2002.

Clinical experiences as a starting point. My own interest in the study of self-mutilation has its roots in clinical nursing practise (Im 2005). I have worked as a psychiatric nurse since 1988 and mostly on logged inpatient wards for adults. In the mid-1990s there were no separate wards for adolescents, so they shared the same wards with adults. At that time we received a new group of patients: young women just having celebrated their 18 or 19 birthdays, who self-

mutilated. I, among other nurses, was confused, and I tried to find some information about self-mutilation in Finnish, but I did not succeed.

I cared for these girls as best as I could, but there were no guidelines for their care. The quality of care varied considerably depending on the nurses and doctors. Sometimes we caused more suffering to the adolescents rather than alleviating their suffering, for example by caring for the wounds in an uncaring way or behaving unprofessionally in interaction with them because of our confusion and emotional state, and also because of lack of awareness of self-mutilation as a phenomenon. I continued to wonder why and how we as professionals reacted to this particular phenomenon. I found this study subject such an important one because if self-mutilation exists in our society, it will not disappear if we close our eyes and try not to see it. These adolescents and young ones suffer and I feel that it is important to have more scientific studies on this subject, and in this way to seek tools for clinical practice to alleviate their suffering.

In addition, any individual in close contact with a self-mutilating adolescent is also emotionally affected and so self-mutilation evokes strong emotions among health care professionals, too (Rayner et al. 2005). To be able to alleviate suffering among these adolescents and their families, more knowledge is needed about self-mutilation as a phenomenon from all these perspectives: the adolescents, their families - especially parents - and nurses. In Finland, where this study was conducted, deliberate self-mutilation is also familiar in health care and in nursing practise. Clinical experience indicates that self-mutilating adolescents are also quite often met in psychiatric clinics and at admittance to school nurses in Finland (Rissanen et al. 2006a).

Nursing science perspective. According to Donaldson and Crowley (1978), the focus of nursing science and research is on the principles that govern human life processes, well-being and human behaviour in health and illness. Furthermore, the focus is on human interaction with the environment in normal

and critical phases of life and on ways to positively influence changes in one's life. (Donaldson & Crowley 1978.) In this study, this means diverse knowledge of self-mutilation as a phenomenon from the viewpoints of adolescents, parents and nurses. This knowledge is needed in helping nurses to understand the phenomenon of self-mutilation and furthermore in developing interventions for individuals and families. These targets are quite practical ones, suggesting nursing science to be a practical discipline. When I began my university studies I conducted a literature review on self-mutilation as part of my Bachelor's thesis. Furthermore, I went on with my Master's thesis by studying self-mutilation among adolescents. After these theses I hoped to ease the work of nurses and other health and social care professionals by producing knowledge for professional use by giving lectures and writing articles for clinical journals (Rissanen & Kylmä 2003, Rissanen & Kylmä 2007a, Rissanen & Kylmä 2007b) and also for scientific journals (Rissanen et al. 2006a, Rissanen et al. 2006b, Rissanen et al. 2008). In addition, as a nurse and researcher I wanted to know more about this phenomenon and what could be done to help adolescents who self-mutilate.

Based on the existing nursing literature, a diagnosis for self-mutilation and the outcome of nursing care have both been defined, but no distinctly defined intervention exists. The North American Nursing Diagnosis Association (NANDA) has defined a nursing diagnosis for self-mutilation, termed "Risk for Self-Mutilation". Previously, it referred to "a state in which an individual is at high risk of performing an act upon the self to injure, not kill, which produces tissue damage and tension relief" (Carroll-Johnson & Paquette 1994, p. 420). In the updated version it refers to "a state in which an individual is at risk to perform a deliberate act upon the self with the intent to injure, not kill, which produces immediate tissue damage to the body" (Carpenito-Moyet 2006, p. 432). Furthermore, the Nursing Outcomes Classification (NOC) defines a good outcome of nursing care as a situation where a self-mutilating person can refrain from self-mutilation. (Johnson & Maas 1997.)

Self-mutilation causes immeasurable suffering among those who self-mutilate and also among their significant others wherever it happens (Isacsson & Rich 2001), such as family members or peers and friends. In addition, it causes permanent scars on the skin. According to Eriksson (1992, 1997), suffering is a part of human life and alleviating it is the aim and task of nurses, being the basis of care. Alleviating suffering is one of the most challengeable tasks in nursing science (Eriksson 1994). Self-mutilation exists among adolescents, and from the viewpoint of nursing science greater knowledge of self-mutilation as a phenomenon is needed from the perspectives of adolescents, parents and nurses. Knowledge of the factors contributing to self-mutilation and, in addition, of the care they have received is needed. The nursing diagnosis and a good outcome of nursing care are not enough in guiding clinical practice. Self-mutilation is a multifaceted phenomenon and so a multidisciplinary approach is needed.

Multidisciplinary collaboration. As Im and Meleis (1999) and Im (2005) have suggested, there are always multiple truths when examining a particular phenomenon, such as self-mutilation in the present case. Although self-mutilation was recognized in a medical doctoral dissertation conducted in adolescent psychiatry 16 years ago (Laukkanen 1993), other studies focused on the problem here in Finland have been scarce. The lifetime prevalence of self-mutilation has recently been reported to be 11.5% among Finnish 13- to 17-year-old adolescents (Laukkanen et al. 2009) and only 18.9% of adolescents who self-mutilate had sought help from health care (Rissanen et al. 2006b).

The best means of care for adolescents who self-mutilate is prevention (Favazza 1996). Prevention and promotion are most effective when carried out by multidisciplinary and multiprofessional teams (Northrup & Purkis 2001**,** Sosiaali- ja terveysministeriön julkaisuja 2006:16). From the viewpoint of nursing science, in addition to acute concrete care, it is also question of health promotion (Delaney 1994), which includes mental health promotion (Nikkonen & Kylmä 2007). At the society level, as in the Health 2015 public health programme in Finland, the main focus is on health promotion, for example, by

increasing child wellbeing and health and appreciably reducing the symptoms and illness caused by insecurity (Sosiaali- ja terveysministeriö 2001). In addition, the recently published plan for mental health and substance abuse work “Mielenterveys- ja päihdesuunnitelma” suggests that mental health promotion is the main focus in developing mental health up to the year 2015 (Sosiaali- ja terveysministeriö2009). Furthermore, in the concluding seminar of the Target and Action Plan for Nursing 2004-2007 program it was pointed out that one of the main future national aims in nursing research will be studies focusing on nursing practice producing knowledge that can be used in easing clinical work (Sosiaali- ja terveysministeriö 2008), for example as a part of supplementary education (Sosiaali- ja terveysministeriö 2004). The ill-being as well as the well-being of adolescents is seen as greatly influenced by their parents, and so the Finnish government has as a challenge the question of how it could be of help for parents in achieving a better balance between family and work (StVM 23/2002). Furthermore, self-mutilation is costly to society due to repeated visits to accident and department wards (Isacsson & Rich 2001).

This study was conducted in collaboration with two larger projects. It was a part of a multidisciplinary research project on mental health promotion (Nikkonen & Kylmä 2007) and also a project on mental well-being among Finnish adolescents aged 13 to 18 years and factors associated to it (Laukkanen et al. 2004).

Literature review. A literature review served as a starting point for theoretical development by gathering information on how self-mutilation and care for it have already been investigated and from which viewpoints they have been investigated in health sciences. A literature review was first conducted as part of the generation of a practice theory (Im 2005) when I was completing my Bachelor’s thesis in 2002. I have repeatedly expanded this review and carried out the most recent update in 2009. This literature review revealed that research on self-mutilation as a phenomenon and care for it have not been investigated from the perspective of unselected adolescents. All adolescents must have an opportunity to talk in their own words about self-mutilation

(Claveirole 2004), including those who have not been inpatients or outpatients because of self-mutilation. In addition, parental viewpoints on self-mutilation and care for it have also been rarely examined. Furthermore, the views of nurses on self-mutilation among adolescents and care for it have not previous been investigated. Thus, it was quite natural to choose a qualitative description approach in theory development. This is described in more detail in Chapter 2.

Qualitative descriptions. The phenomenon of self-mutilation and help for it was approached from the viewpoint of self-mutilating adolescents, their parents and nurses who have cared for them. All these viewpoints are needed to achieve multiple truths considering self-mutilation as a phenomenon (Im 2005). As a result, six different descriptions were produced and were further synthesized into a theory. For more detail, see Chapter 4.

Theorizing. Theorizing means that by synthesizing these different viewpoints a practise theory is constructed in which these viewpoints constitute a new construct that is more than the viewpoints separately. Theorizing began by initiation (Im 2005), which in practice means that all the findings considering self-mutilation as well as those considering help on self-mutilation were collected together. Metasynthesis was used in synthesizing the findings. As a result of this metasynthesis, new concepts were constructed and their content and relation to each other were discussed with other researchers. (Kylmä et al. 2007.) Based on these concepts and their relation to each other I constructed a practice theory on helping adolescents who self-mutilate. This process is described in more detail in Chapters 4 and 5.

2 LITERATURE REVIEW

The literature searches were executed in the CINAHL and MEDLINE databases on 28 May 2009. In the CINAHL database the search was executed using words the words “Injuries, Self-inflicted” or “Self-Injurious Behavior” or “Risk for Self-Mutilation (NANDA” or “Self-Mutilation Risk (Saba CCC)” or “Self-mutilation” for the period 1982-2009 and limited to adolescence (13 to 18 years). In the Medline database the search was executed using the words “Self-mutilation” or “Self-Cutting”, for the period 1996-2009 and limited to adolescence (13 to 18 years**)**. (See Figure 2.) It is noteworthy that during this research process the existing knowledge of self-mutilation has grown considerably (see Rissanen et al. 2006b).

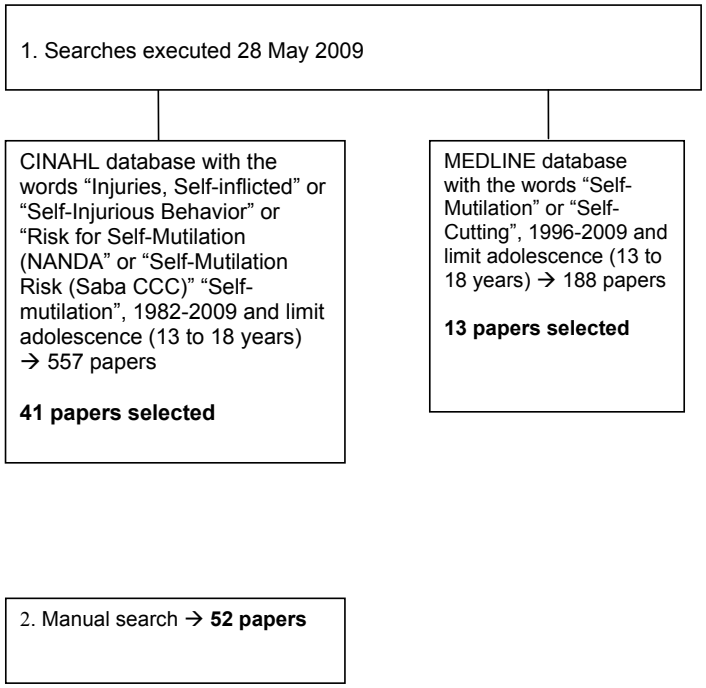

Figure 2. The literature searching process

According to Subirana et al. (2005), the CINAHL and MEDLINE databases are suitable and recommendable in executing systematic reviews in nursing science. Altogether, abstracts of 745 identified articles were scanned and those that either focused on or included adolescents were selected for this review. Articles focusing on adolescent psychiatric disorders were excluded because they did not fit the purpose of this study. Furthermore, the original articles (I and II) from this study, were excluded. In addition, reference lists were reviewed and relevant references were included, and a manual search was also carried out. Furthermore, studies that focused on the care of self-harming humans were included, because there were no studies focused on the care of adolescents who self-mutilate. Content analysis was used in the literature analysis (Burns & Grove 2001). The literature consisted of various reviews, case studies and surveys and in addition, a concept analysis of self-mutilation is presented. Most of these studies had been conducted among hospitalized or outpatient individuals or the study subjects had been selected beforehand (e.g. Murray et al. 2005). Population-based studies were also included. Altogether, 106 papers were included to the literature review.

Based on these searches and on content analysis of the literature, existing knowledge of self-mutilation was categorized into the following two classes: 1) self-mutilation as a phenomenon and 2) caring for persons who self-mutilate or self-harm.

2.1 Self-mutilation

The description of self-mutilation is based on multidisciplinary research, for example in medicine, social sciences, psychology, education, psychiatry and nursing science. In addition, some individual descriptions are included. The description presented here is a synthesis of all these different viewpoints considering the phenomenon of self-mutilation.

2.1.1 Self-mutilation as a phenomenon

Self-mutilation is an old phenomenon. The first scientific article on self-mutilation, published in 1935 by Karl Menninger, focused on its significance (Menninger 1935). However, despite the large number of studies on self-harm, including self-mutilation, or further modelling of it (see Ross & Heat 2003, Messer & Fremouw 2008), it is still a difficult phenomenon to understand. In helping to understand this, Clarke and Whittaker (1998) stated that self-mutilation should be seen and known as a culturally defined ancient phenomenon and all kinds' knowledge of it is therefore important.

Favazza (1996) has defined pathological self-mutilation as a deliberate act to destroy one's own body tissue without a conscious intent to die. He made a distinction between culturally-accepted and pathological self-mutilation and this definition was therefore chosen as a starting point in this study. The concept of self-mutilation applied here (see also Favazza 1996) means pathological self-mutilation and includes both self-cutting and self-burning. Pathological self-mutilation consists of three categories: major, stereotypic and moderate/superficial. The category of major self-mutilation includes acts in which a significant amount of body issue is destroyed. An example is self-castration, which is not a frequent act. Stereotypic self-mutilation has been suggested to be more organically driven than the others, being more common among persons who have mental retardation or who have specific neurological disorders such as Lesch Nyhan syndrome. Stereotypic self-mutilation includes rhythmic head banging against a wall. The category of moderate/superficial self-mutilation includes self-burning and self-cutting among other forms of self-injurious behaviour. These forms might have characteristics such as repetitious and episodic occurrence. (Favazza 1996.)

Hicks and Hinck (2008) have recently presented a theoretical definition of the concept of self-mutilation based on the existing literature prior to 2007 offering the basis for intervention development. Their definition was: "Self-mutilation is the intentional act of tissue destruction with the purpose of shifting

overwhelming emotional pain to a more acceptable physical pain" (Hicks & Hinck 2008, p 409). However, in most study reports, self-mutilation has not been precisely conceptualised. It has either been included or excluded in the terms self-harm or self-injurious behaviour, or the occurrence of self-mutilation has not been considered (Tulloch et al. 1997, Klonsky & Muehlenkamp 2007) or considered as just one aspect of self-harm or self-injurious behaviour (Roux & Overcash 2008). These concepts also include many forms of harming oneself and they are given multiple meanings (Webb 2002, McAllister 2003a, Onacki 2005, Skegg 2005). This has led to difficulty in estimating the real prevalence or incidence of self-mutilation (McAllister 2003a).

2.1.2 Prevalence of self-mutilation

Self-mutilation as one form of deliberate self-harm has recently become quite prevalent among adolescents (Klonsky et al. 2003). In an Australian study by De Leo and Heller (2004) the prevalence of self-harm was determined to be 6-7% and appeared to be higher among females than males (see also Morey et al. 2008, Kirkcaldy et al. 2009, Laukkanen et al. 2009). However, it has also been reported that there is no difference between sexes in the prevalence of self-harm (Resch et al. 2008). Furthermore, according to De Leo and Heller (2004), self-mutilation, often referred to as self-cutting, was the main method, accounting for 59.2% of all instances of self-harm. According to the meta-analysis of Evans et al. (2005), the prevalence of self-harm, including self-mutilation, was 13% and highest among adolescents under 18 years of age (Hawton et al. 2002). In North America, the prevalence of self-harm is reported to be 16.9% in Canada (Nixon et al. 2008) and 17% in the USA (Whitlock et al. 2006). In Europe, the prevalence of self-harm varies, being reported as 4.1% in the Netherlands, 10.4% in Belgium (Portzky et al. 2008) and 10.9% in Germany (Brunner et al. 2007). In Finland, the prevalence of self-cutting was observed to be 11.5% and that of other self-harm was 10.2% (Laukkanen et al. 2009). Intoxication and self-mutilation are the most typical forms of self-harm that are seen in hospitals (Schnyder et al. 1999, Fortune 2006).

2.1.3 Previous life events of self-mutilating adolescents

In earlier studies the previous life events of self-mutilating adolescents have included various traumatic experiences, such as violence of any kind and childhood physical or sexual abuse (Pawlicki & Gaumer 1993, Ledray 1994, McLane 1996, Solomon & Farrand 1996, Batty 1998, Crowe & Bunclark 2000, Harris 2000, Gardner 2001, Cavanaugh 2002, Derouin & Bravender 2004, Balch 2006), or problems in relationships or interactions with parents (Tulloch et al.1997, Webb 2002, Yip et al. 2003). The influence of peers and problems or misunderstandings with them can also be a source of traumatic experiences for at least some adolescents (Yip 2005, Puskar et al. 2006, Rissanen et al. 2006a). The severity of traumatic experiences, such as the existence of violence in everyday life (Levenkron 1998, Derouin & Bravender 2004, Yip 2005), and the level of parental dysfunction tend to vary and, due to the differences in dysfunction, are difficult to categorize. Furthermore, Croyle and Waltz (2007) have suggested self-mutilation as being associated with emotional abuse among undergraduate adolescents.

2.1.4 Attributes of self-mutilating adolescents

Self-mutilating adolescents are often unable or unwilling to ask for or seek help verbally (McLane 1996, Isacsson & Rich 2001, Derouin & Bravender 2004, Law et al. 2009), and they often also have other problems, such as eating disorders (Allen 1995, Sueymoto 1998, Gardner 2001, Machoian 2001, Hintikka et al. 2009), depression (Webb 2002, Rissanen et al. 2006b), a high consumption of alcohol and other substances (Rodham et al.2005, Rissanen et al. 2006b) or a low self-esteem (Derouin & Bravender 2004). Moreover, their problem-solving skills are often quite poor (Haines & Williams 1997, Webb 2002, Rodham et al. 2004, Andover & Pepper 2007) and in addition, they have a high level dissociation, predicting self-cutting (Tolmunen et al. 2008). Murray et al. (2005, p. 1) described an adolescent self-injurer to be “a female who often has a history of sexual or/and physical abuse and an eating disorder. She cut her arms on a daily or weekly basis and usually hides her self-injury from others.”

2.1.5 Purposes and characteristics of the self-mutilation act

Self-mutilating adolescents use self-cutting or self-burning as a means to help themselves (Allen 1995, Favazza 1996, Kehrberg 1997, Favazza 1998, Sueymoto 1998, Gardner 2001, Machoian 2001, Derouin & Bravender, 2004, Lloyd-Richardson et al. 2007, Moyer & Nelson 2007, Schoppmann et al. 2007, Hicks & Hinck 2008, Swannell et al. 2008) and in addition, as a form of self-preservation (Balch 2006). Furthermore, Oldershaw et al. (2008) suggested that self-mutilation can serve some purpose in an adolescent's life. According to McAllister (2003), the main purpose is to self-soothe, but the effect is often temporary because of the depression and hopelessness that have developed during the life span of the adolescent (Webb 2002). Favazza (1989) suggested that the purpose is an attempt at self-healing by reducing symptoms. One characteristic of self-mutilation is that it is often performed privately (Pawlicki & Gaumer 1993, Clarke & Whittaker 1998, McAllister 2003a), being a taboo (McAllister 2003a), and the adolescent does not tell anyone about it (Faye 1995). Furthermore, self-mutilation causes guilt and shame among the parents of adolescents who self-mutilate, shaping parents' reactions and responses towards their children (McDonald et al. 2007). An interesting but problematic characteristic of self-mutilation is the possibility of addictive characteristics of the act (Winchel & Stanley 1991, Puskar et al. 2006), and so it may become a repetitive act (Cleaver 2007). Furthermore, the contagiousness of this behaviour may be one factor that has contributed to the increase in self-mutilation among adolescents, not only on adolescent psychiatric wards (Taiminen et al.1998), but also among adolescents' peer groups (Favazza 1998).

2.1.6 Interrelation between self-mutilation and suicide

Self-mutilation can be a way to avoid committing suicide (Favazza 1996, Solomon & Farrand 1996, Sueymoto 1998, Williams & Bydalek 2007), but it also offers a possibility to carry it out (Machoian 2001). However, self-mutilation and attempted suicide should not be used as synonyms, because they mean

different things (Cerdorian, 2005), and there are significant differences in attitudes towards life between adolescents who have attempted suicide and those who have self-injured. According to Muehlenkamp & Gutierrez (2004), adolescents who attempted suicide wanted to die and those who self-injured did not want to die**.** Although adolescents who self-mutilate are at greater risk of suicidal behaviour such as attempted suicide (Stanley et al. 2001, Evans et al. 2005, Fortune 2006, Whitlock & Knox 2007), not all of them attempt suicide (McAllister 2003a). In practice, nurses have problems differentiating between the presence or absence of suicidal intent (O'Donovan & Gijbels 2006).

In conclusion, existing nursing literature has mainly considered the phenomenon of self-mutilation based on existing research or reviews that have been conducted in psychology or medicine among outpatients or inpatients. In addition, the concept of self-harm has been used in many articles. However, authors have also noted that the use of the concept of self-harm is confusing.

2.2 Caring for persons who self-harm or self-mutilate

2.2.1 Self-harm and nursing

Self-mutilation among adolescents has rarely been studied in nursing science, despite its common occurrence. Previous nursing research has mainly focused on the experiences of self-harming in-patient adults (Weber 2002, Lindgren et al. 2004) and out-patient adults (Pembroke 1998), and on nurses' experiences of caring for adult psychiatric patients who self-harm (Wilstrand et al. 2007). Nurses' attitudes towards self-harming clients have been investigated (Sidley & Renton 1996, McAllister et al. 2002, McCann et al. 2007) and experiences of nurses and in-patient adults have been combined (Reece 2005). Furthermore, Cooper and Glasper (2001) suggested that belief systems of the nurses concerning self-harm have an effect on their practices in relation to child and adolescent patients. Clarke and Whittaker (1998) presented a self-mutilator's perspective of self-mutilation and also highlighted the cultural framework of self-

mutilation. Some nursing interventions for the inpatient milieu have been described (Pawlicki & Gaumer 1993, Brodtkorb 2001, Aanderaa & Meling 2004). Guidelines for nursing practice based on previous literature have been presented (Woldorf 2005, Lesniak 2008, Roux & Overlash 2008), especially for the school context (Onacki 2005, Shapiro 2008), for Accident & Emergency departments (Whotton 2002, McAllister 2003b), and from the viewpoint of mental health nurses (Anderson et al. 2004). The practices of psychiatric nurses in relation to self-harming adult inpatients have been investigated (O'Donovan & Gijbels 2006, O'Donovan 2007), but no evidence-based interventions exist (Sharkey 2003, Burns et al. 2005).

From the viewpoint of education, McAllister and Estefan (2002) have presented strategies for teaching the therapeutic response to self-harm to nurses. However, according to Allen (2007), effective education for those working with people who self-harm is needed and necessary and in addition, there is also a lack of basic knowledge of self-harm among health-care students (Law et al. 2009). Furthermore, McDonald (2006) stated that particularly school nurses are in need of education concerning self-mutilation. The effectiveness of an educational intervention lasting 15 weeks aimed at changing negative attitudes of nurses towards self-harming clients has been investigated and proved to be effective**.** Antipathy and hostile attitudes towards self-harm were most effectively reduced by providing factual information on self-harm and by reflecting on it in clinical nursing (Patterson et al. 2007).

2.2.2 Self-harm and help from the perspective of other disciplines

Crowe and Bunclark (2000) pointed out in their multidisciplinary working model that self-harm is one symptom of distress, and their therapeutic aim was to enable individuals to develop alternative and more healthy ways of coping. Intervention for self-harm as early as possible is very important because of suicide prevention (Hirvonen et al. 2004). The relationship between the nurse and the youth is often the basis for help to ensure a smooth interdisciplinary treatment process, and nurses as members of treatment teams are therefore in

need of information on self-injury (Woldorf 2005). However, an evaluation of non-suicidal self-injury and treatment by medication based on existing literature has been presented by Smith (2008).

According to Murray and Fox (2006), participation in Internet discussion groups was of help to the members of these groups in alleviating self-harming behaviour. In social sciences, teachers' awareness of self-cutting among the adolescent population has been investigated (Carlson et al. 2005) and shown to be insufficient. According to Moyer and Nelson (2007), to understand self-mutilation, better knowledge of it is necessary. Implications and strategies for school counsellors based on previous knowledge have been presented (White et al. 2002), including intervening and preventing self-mutilation by individual contextual interventions (Hilt et al. 2008). According to Fortune et al. (2008), friends, family and school are seen as the main sources of support in preventing suicidal behaviour. However, the parents and carers of self-harming children and adolescents are in the need of support themselves (Byrne et al. 2008). In addition, Yip (2005) re-conceptualized a multidimensional model of adolescent self-mutilation based on existing literature including explanatory models of self-mutilation (see Messer & Fremouw 2008).This multidimensional view includes sociocultural contexts, peer and parental influences on the process of self-cutting among adolescents from antecedences to sequels of self-cutting, but it excludes the view of professional helpers such as nurses (Yip 2005). In addition, no empirical support has been presented for this model. According to Cook (1999), as self-mutilation is a cultural phenomenon, it is necessary to investigate it within the culture where it happens, and existing research is therefore not sufficient.

2.3 Evaluation of existing literature

Self-mutilation among adolescents has thus far been examined as a disease process or disorder that some adolescents practice, and information has mainly been obtained from hospitalized or outpatient individuals and from otherwise selected individuals. Guidelines for nursing practice have also been constructed

by using this restricted information. Because self-mutilation exists among all kinds of adolescents, the viewpoint of all adolescents is thus also very important in addition to that of inpatient or outpatient individuals to expanding our knowledge of self-mutilation. As self-mutilation is seen to be a cultural phenomenon, the importance of research focused on it as a phenomenon here in Finland is also indisputable.

In addition, although many studies have been conducted on self-harm, including or excluding self-mutilation, help and care for adolescents who self-mutilate have not previously been investigated from the viewpoints of adolescents **in** non-clinical settings or from the viewpoint of their parents. The parental viewpoint is very important because many of these adolescents are under the age of 18, and according to Finnish law they are minors. Furthermore, nurses have not been asked about their conceptions or experiences of nursing adolescents who self-mutilate. There is a need for effective interventions in clinical nursing, but nurses also need a better understanding of self-mutilation.

In conclusion, there is a need for basic information on self-mutilation as a phenomenon in Finnish culture and for interventions in clinical nursing. By adding to our understanding of self-mutilation and the appropriate nursing practice from different perspectives it is possible to construct a practice theory of self-mutilation as a phenomenon and help for it from the viewpoint of adolescents, their parents and nurses. This knowledge of self-mutilation among Finnish adolescents could be used in nursing education and also in supplementary education. Furthermore, it could serve as a basis for further research on self-mutilation in nursing science and also as a part of the development of nursing science. In addition, it might serve as a basis for further research on self-mutilation in general. This practice theory might also be of assistance to teachers and school counsellors in helping adolescents and students who self-mutilate.

3 AIMS OF THE STUDY

The purpose of this study was to describe self-mutilation among Finnish adolescents and help for it, and to develop a practice theory of helping adolescents who self-mutilate. The Roman numerals refer to the original articles.

In this study, the main research questions were:
What are the concepts, their definitions and associations between them describing self-mutilation among adolescents and help for it in Finland, and what kind of practice theory can be produced by using these concepts?

The main questions were answered by means of the following sub-questions (I, II, III, IV, V and VI):

1.1 How is the concept of self-mutilation defined?

1.2 What concepts are associated with self-mutilation?

1.3 How is the concept of a self-mutilating adolescent defined?

1.4 How is the concept of help defined?

4 QUALITATIVE DESCRIPTION AS A METHODOLOGICAL CHOICE

4.1 Qualitative description - an overview

Qualitative description as one mode of qualitative research is based on naturalistic inquiry, where a phenomenon is studied in as naturalistic circumstances as possible (Sandelowski 2000, Marshall et al. 2003, Gallo et al. 2005, Sullivan-Bolyai et al. 2005, 2006, Kylmä et al 2007).

Qualitative description has been used extensively in nursing research, but some scholars have considered it as less valuable than other methods of qualitative research (Sandelowski 2000). Kylmä et al. (2007) also pointed out that qualitative description has been criticized and has sometimes been considered as an unfinished analysis (Milne & Oberle 2005, Sullivan-Bolyai et al. 2005). One reason for their undervaluation may be the practical orientation of qualitative description (Hertzberg et al. 2003, Johnstone & Kanitsaki 2005) and the fact that the findings are presented in as comprehensible a way as possible to be of use in clinical nursing (Sandelowski 2000). However, qualitative description as a methodological choice is justifiable when the goal is to achieve a concrete description to help in clinical work such as nursing (Sandelowski 2000, Milne & Oberle 2005, Sullivan-Bolyai et al. 2005), as for example when working with adolescents who self-mutilate and determining how they can be helped. This methodological choice offered a practical and concrete way to study this phenomenon and help for it and, in addition, to provide better knowledge on it for clinical nursing and nursing science.

Qualitative description has been found very useful in developing and refining interventions in persons with health disparities, such as adolescents with health problems (Sullivan-Bolyai et al. 2005). Finnish adolescents who self-mutilate can be seen as having health disparities. These adolescents are vulnerable and their problems are embedded in cultural (Cook 1999) and contextual issues; sometimes, these issues might also be quite complex.

A qualitative descriptive design was used in the original studies of this whole study to provide rich and comprehensive summaries of self-mutilation (I, III, V) and of help for it (II, IV,VI) in everyday terms from the viewpoints of adolescents who self-mutilate, the parents of self-mutilating adolescents and nurses who have experience of caring for adolescents who self-mutilate.

In data collection it is important to find persons who have experiences and who know about the topic under exploration (Milne & Oberle 2005, Sullivan-Bolyai et al. 2005), and then to use methods that are as unstructured as possible (Milne & Oberle 2005) to enable the participants to describe the explored phenomenon in their own words and thereby acquire multiple and rich data (Sullivan-Bolyai et al. 2005).

The data obtained with this approach should be interpreted with as little inference as possible, although the analysis is not free from interpretation. In practice, this means that the researcher remains close to the original data and performs as detailed an analysis as possible without losing touch with the actual words and events described (Sandelowski 2000). Furthermore, as Sandelowski (2000, 336) points out: "The description in qualitative descriptive studies entails the presentation of the facts of the case in everyday language." The findings therefore reflect and describe the reality of the participants as closely as possible. (Sawatzky & Fowler-Kerry 2003, Ellett & Swenson 2005, Williams 2004.) In practice, this means that far-reaching abstraction is avoided (Sandelowski 2000, Sullivan-Bolyai et al. 2004) and this approach also enhances the utilization of the findings in nursing practice (Sullivan-Bolyai et al. 2005). According to Sandelowski (2000, 337), "qualitative description is especially amenable to obtaining straight and largely unadorned (i.e. minimally theorized or otherwise transformed or spun) answers to questions of special relevance to practitioners."

4.2 Data collection and analysis

4.2.1 Recruitment of the participants

Adolescents

Previous studies on this topic have been conducted among selected participants, mostly among psychiatric patients (for example Sueymoto 1998, Weber 2002). In this study the purpose was to invite ordinary adolescents to participate by advertising the study in four magazines targeted at adolescents, on magazine websites and on my own website between October 2002 and February 2003. The advertisement included background information on the research project (Appendix 1). Adolescents sent their descriptions by e-mail (n = 50) or by post (n = 20). They were asked to write whatever they wanted about their experiences concerning self-mutilation (I, II). This meant that descriptions of help were quite short and additional and deeper information about help to self-mutilation was thus needed to achieve the purpose of this study. I invited ten adolescents to participate in a personal open-ended interview focusing on self-mutilation and help for it (II) (Appendix 2). These ten informants were selected from a population sample of 4205 13- to 17-year-old adolescents (Laukkanen et al. 2009). The inclusion criterion was personal experience of self-mutilation (n = 475). Altogether, 25 adolescents were invited to be interviewed, but 15 refused. Interviews were carried out in summer 2005. The interviewees were girls because all asked boys refused to participate to the study. All the interviewees were asked to provide written informed consent (Appendix 3). The interviewed adolescents were 12 to 22 years of age. Altogether, 80 adolescents participated in the study (I, II).

Parents

Self-mutilation is more common under the age of 18 years (Hawton et al. 2002), which is why the viewpoint of parents concerning self-mutilation (III) and help for it (IV) is very important. Parents were invited via the adolescents who participated in personal interviews (see above). The inclusion criteria were that the parents were aware of the adolescent's self-mutilation and that permission

had been given by the adolescents to invite their parents to participate. After written informed consent was provided by the adolescents (Appendix 4), they were given an advertisement concerning this study to pass on to their parents (Appendix 5). I asked for their parents' phone numbers and I called them a couple of days after meeting the adolescent to explain about this study. If they wanted to participate we arranged a time for the interview. Four parents wanted to participate, one father and three mothers. All the interviewees were asked to sign an informed consent form (Appendix 6).

Nurses

Nurses were invited to participate by the head nurses of adolescent psychiatry wards in one of the University Hospitals in Finland. Advertisements concerning this study were sent to the head nurses, who were asked to give a copy of it to each nurse. The inclusion criteria were being a qualified nurse (Registered Nurse or Practical Nurse) and having experience of caring for self-mutilating adolescents. The advertisement included background information on the research project and also some questions to help them in focus on the study (Appendix 7). These questions were modified by using Kirkevolds' (1993) thoughts about practice theory being as follows: How do you as a nurse define self-mutilation? Why do adolescents self-mutilate? What are the values that guide your nursing acts and the choice of interventions? What are the aims of yours nursing care? How do you as a nurse define the context of nursing; where, by whom and how an adolescent who self-mutilates will be cared for?

However, the questions were found too theoretical and rejected by the participants. These questions presented beforehand could have been of help in focusing on the aim of the study (see also Saaranen et al. 2007), even though they were not used in the interviews. Five nurses wanted to participate in focus group interviews and two nurses asked about the possibility to be personally interviewed, which was allowed. All the interviewees were asked to provide written informed consent (Appendix 8).

In order to obtain further descriptions from other parts of Finland, and also a greater number of descriptions altogether, the study was advertised in three magazines targeted at health care professionals. The advertisement included background information on the research project and also some questions to help them in focus on the study (Appendix 9). The health care professionals (Registered Nurses or Practical Nurses) who wanted to participate were asked to send their descriptions of self-mutilation and help for adolescents who self-mutilate anonymously by mail or by e-mail to the researcher to protect their privacy. Three written descriptions were obtained.

4.2.2 Triangulation in the data collection

The term triangulation means that in conducting a study the researcher does not use only one theory, method or data set concerning the explored phenomenon (Denzin & Lincoln 1994). Furthermore, according to Thurmond (2001), triangulation means that the study design combines at least two or more theoretical approaches, methods, researchers, data sources or methods of data analysis.

According to Breitmeyer et al (1993), triangulation can be used in two ways: to confirm knowledge that has been achieved by another method (Sandelowski 1995) and to enhance data richness by increasing the understanding of a phenomenon (Breitmeyer et al. 1993, Lackey & Gates 1997, Sim & Sharp 1998, Lambert & Loiselle 2007). In a qualitative study, data triangulation is used as a means to ensure trustworthiness and in this study to ensure completeness (Kylmä et al. 2003, Lambert & Loiselle 2007). Triangulation was carried out in this study as a triangulation of data within the original studies (II, V, VI) and also for the whole study (I-VI).

According to Malterud (2001), when using more than one separate set of data the content of every data set is significant, while the number of informants in

one data set is not. This means that one participant in her or his description can produce a large amount of rich knowledge concerning self-mutilation (I, III, V) or help for it (II, IV, VI), and so the number of descriptions from one viewpoint is not significant in ensuring the total amount of information.

Triangulation of data collection methods was carried out in each original study (II, V, VI) and in the whole study (I-VI) (Denzin & Lincoln 1994). Methodological triangulation was also used to enhance credibility (Tobin & Begley 2004), with written descriptions (I, II,V,VI), with personal interviews (II,III,IV,V,VI) and with focus group interviews (V, VI) to achieve as complete a picture as possible of self-mutilation as a phenomenon and help for it.

Written descriptions

Written descriptions focusing self-mutilation and help for it were requested from both adolescents (I, II) and nurses (V, VI). The aim was to offer an easy opportunity to participate in this study (see also Murray et al. 2005). Participants were asked to send their descriptions of self-mutilation and help for it anonymously by mail or by e-mail to the researcher to protect their privacy. This also enabled descriptions to be obtained throughout Finland. According to Kuula (2006), there is no difference in using e-mail as a data collection method compared to other methods of data collection in relation to ethics or protection of informants.

According to Eysenbach and Till (2001), when using Internet communities as a data collection method there is difference depending on whether the community is a “private “or “public” one. This is because members of Internet communities cannot expect to be used as subjects in research. The internet community can be defined as a “private” one if there is a need for some kind of registration before participation in discussion in the community is possible, or if there are large numbers of participants or there is a prohibition or limitations on use by those other than defined persons. If the community is a “public” one, data collection can be carried out without obtaining consent, as in other public

places, for example when using public writings as a source of data (Eysenbach & Till 2001). In this study, the internet communities used were public ones and they were used only in presenting the request for written descriptions.

From the viewpoint of information protection, care needs to be taken in the use of e-mail. For example, the saving of e-mails as files and their removal from the inbox has to be planned beforehand and carried out regularly. This means that the researcher has to check her or his e-mail regularly (Kuula 2006). In this study, I checked my e-mails daily and all the incoming e-mails including written descriptions were daily saved to the computer and removed from the e-mail inbox.

Writing was selected as a method of data production and collection because self-mutilation has been suggested to be a taboo subject (Clarke & Whittaker 1998), and therefore writing about it might be easier than telling about it to a stranger. In addition, creative writing has been used as a means to prevent self-mutilation, among other activities (Crowe & Bunclark 2000). Writing a diary is one means of processing feelings (Pawlicki & Gaumer 1993), and has also been used as a part of dialectical therapy (Kåver & Nilsonne 2004) among self-destructive clients.

Personal interviews

According to DiCicco-Bloom and Crabtree (2006) interviews are a typical and common way to collect data in qualitative research (Sandelowski 2000). Qualitative interviews have often been divided into structured, semi-structured and unstructured types, but in fact no interview can be completely unstructured (DiCicco-Bloom& Crabtree 2006) or it would then be regarded as a conversation. The level of structure of interviews varies (Lambert & Loiselle 2007), but in qualitative descriptive studies interviews are minimally structured and open-ended (Sandelowski 2000). Individual interviews have often been used when the purpose is to collect thoughts, experiences or basic knowledge of a given phenomenon (DiCicco-Bloom & Crabtree 2006).

In this study, interviews were used to gather deeper and richer knowledge of self-mutilation from parents (III) and nurses (V) and help for it from adolescents (II), parents (IV) and nurses (VI). Minimally structured personal open-ended interviews have been used especially as a data collection method for examining sensitive topics among vulnerable populations (Murray 2003, Sullivan-Bolyai et al. 2005). According to Murray (2003), interviews might have therapeutic benefits for the participants. Talking to another person who is really interested in listening might help the participants to understand what has happened to them (Murray 2003). The open-ended interviews in this study started by asking the participants about their conceptions and thoughts concerning self-mutilation and help for it. The interviews proceeded individually, exploring different topics relating to self-mutilation (II, III, V) and help for it (II, IV, VI). The interviews lasted 45 to 75 minutes and all except one were audio- taped. One participant did not allow audio-taping, so I wrote as detailed notes as possible during the interview (V, VI).The audio-taped interviews were transcribed verbatim.

Focus group interviews

According to McLafferty (2004), focus group interviews as a data collecting strategy provide a rich source of information, especially in qualitative descriptive studies (Sandelowski 2000). Even though focus group interviews require pre-interview arrangements (see also Sipilä et al. 2007), they are also useful from the viewpoint of participants because by discussing the topic together they have a possibility to learn about one another's experiences (Pötsönen & Välimaa 1998).

The viewpoint of nurses was of utmost importance in this study because it aimed at gathering as rich a set of data as possible about caring for adolescents who self-mutilate. Using minimally structured focus group interviews as a method for data collection was the first choice (V, VI). I organized and moderated two focus group interviews, which started by asking the participants to tell about their conceptions of self-mutilation and their experiences and conceptions of caring for self-mutilating adolescents. The focus group

interviews proceeded case-specifically, exploring different topics relating to help and care from the viewpoint of the participants. Both focus groups lasted 60 minutes and were audio taped and transcribed verbatim. Table 1 summarises the original sub-studies of this study.

Table 1. Summary of the original studies including their purposes, data collection methods and materials for analysis.

Purpose of the original publication or study	Time of data collection, methods and materials
Paper I To describe self-mutilation from the perspective of self-mutilating adolescents	2002-2003 Written descriptions of adolescents who self-mutilate (n = 70)
Paper II To describe help for self-mutilation from the perspective of self-mutilating adolescents	2002-2005 Written descriptions of adolescents who self-mutilate (n = 62) and individual open-ended interviews with adolescents who have self-mutilated (n = 10)
Paper III To describe self-mutilation from the perspective of parents of self-mutilating adolescents	2005 Personal interviews with parents of adolescents who self-mutilate (n = 4)
Paper IV To describe help for self-mutilation from the perspective of parents of self-mutilating adolescents	
Paper V To describe self-mutilation among adolescents from the perspective of nurses	2005 Focus group interviews with nurses (2 groups including 5 nurses), personal interviews with nurses (n = 2) and written descriptions (n = 3), altogether 10 nurses
Paper VI To describe help for self-mutilating adolescents from the perspective of nurses	

4.2.3 Data analysis: inductive content analysis

Content analysis is a well-established method that was first used in analysing quantitative data (Graneheim & Lundman 2004) but has subsequently also been developed for use in qualitative research (Kohlbacher 2006). Qualitative content analysis is a basic method in analysing any kind of qualitative data. The aim is to produce information on the topic that is being explored by arranging

and describing the data. Qualitative content analysis can be inductive, deductive or abductive (Tuomi & Sarajärvi 2002). Inductive content analysis is a systematic process based on the exploration of data and guided by the purpose of the research as openly as possible (Kylmä et al. 2008).

Inductive content analysis was used in the original studies of this thesis because it had been proposed as a suitable analysis strategy in qualitative descriptive studies (Sandelowski 2000, Sullivan- Bolyai et al. 2004, Cheek et al. 2005, Kylmä & Juvakka 2007). The analysis began by reading all the descriptions (interviews were transcribed verbatim) several times to obtain an overview and to explore the information about self-mutilation or help for it provided by the participants**.** Recognition of all the statements concerning self-mutilation or help for it was very important, because they were the basis for later work (Kohlbacher 2006).

All the statements in which participant mentioned anything about self-mutilation or help for it were coded by the researcher. The codes were grouped into categories and subcategories based on their similarities and differences, and the categories were named according to their content. This process of abstraction was continued as far as deemed reasonable (Morse & Field 1996, Kyngäs & Vanhanen 1999, Burns & Grove 2001, Kylmä et al. 2008) bearing in mind the qualitative descriptive design (Sandelowski 2000, Miller et al. 2005, Sullivan-Bolyai et al. 2005). The use of the same analysis method in each original study provided a good basis for further theory construction and for the use of metasynthesis.

4.2.4 Metasynthesis

Metasynthesis is a qualitative research method aimed at studying qualitative research reports (Sandelowski & Barroso 2003a & b, Kylmä et al. 2007a). According Thorne et al. (2004), metasynthesis is used as an appellative for all

the methods that are used in synthesizing several studies aimed to produce new understanding from the explored topic. The number of completed syntheses of qualitative research is still limited but is growing (Flemming 2007). In Finland, the number of metasyntheses has so far been small (Kylmä et al. 2007a), but is growing.

The aim of metasynthesis is to construct a multifaceted and rich new description of the explored topic (Thorne et al. 2004), as in the presenting study considering self-mutilation and help for it. Another possible method for combining the findings of the original studies might have been metasummary, which is usually used in summarizing the findings of summaries or surveys. However, in this study, as the findings themselves were a synthesis of interpretive data, metasynthesis was the most suitable research method to apply (Sandelowski & Barroso 2003a).

Views on the synthesizing of research vary among researchers (see Kylmä et al. 2007a), but in any case the purpose of the metasynthesis is the element that guides the analysis. In synthesizing the findings of original research conducted by others, there are limitations that must be taken into consideration, such as the descriptions of original research processes or descriptions of contexts in original studies (Sandelowski & Barroso 2003b). It is also possible to synthesize the findings of one's own original research (Kylmä 2005, Sandelowski et al. 1997), as was done in the present study, where the ontological basis, the analytical methods and the researchers conducting all the original studies were the same.

Typically, the synthesis of qualitative research constitutes a large amount of organized information that can also be used in developing a theory for practice (Flemming 2007, Kylmä et al. 2007a). There might sometimes be difficulties in finding the information because of different types of reporting or because reporting is unclear (Sandelowski & Barroso 2002). In metasynthesis the findings of qualitative research reports are critically examined, analysed,

interpreted, compared and united (Sandelowski et al.1997, Jones 2004, Walsh & Downe 2005, Kylmä et al. 2007a). In this investigation I firstly combined the findings of the original studies focused on self-mutilation among adolescents and then the findings of the original studies focused on help for adolescent self-mutilation. Secondly, these two combined data sets were examined separately and critically using as little interpretation as possible to avoid losing the voice of the original informants. Thirdly, the categories were compared and united to gain a new understanding of the phenomenon of self-mutilation and help for it.

5 SELF-MUTILATION AMONG FINNISH ADOLESCENTS AND HELP FOR IT: A PRACTICE THEORY

Based on the findings of the present study, a practice theory of self-mutilation among Finnish adolescents and help for it was constructed that consisted of the concepts of self-mutilation, of an adolescent who self-mutilates, and of help for adolescent self-mutilation, including help and nursing care (see Figure 3). In this chapter these concepts are described in more detail in Figures 4-6 (on pages 48 and 57) and also in the following text. The Roman numerals in the text refer to the original articles.

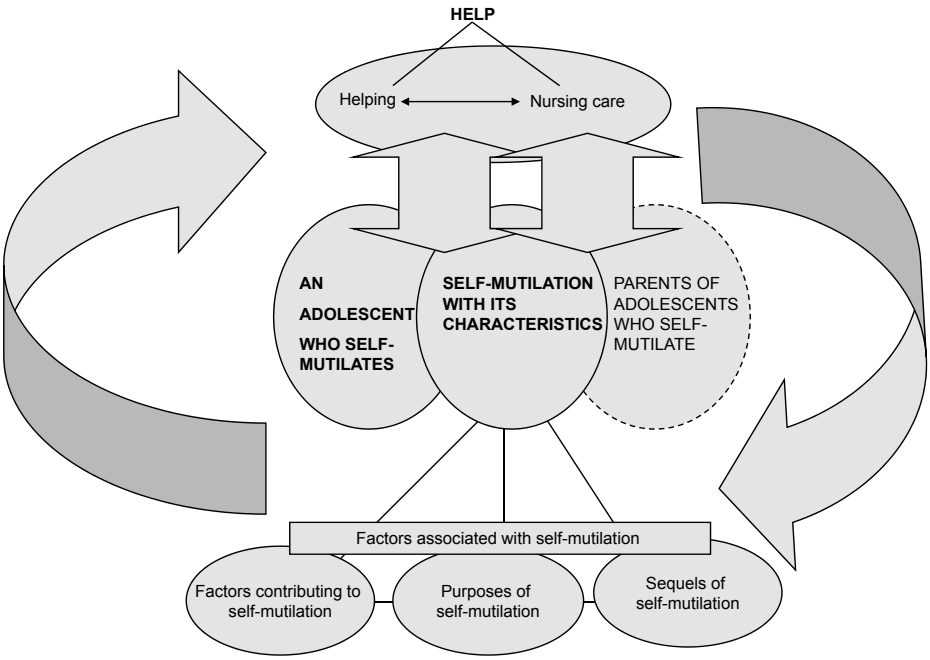

Figure 3. The practice theory of self-mutilation among Finnish adolescents and help for it

5.1 The concept of self-mutilation and factors associated with it

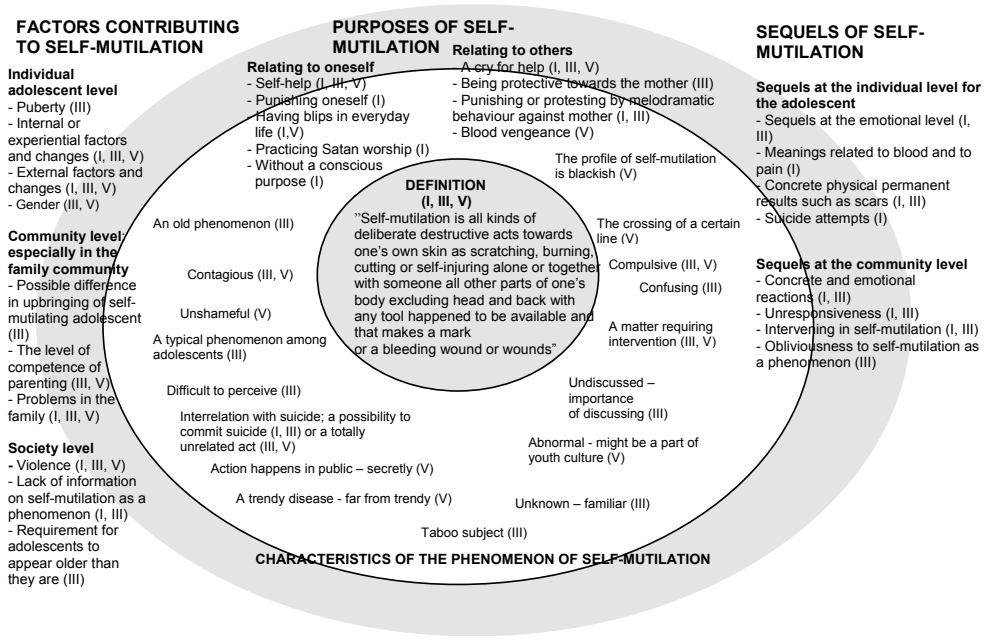

Figure 4. Definition of self-mutilation and factors associated with it

5.1.1 Definition and characteristics of self-mutilation

Self-mutilation includes all kinds of deliberate destructive acts towards one's own skin such as scratching, cutting, burning or self-injuring, alone or together with someone, on all parts of one's body excluding the head and back, performed with any tool that happens to be available and that makes a mark or a bleeding wound or wounds (I, III, V). As this definition indicates, the concept of self-mutilation has multiple meanings and is a multidimensional phenomenon that cannot be unambiguously described. This variety can also be seen in the reported characteristics of self-mutilation: an old phenomenon (III); contagious (III, V); unshameful (V); a typical phenomenon among adolescents (III); difficult to perceive (III); a taboo subject (III); a matter requiring intervention (III, V); compulsive (III, V); confusing (III); the profile of self-mutilation is blackish (V);

the crossing of a certain line (V); unknown – familiar (III); undiscussed – importance of discussing (III); an action that happens publicly – secretly (V); a trendy disease – far from trendy (V); abnormal – might be a part of youth culture (V); interrelated with suicide, the possibility to commit suicide (I, III) or a totally unrelated act (III, V).

5.1.2 Factors associated with self-mutilation

The factors associated with self-mutilation among adolescents are divided into three categories: the factors contributing to, the purposes of and the sequels of self-mutilation. The factors contributing to self-mutilation are further divided into three levels: the level of the adolescent, of the family community and of society. The purposes of self-mutilation relating to oneself and in relating to others are described below. In addition, the sequels at the individual level for the adolescent and also at the level of the community are presented.

5.1.2.1 The factors contributing to self-mutilation

Individual adolescent level. Factors contributing to self-mutilation at the individual adolescent level include puberty (III), which simply occurs for all adolescents. Internal and experiential factors (I, III, V) are varied and cannot usually be seen by others (for more detail, see Table 2). External factors and changes (I, III, V) can be seen by others (see Table 2). Gender (III, V) and in this particular study female gender, can be seen as a factor contributing to self-mutilation.

Table 2. Factors contributing to adolescent self-mutilation at the individual adolescent level

CATEGORIES	SUBCATEGORIES
Puberty (III)	Puberty (III)
Internal and experiential factors (I, III, V)	• Unawareness of self-mutilation as a phenomenon might cause self-mutilating due to the conception of it being trendy (III) • Vulnerable experiences (I, III, V): - Experience of conflicts (I): difficulties and troubles in relationships with significant others (V), quarrels or conflicts with significant others (I) - Loneliness as an experience (III) - Experience of changes in life (I) - Experience of all kinds of violence (I, III) - Experience of disease (I) - Experience of being different (I, III) - Any kind of experienced downheartedness (V) • Hearing voices that order one to cut oneself (V) • Attempts to appear older than one is owing to oneself (III) • Inability to cope alone with the surge of emotions in adolescence (V), especially negative emotions (anger, rage and low mood) (I) • Poor/low self-esteem (I, V) • Fear of violence (I) • No conscious antecedent (I)
External factors and changes (I, III, V)	• Changes in life (I): concrete changes in life (I) changes in relationships with peers (III), changes in behaviour (III) • Abuse of spirits, intoxicants or analgesics (I, III, V) • Bullying at school - many mates at school (V) • Interest in Satanism (I) • Visible negative emotional changes (III) • Loneliness as a fact (III) • Quarrels or conflicts between with significant others (I) • Modelling others who self-mutilate (V) • All kinds of self-destructive behaviour (V)
Gender (III, V)	• Commitment to female gender (III) • Associated mainly to female gender (V)

Community level and especially in the family community. Factors contributing to adolescent self-mutilation at the community level, especially in the family community, include the possible differences in upbringing of a self-mutilating adolescent (III), meaning a parent's personal reflection on this. The level of competence in parenting (III, V), for example if parents are unable to take care of themselves, whether they are able to take care of their children, or if everything seems to be okay in the family but an adolescent herself feels that she has to protect her mother or father by keeping her own difficulties hidden. However, there are parents who intuitively know that a child has problems. Problems in the family (I, III, V) vary from typical quarrels in a family with teenagers to violence between members of the family (see Table 3 for details).

Table 3. Factors contributing to adolescent self-mutilation at the community level, especially in the family community

CATEGORIES	SUBCATEGORIES
Possible difference in upbringing of self-mutilating adolescent (III)	• Being open to whether there had been differences in the upbringing of the self-mutilating adolescent compared with siblings (III)
The level of competence in parenting (III, V)	• Competent family - abusive family (V) • A lack of motherliness (III) • The mother's intuitive feeling that everything is not fine (III) • Unconscious belief in families that an adolescent is mature (III)
Problems in the family (I, III, V)	• Difficulties and troubles in the family (III, V) • Quarrels or conflicts with family members (I) • Quarrels or conflicts between family members (I)

Society level. At the society level, violence (I, III, V), a lack of information on self-mutilation as a phenomenon (I, III) and a requirement for an adolescent to appear older than she/he really is (III) are seen as factors contributing to self-mutilation. Violence (I, III, V) includes all kinds of concrete violence and the threat of it existing in our society. The lack of information on self-mutilation as a phenomenon (I, III) means, for example, the belief that an adolescent who self-mutilates is a freak. The requirement for adolescents to appear older than they really are (III) includes coping alone with difficulties when they feel the need for support (Table 4)

Table 4. Factors contributing to adolescent self-mutilation at the society level

CATEGORIES	SUBCATEGORIES
Violence (I, III, V)	Violence (I,III,V)
Lack of information about self-mutilation as a phenomenon (I, III)	Unawareness of self-mutilation as a phenomenon (I, III)
Requirement for adolescents to appear older (III)	Attempts to appear older due to society as a whole (III)

5.1.2.2 The purposes of self-mutilation

The purposes of self-mutilation are divided into two categories: in relation to oneself and in relation to others. In relation to oneself, the purposes include: self-help (I, III, V), varying from controlling oneself to having the possibility to kill oneself if needed; punishing oneself (I), for example, when an adolescent experiences that she has hurt a significant other; having blips in everyday life (I, V); and Satan worship (I). There is also the possibility that a conscious purpose does not exist (I) (see Table 5 for more detail).

Table 5. Purposes of adolescent self-mutilation in relation to oneself

CATEGORIES	SUBCATEGORIES
Self-help (I, III, V)	• Experience of feeling alive (I) • By bringing something internal out to be perceived by oneself, such as anxiety or pain (I), by revealing bad feelings, anxiety and releasing internal pain (III) • Controlling oneself (I) • Possibility to kill oneself if needed (I) • Helping oneself (V)
Punishing oneself (I)	• Punishing oneself (I)
Having blips in everyday life (I, V)	• Having a change in everyday life (V) • Experimenting (I) • Self-mutilation as a pastime (I)
Satan worship(I)	• Practicing Satan worship (I)
Without a conscious purpose (I)	• Without a conscious purpose (I)

Relating to others, the purposes include a cry for help (I, III, V), protecting the mother (III), for example by keeping one's difficulties secret as far as possible, punishing or protesting by melodramatic behaviour directed at the mother (I, III) and blood vengeance (V) (see Table 6 for details).

Table 6. Purposes of adolescent self-mutilation in relation to others

CATEGORIES	SUBCATEGORIES
A cry for help (I, III, V)	• Helping oneself by bringing something internal out to be perceived by others, such as a cry for help (I) • A cry for help (III, V)
Protecting the mother (III)	• Being protective towards the mother (III)
Punishing or protesting by melodramatic behaviour directed at the mother (I, III)	• Protesting against the mother (III) • Punishing someone else (mother) (I) • Being melodramatic towards mother (III)
Blood vengeance (V)	• Blood vengeance (V)

5.1.2.3 Sequels of self-mutilation

Sequels of self-mutilation are divided into two categories: sequels at the individual level for the adolescent and sequels at the level of the community. Sequels for the adolescent include sequels in the emotional level (I, III), meanings related to blood and pain (I), concrete physical results such as scars (I, III) and suicide attempts (I). Sequels in the emotional level (I, III) can include different kind of positive, negative and also neutral feelings. An experience related to blood is a feeling that all the internal evil will be released with the blood. Examples of experiences related to pain include the experience that physical pain either weakens or strengthens mental pain. Meanings related to blood and pain (I) are, for example, that drops of blood are a substitute for real tears, and an adolescent finding that she reserves pain as an punishment for self-mutilating (see Table 7).

Table 7. Sequels of adolescent self-mutilation at the individual level for the adolescent

CATEGORIES	SUBCATEGORIES
Sequels in the emotional level (I, III)	• Addiction (I,III) • Sequels in emotional life, including getting rid of "badness" (III) • Positive feelings and experiences (I) • Negative feelings and experiences (I) • Experiences related to blood (I) • Experiences related to pain (I) • Neutral feelings and experiences (I) • Sequels in the level of emotions (III)
Meanings related to blood and to pain (I)	• Meanings related to blood (I) • Meanings related to pain (I)
Concrete physical permanence results such as scars (I, III)	• Concrete physical results such as scars (I) • Permanence of scars (III)
Suicide attempts (I)	• Suicide attempts (I)

The community level includes parents, significant others, nurses and school personnel. At the community level the sequels include both concrete and emotional reactions (I, III), varying from different kinds of violent or abusive reactions and behaviour, for example angrily yelling at an adolescent, to taking care of both an adolescent who self-mutilates and others who are involved. Unresponsiveness (I, III), for example a lack of actions by parents and other adults evoked in adolescents feelings of insignificance. Examples of intervening in self-mutilation (I, III) include checking the arms of adolescents, or on the other hand a fixed attitude including the idea that all self-mutilating adolescents are manipulative and attention-seekers and just behave poorly. This idea can lead to a poor outcome of intervention and a lack of awareness of self-mutilation as a phenomenon (III), when there is nobody to tell about its content (see Table 8).

Table 8. Sequels of adolescent self-mutilation at the community level

CATEGORIES	SUBCATEGORIES
Concrete and emotional reactions (I, III)	• Concrete and emotional reactions of parents (I) • Concrete and emotional reactions of significant others (I) • Parents and daughter becoming closer (III) • Parents and daughter learning to discuss (III) • Parents noticing the seriousness of their daughter's problems (III) • Some healthcare staff viewing self-mutilation as irrelevant because it evokes repulsion (III) • Taking self-mutilation seriously (III) • Negative emotions (III) • Younger siblings of the self-mutilating adolescent receiving less attention at home (III) • The influence on younger siblings of participating in the treatment of the self-mutilating adolescent (III)
Unresponsiveness (I, III)	• Concrete or emotional unresponsiveness of parents (I) • Concrete or emotional unresponsiveness of significant others (I) • Unresponsiveness (I) • Deliberate blindness to the self-mutilation of their own child (III)
Intervening in self-mutilation (I, III)	• Checking the arms of adolescents (III) • Peers intervening in adolescent's self-mutilation and referring her or him to care (III) • Hospitalization (I) • Medical care (I) • Fixed attitude (III)
Unawareness to self-mutilation as a phenomenon (III)	• Unawareness of self-mutilation as a phenomenon (III)

5.2 The concept of an adolescent who self-mutilates

In this study, an adolescent who self-mutilates is defined in the following way: she externally appears to feel great. She is conscientious and takes care of others, including peers, friends and members of the family, if they are in trouble or in any kind of difficulty. She is the one who will become mistreated by others because of her self-mutilation. On the other hand, internally she is very sensitive, having a low self-esteem: she considers herself inferior to others. She

feels lonely and ashamed of her self-mutilation (III). This definition is constructed from parents' descriptions. Other participants of these original studies did not produce descriptions of an adolescent who self-mutilates. They described the act and its characteristics separately, not combining them in an adolescent (see Figure 5).

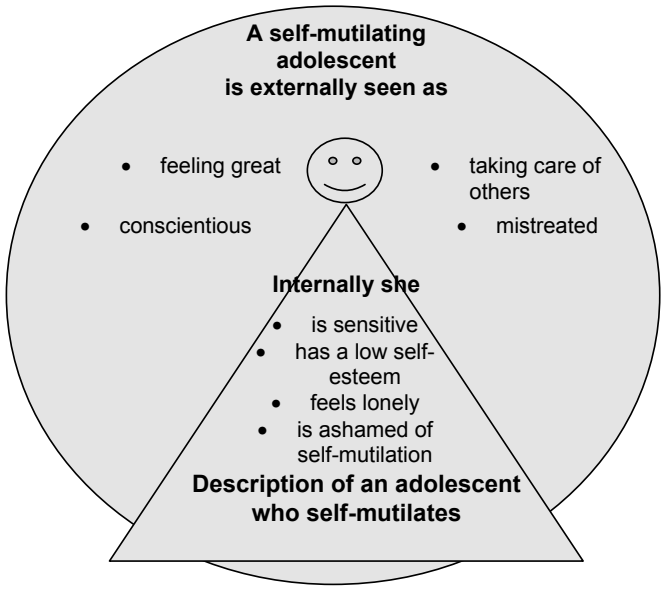

Figure 5. An adolescent who self-mutilates (III)

5.3 The concept of help for adolescent self-mutilation

Help includes all kinds of help and nursing care for an adolescent who self-mutilates provided by the adolescent herself and by other people. Helping in this context refers to the help provided by persons other than health care personnel. Nursing care in this context includes care provided by health care

personnel. Helpers include all persons who can be of help and are described by informants in their own words (see Figure 6).

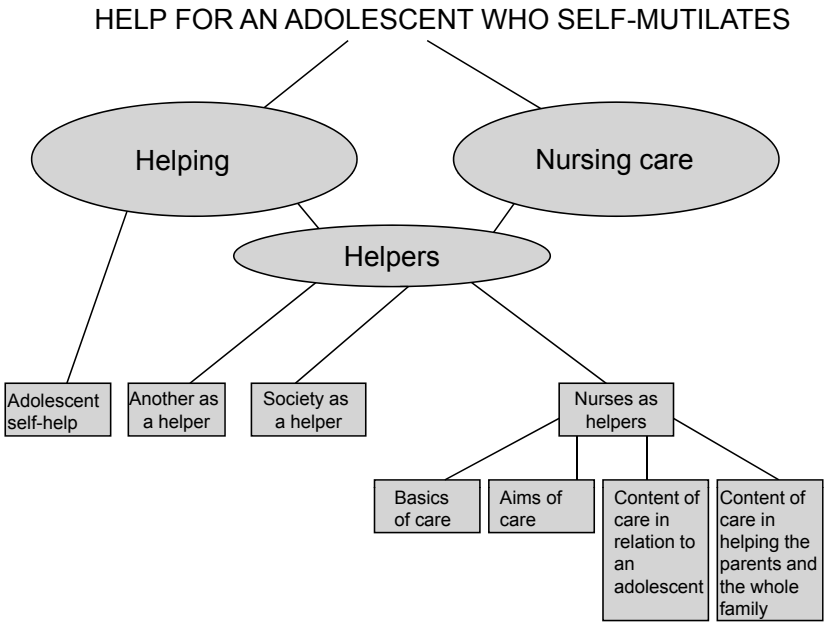

Figure 6. The content of help for an adolescent who self-mutilates

5.3.1 Helpers

All the informants, meaning adolescents, parents and nurses**,** stated that: “Any person who knows about self-mutilation can be a helper” (II, IV, VI). This definition includes all persons, irrespective of whether they are health care professionals. The helpers were listed in detail as follows: “any person who knows about self-mutilation” (VI); a self-mutilating adolescent herself (II, IV, VI); adults, namely parents, school personnel (VI), other possible unknown adults, teachers, school counsellors, parents, health and social care professionals (II, IV) and health care staff (IV); schoolmates (VI); age-mates (II); and loved-ones (II). In the following chapters, helpers have been divided into persons who can be of help without a professional education in healthcare and those who can nurse and care for self-mutilating adolescents because of their professions.

5.3.2 Helping

Helping as a concept refers to the help from people other than health care personnel. It includes three categories: 1) self-help by adolescents, 2) another person as a helper, i.e. the existence of safe and trusting human relationship with someone as a help and 3) society as a source of help.

Adolescent self-help. Adolescent self-help includes the factual knowledge of self-mutilation as a phenomenon and help for it (II, VI), consciousness of being in need of help (II), constructive or destructive activities done alone to keep thoughts of self-mutilation under control (II, IV) and expressing the need for help explicitly or implicitly to others, including self-mutilation itself (II, IV, VI). The factual knowledge of self-mutilation as a phenomenon and help for it (II, VI) includes knowledge of self-mutilation as a phenomenon. This information is needed for a self-mutilating adolescent to become conscious of being in need of help (II). Constructive or destructive activities done alone to keep thoughts of self-mutilation under control (II, IV) include writing, painting, shouting and smoking. Expressing the need for help explicitly or implicitly to others, including self-mutilation itself (II, IV, VI), includes giving sharp objects to the father in order to make self-mutilation less easy to execute, refusing to leave the hospital, concrete changes in human relationships and calling a friend or boyfriend (see Table 9 for more detail).

Table 9. Adolescent self-help

CATEGORIES	SUBCATEGORIES
Factual knowledge of self-mutilation as a phenomenon and help for it (II, VI)	• Knowledge of self-mutilation as a phenomenon (II) • Knowledge of the available help for self-mutilation (II) • Lack of information on self-mutilation as opposed to knowledge, for example, that self-mutilation is becoming a trend, and is no longer considered as an abnormal or a pathological act (VI)
Consciousness of being in need of help (II)	• Becoming conscious of being in need of help (II) • Being conscious of being in need of help (II)
Constructive or destructive activities done alone to keep thoughts of self-mutilation under control (II, IV)	• Doing something to keep thoughts of self-mutilation under control (IV) - Constructive activities • Writing about bad feelings (IV) • Writing (II) • Thinking about killing oneself (IV) • Playing music(II) • Listening to heavy metal II) • Reading (II) • Painting (II) • Drawing (II) • Shouting (II) • Doing anything (II) • Walking (II) • Jogging (II) • Eating (II) • Sleeping(II) • Shooting pool (II) • Cleaning (II) • Crying (II) • Picking at a wall (II)
Expressing the need for help explicitly or implicitly to others, including self-mutilation itself (II, IV, VI)	• Constructing new human relationships (IV) • Concrete changes in human relationships (IV) • Telling about self-mutilation to someone and discussing it (IV) • Asking the mother to come along to the doctors' (IV) • Giving sharp objects to the father in order to make self-mutilation less easy to execute (IV) • Refusing to leave the hospital (IV) • Explicitly seeking help by going to meet a nurse (VI) • Calling a friend or boyfriend (II) • Visiting a friend (II) • Joining other people (II) • Showing the positive results of a depression test to the mother (IV) • Leaving a diary including text about self-mutilation so that it will be seen by the mother (IV) • Gravitating to the parent when feeling the need for self-mutilation (IV) • Self-mutilation as a form of attention-seeking with the intention that somebody would notice: an implicit plea for help (VI)

Another person as a helper: the existence of a safe and trusting human relationship with someone as a source of help. Human relationships were relationships with adults and with age-mates. Adults as helpers included parents, adult siblings and school personnel.

Parents were described as principal helpers. The content of help from parents includes factual knowledge of help for self-mutilation and being aware of concrete acts to obtain it (IV) and being an authentic parent (II, IV). An example of parental cognitive intrapsychic functions is keeping the adolescent and the act of self-mutilation separated. Recognizing their own incapacity to help and seeking support and acute help when needed from society (IV) is one part of the content of helping by parents (see Table 10 for further detail).

Table 10. Parents as helpers: content of help

CATEGORIES	SUBCATEGORIES
Factual knowledge of help for self-mutilation and concrete acts to obtain it (IV)	Parental activities in relation to others to ensure professional help (IV), for example phone calls to their friends, using the Internet as a source of information on help
Being an authentic caring parent (II, IV)	• Parents' cognitive intrapsychic functions (IV) • Parental interaction with the adolescent (IV) • Interaction of parents with each other (IV) • Intervening in adolescent self-mutilation by parents (II) • Authentic caring for the adolescent by parents (II) • All kinds of support from parents (II)
Recognizing one's own incapacity to help and seeking support and acute help when needed from society (IV)	The incapacity of parents to help and their lack of time to offer help (IV)

Parents' abilities to help are limited, and factors associated with their limited abilities to help are follows: parents are in need of factual knowledge of self-mutilation as a phenomenon (IV, VI) as well as the content of parenthood, including knowledge of development from childhood to adulthood during adolescence (II,VI). The needs of parents for factual knowledge of self-mutilation as a phenomenon are seen, for example, in a lack of awareness of

what self-mutilation is or when it already exists in the family. Their needs for factual knowledge of the content of parenthood, including knowledge of development from childhood to adulthood during adolescence, are seen in their desire to not talk about things that are not nice or in their understating of the importance of psychological problems (see Table 11 for more detail).

Table 11. Factors associated with parents' limited abilities to help

CATEGORIES	SUBCATEGORIES
Parents are in need of factual knowledge of self-mutilation as a phenomenon (IV, VI)	• The idea of self-mutilating existing in their family (VI) • Parental unawareness of self-mutilation (IV) • Parental unawareness of self-mutilation by their adolescent child (have not noticed or may be unable or unwilling to notice) (VI)
Parents are in need of factual knowledge of the content of parenthood, including knowledge of development from childhood to adulthood (II, VI) during adolescence	• Parental desire to keep the exterior appearance of "how well we are managing in our family" (VI) • Adolescents being worried about the ability of parents to manage → protecting the parents (VI) • Not used to discussing difficult matters (VI) • Parental expression of contemptuous or understating attitudes towards psychological problems, either verbally or nonverbally (VI) • Parental inability to react because they accept the adolescent's premature independence or feel that the adolescent has a real obligation to become independent (VI) • Over-expectations of adolescents and their parents concerning the ability of adolescents to fend for themselves (II)

Help from *adult siblings* includes showing their care by listening and discussing self-mutilation and associated factors (IV).

The idea of the role of *school personnel* in helping is partly based on the conception that self-mutilation is easier to perceive at school than at home, because adolescents spend a lot of time at school (IV), and partly on the conception of adolescents that adults (also adults at school) who know about self-mutilation have duty to intervene (II). Helping consists of preventing self-mutilation (II, IV, VI) and interfering in it (II, IV, VI). Prevention of self-mutilation (II, IV, VI) can be realized by an authentic caring attitude in all school practices, particularly when the parents and family cannot be of help (II, VI), and by co-

operation with all parents (IV). Interfering in self-mutilation (II, IV,VI) can occur on an individual level by noticing and asking about it (II, IV, VI), and on a community level by telling about self-mutilation as a phenomenon (IV, VI) (see Table 12 for more details).

Table 12. The idea of school personnel as helpers: content of help

CATEGORIES	SUBCATEGORIES
Prevention of self-mutilation (I, IV, VI) • Authentic caring attitude in all school practices, particularly when the parents and family cannot be of help (II, IV, VI)	• Appreciating adolescents as human beings at school and bringing this appreciation to all school practices, particularly when the parents and family cannot be of help (VI) • Cognitive intrapsychic functions of school personnel (IV) • Following the development of their adolescent students (VI) • Asking how their students are, especially when problems can be seen (VI) • Supporting adolescents in coping by telling them how to protect themselves and obtain help if they have any difficulties or problems (VI) • Telling about the psychical growth of their body (VI) • Supporting an appreciative and protective attitude towards their own body and themselves as an entity (VI) • Helping the adolescents to find ways to cope with life (VI) • Intervening in self-mutilation by others (II) • Authentic caring for the adolescent by others (II) • The ability to recognize depression can help prevent adolescent self-mutilation (VI)
• Co-operation with all parents (IV)	• Co-operation with parents (IV)
Interfering in self-mutilation (II, IV, V) • On an individual level by noticing and asking about it (II, IV, VI)	• By noticing and asking about it (self-mutilation)(VI) • Appropriate and exemplary interaction with a self-mutilating adolescent (IV) • Authentic care for the adolescent by others (II)
• On a community level, telling about self-mutilation as a phenomenon (IV, VI)	• Intervening in self-mutilation (II, IV) by sending a letter dealing with self-mutilation in general and its existence at school to all parents (VI) • Explicitly talking about self-mutilation as a phenomenon (IV)

Certain help-hindering factors exist among school personnel, including: a lack of factual knowledge of self-mutilation as a phenomenon (IV); difficulties in discussing self-mutilation as a phenomenon (VI); a lack of factual knowledge of help for self-mutilation (IV); a lack of factual knowledge of the demands of society placed on parents, for example work duties taking more time than earlier (IV); a the lack of knowledge of the growing number of psychic problems among adolescents (IV).

Help from *age-mates* includes the existence of peers and friends (IV), which underlines their importance. Age-mates can help by intervening in self-mutilation (II, IV, VI), supporting an adolescent who self-mutilates (II, IV, VI) and by authentically caring (II, IV, VI) (see Table 13 for more detail).

Table 13. Age-mates as helpers: content of help

CATEGORIES	SUBCATEGORIES
Existence of age-mates (IV)	Having peers and friends (IV)
Intervening in self-mutilation (II, IV, VI)	Intervening in self-mutilation (II, IV) Interfering in an adolescent's public self-mutilation (VI), telling the school nurse about self-mutilation (VI)
Supporting (II, IV, VI)	All kinds of support from friends and peers (II) Supporting an adolescent in obtaining professional care (IV) Supporting an adolescent in coping as a way to prevent self-mutilation (VI)
Authentic care by others (II)	Authentic care for the adolescent by others (II)

Society as source of help. The content of society's help includes prevention (II) and interfering in problems (IV). Prevention consists of offering early and practical intervention for adolescents' problems (II). Interfering in problems includes support and acute help for parents and the whole family when needed (IV). Acute help should be immediately available.

5.3.3 Nursing care

Nursing care refers in this context to care provided by health care personnel. Nursing care here consists of care that is wished for and received. Nursing care

includes four categories: the basis of care, aims of care, content of care in relation to an adolescent and content of care in helping the parents and the whole family.

Basis of care. The basis of care includes a professional, genuine caring attitude (II, IV, VI), professional skills that include knowledge of self-mutilation as a phenomenon and knowledge of the development of a child (IV, VI) and pertinent, explicit and realistic co-operation with an adolescent and with the whole family (IV) (see Table 14 for more detail).

Table 14. Basis of care

CATEGORIES	SUBCATEGORIES
Professional, genuine caring attitude (II, IV, VI)	• Authentic caring for the adolescent (II) • Respect for individuality (VI) • Professional, genuine caring attitude (IV, VI) • Not denouncing (IV) • Not reproaching (IV) • Individuality (IV)
Professional skills that include knowledge of self-mutilation as a phenomenon (IV, VI)	• Professional skills that include understanding that self-mutilation might be a sign of something more serious (IV, VI) • Good professional skills to guide the destructive preference to an act that does not cause pain or harm (VI) • Making contact with adolescents as human beings (VI) • Ability to discuss self-mutilation (VI) • Trustworthiness (IV) • Acquaintance (IV) • Knowledge of factors associated with the development of a child (IV) • Working communication between nursing units (IV)
Pertinent, explicit and realistic co-operation with an adolescent and with the whole family (IV)	• A sceptical attitude of health and social care personnel concerning the parents' desire to do everything possible to helping their youngster does not help(IV) • A sceptical attitude of social workers when visiting the home of self-mutilating adolescents does not help(IV) • Co-operating (IV) • Pertinent, explicit and realistic co-operation with the whole family (IV)

Aims of care. The aims of care include soothing the situation (VI), avoiding extra traumatization (VI), providing and keeping up hope (VI) and enabling change (VI). Enabling change includes, in practice, helping an adolescent to understand her behaviour and also, through her actions, to find a shared understanding among the personnel on the ward for adolescent self-mutilation (see Table 15 for more details).

Table 15. Aims of care

CATEGORIES	SUBCATEGORIES
Soothing the situation (VI)	• Easing the situation (VI)
Avoiding extra traumatization (VI)	• Avoiding extra traumatization (VI)
Providing and keeping up hope (VI)	• Providing hope in life (VI) • Keeping up hope (VI)
Enabling change (VI)	• Helping adolescents to understand their behaviour (VI) • Finding a shared understanding for this behaviour, for example, among healthcare personnel on the ward (VI) • Enabling change so that wounds in the mind as well as those on the skin can be healed and their burden can be lightened (VI) • Finding alternatives to self-mutilation (VI)

Content of care in relation to an adolescent. The content of care in relation to an adolescent has three subcategories: the emotional interactional level of care (II, VI), concrete acts of care (II, IV, VI) and therapeutic discussion (IV, VI). The emotional interactional level of care consists of emotions that are needed or appear in the interaction with an adolescent who self-mutilates. Concrete acts of care happen together, sometimes interlaced with the emotional level. Therapeutic discussion includes not only listening and hearing, but also active talking and asking, and it is time consuming (see Table 16 for more detail).

Table 16. Content of care in relation to an adolescent

CATEGORIES	SUBCATEGORIES
Emotional interactional level of care (IV, VI)	• Patience (VI) • Pertinence (IV) • Perseverance (VI) • Helplessness and powerlessness against anger (VI) • Feelings of loneliness and unrecognized emotions were mentioned as transference (VI) • Irritation (VI) • Burdensome (VI) • Boredom (VI) • Worry (VI) • Deep grief (VI) • Compassion (VI) • Empathy that arouses a strong desire to help referred to as motherliness (VI) • "Holding" (VI) • Relationship between motherliness and professionalism (VI) • Self-mutilation as one means of reacting to problems among others (VI) • Interaction with her or him (VI) • Sensitiveness in the interaction (IV, VI)
Concrete acts of care (II, IV, VI)	• Making it possible for a self-mutilating adolescent to have a safe and trusting human relationship by forming one (IV) • Intervening in or reacting to self-mutilation (VI) - discussing the possibility of self-mutilation during an appointment with an adolescent with mood disorders (VI) - offering functional means instead of or in addition to discussing (IV) - always intervening in self-mutilation when it happens (II, VI) - observing with or without using indicators (VI) - wound care (VI) - combining concrete wound care with discussion of emotions and the desire to self-mutilate (IV) - taking care of an adolescent's social position (VI) - checking arms daily (IV) - checking the personal possessions of a self-mutilating adolescent on the ward when needed (VI) - discussing self-mutilation as a phenomenon with the visitors of an adolescent (VI) - evaluating the adequacy of the helper for the one to be helped (IV) - allowing feelings to be expressed (IV)

Therapeutic discussion (IV, VI)	• Listening and hearing (IV) • Keeping up hope by telling that there are other means in everyday life to vent feelings and to process downheartedness (VI) • Estimating the level of self-destructiveness (VI) • Discussing the situation that has led to a self-mutilation act, and the act itself (II, IV, VI) • Asking about the feelings and emotions of the adolescent at the time of self-mutilation (VI) • Discussing the feelings and emotions that self-mutilation has evoked in her (VI) • Discussing the potential sequels of self-mutilation that will occur in her later (VI) • Talking through the acute situation of life and previous life events with an adolescent (IV) • An effort to make an agreement that the adolescent will not self-mutilate before the next appointment (VI) • Highlighting that recovery begins with small things (IV) • Exploring changes in an adolescent's inner well-being over time (VI) • Helping an adolescent to learn more about herself through conversations, for example to perceive when it will feel necessary to self-mutilate (IV)

Content of care in helping the parents and the whole family. The content of care in helping the parents and the whole family includes acute therapeutic discussion (IV), for example supporting parents, a possibility to obtain peer support acutely (IV), and acute concrete acts such as organizing a supporting family and other official support as a substitute for a lack of personal support (IV), for example, from relatives.

In conclusion, the concepts of self-mutilation, an adolescent who self-mutilates and help for adolescent self-mutilation, including helping and nursing care, construct this practice theory of self-mutilation among Finnish adolescents and help for it. (See Figure 3, p. 47.)

6 DISCUSSION

The purpose of this study was to describe self-mutilation among Finnish adolescents and help for it, and further to develop a practice theory of helping adolescents who self-mutilate. A starting point for this study was my own confused experiences as a nurse, when nursing adolescents who self-mutilate and wondering what this phenomenon was all about and what I should do. This study provided an overview of and knowledge on self-mutilation as a phenomenon and help for it.

This is the first time that knowledge about self-mutilation among adolescents as a phenomenon and help for it has been organized using broad empirical research. The outcomes of the research help in identifying the principles of self-mutilation and in addition the principles of helping adolescents who self-mutilate. This study produced a considerable amount of new knowledge and partly strengthened previous knowledge.

In this study the phenomenon of self-mutilation and help for it was approached from different viewpoints using qualitative description. These viewpoints included those of non-clinical adolescents who self-mutilate, their parents and nurses who have cared for self-mutilating adolescents. In previous studies the phenomenon and help for it have been mostly described by adults who are inpatients or outpatients, or those who have been selected in other ways, for example as users of websites for self-harmers (Murray et al. 2005, Murray & Fox 2006). Among the participants of these previous studies the number of adolescents is small. There have been no previous studies in nursing science considering the viewpoint of the parents of adolescents who self-mutilate. The viewpoint of nurses who have experience of caring for adolescents who self-mutilate has also not previously been examined. This is the first time that all these three viewpoints have been synthesised in the same study.

Metasynthesis was used in synthesising the findings of the original studies and a practice theory of self-mutilation among Finnish adolescents and help for it was constructed. No previous theories on self-mutilation have been presented in the national or international literature. The practice theory includes the concept of self-mutilation and factors associated with it among Finnish adolescents, the concept of an adolescent who self-mutilates and the concept of help for adolescent self-mutilation. The concept of help consists of helping and nursing care.

In this chapter the totality of the practice theory of self-mutilation among Finnish adolescents and help for it is first reflected on. Secondly, the practice theory of self-mutilation among Finnish adolescents and help for it is discussed. Further, the elements of this practice theory are individually considered, focusing on the differences compared to previous studies if possible, but keeping in mind that there have been no previous similar studies of this kind on the topic.

6.1 Reflection on the theory development and evaluation of the theory

6.1.1 Trustworthiness of the study

The qualitative approach was justified because there had been no previous studies on self-mutilation and help for it among nonclinical adolescents who self-mutilate and, in addition, among parents of adolescents who self-mutilate and among nurses who have cared for self-mutilating adolescents.

Qualitative description as a mode of qualitative research was a suitable choice because it is based on naturalistic inquiry, where a phenomenon is studied in as naturalistic circumstances as possible and because the goal was to achieve a concrete description to help in clinical work, such as nursing (Sandelowski 2000, Sullivan-Bolyai et al. 2005), when working with adolescents who self-mutilate and determining how they can be helped. In this study the circumstances were as naturalistic as possible. Non-clinical adolescents who

self-mutilate were able to write their descriptions wherever they wanted to and further, adolescents and parents were interviewed in the researcher's workroom and were told that this study was not connected with their earlier nursing care. In addition, telling about or discussing the content of one's work, in this case a nurse's work, can also be seen to have happened in naturalistic circumstances.

Concerning trustworthiness in qualitative methodologies, the whole study process has to be considered, including data collection and analysis as well as the presentation of findings (Lincoln & Cuba 1985). According to Higginbottom (2004), all qualitative methodologies have been criticised because the processes and procedures are not transparent. In this study I have tried to describe all the processes and steps very explicitly. Trustworthiness in qualitative research can be estimated by using the following criteria: credibility, dependability, transferability (Lincoln & Cuba 1985, Graneheim & Lundman 2004) and reflexivity (Im 2005, Kylmä & Juvakka 2007, Kylmä et al. 2007, Kylmä et al. 2008).

Credibility. Credibility means truth value (Cutcliffe & McKenna 1999): how well the findings reflect the original data and how it is presented by the researcher. The data used in this study were collected using methodological triangulation to enhance credibility (Tobin & Begley 2004), with written descriptions (I, II,V,VI), personal interviews (II,III,IV,V,VI) and focus group interviews (V, VI) to achieve as complete a picture of self-mutilation as a phenomenon and help for it as possible. Written descriptions and individual interviews worked well among adolescent girls, but not with boys. There were no suitable magazines that had been directed to adolescent boys and, in addition, boys did not want to participate in interviews. The width of written descriptions varied from a couple sentences to many pages. Individual interviews were also a suitable method for collecting data from parents, offering them a possibility to describe their experiences. As Murray (2003) has noted, interviews might have had therapeutic benefits for all the participants, both adolescents and parents. Focus group interviews appeared to be an excellent method and their use produced versatile knowledge of self-mutilation as a phenomenon and help for it

from nurses. However, it was not easy to obtain participants for these focus group interviews, and so three individual interviews were carried out. In addition, nurses were not willing to write descriptions of their conceptions of self-mutilation among adolescents and further, their experiences of nursing adolescents who self-mutilate. Triangulation was used as a means to add the trustworthiness of the findings by using multiple methods in data collection (Kylmä et al. 2003, Lambert & Loiselle 2007).

In addition, I have become familiar with the phenomenon of self-mutilation because the starting point of this study was rooted in my clinical experiences as a nurse and I have worked with this aim for years. I have written audit trail and discussed the research process and the findings a great deal with collegues and other researchers during the years I have been conducting this study. (Rodgers & Cowles 1993, Graneheim & Lundman 2004, Kylmä & Juvakka 2007,Schoppmann et al. 2007, Kylmä et al. 2008.) However, another researcher might not have achieved exactly the same findings as me, because inductive content analysis always involves interpretation (Malterud 2001).

In synthesizing the findings of original research reported by others, there are limitations that must be taken into consideration, such as descriptions of original research processes or descriptions of contexts in original studies (Sandelowski & Barroso 2003b). In all the studies forming this thesis, the ontological basis, analytical methods and the principal researcher were the same. The possible lack of boys, or at least the minor proportion of them, as participants of the original studies, and in addition, their lack in adolescents' and parents' descriptions can be seen as a limitation of this study. In addition, participants wrote their descriptions in Finnish and all the interviews were carried out in Finnish. However, reports of the findings of all original studies as well as this study have been carried out in English using a native professional translator. It is possible that during this translation process something of participants' vivid descriptions have been missed.

Dependability. Dependability means how well the research process is documented from the beginning to the end: whether the research process is logical, easy to follow and clearly reported (Im 2005, Kylmä et al. 2008). The whole research process has been described as well as possible to enhance dependability and, for example, authentic quotations from the data in the original studies (I-VI) have been used when presenting and discussing the findings (Kylmä & Juvakka 2007).

Reflexivity. Reflexivity means the researcher's consciousness of his or her own values and meanings, preconceptions and experiences in relation to the study topic and, in addition, his or her evaluation of their effect on the whole research process (Malterud 2001, Im 2005, Kylmä et al. 2008). I have experiences of caring for adolescents who self-mutilate (see Chapter 1) and on the other hand, I have not worked in clinical nursing since beginning my research to retain my position as a researcher. In addition to this study, I have written other scientific articles with other researchers during these years as part of the process of learning and studying. This co-operation has also been very useful in strengthening my viewpoint on the importance of qualitative descriptive research in addition to all other research.

Transferability. Transferability means if and when the findings of the study can be used in other similar situations. In practice, the informants and their backgrounds were described in as much detail as possible so that the readers could evaluate transferability themselves (Lincoln & Cuba 1985, Graneheim & Lundman 2004, Kylmä et al. 2008). The practice theory of helping adolescents who self-mutilate cannot be used in helping adolescents who have other problems. The elements of helping are general, but quite structured guidelines for helping adolescents according to context of self-mutilation are given through this study. In addition, the participants of the original studies and the context of the studies have been described as far as possible.

6.1.2 Ethical considerations

Self-mutilation is a sensitive research topic. Permission to conduct the study was sought from and granted by the Ethical Committee of Kuopio University Hospital and the University of Kuopio (81/2004).

It was also important to protect both the participants and the researcher (Kylmä 2008), and so I did not work in clinical nursing at the time of conducting this study. By staying away from nursing practice it was also easier to remain in the position of a researcher and distance myself from my own experiences of caring for adolescents who self-mutilate, thereby adding to the trustworthiness of this study. In addition, protecting the researcher meant in practice the extensive support of other researchers and colleagues when conducting this study.

The advertisements directed at the participants (I, II, V, VI) included basic information on the research project and also a request to the adolescents (I, II) to notify their age and gender in their descriptions. Parents were contacted only after their children's signed informed consent to contact them had been provided, and the information provided by phone and was also repeated when conducting the interview before signing the consent form (III, IV). The advertisement targeted at nurses also included basic information on the research project (V, VI) and signed informant consent was requested from the nurses who participated in the interviews (V, VI).

Writing was chosen as a data collection method to protect the privacy of the participants and make it easier for them to participate (I, II, V, and VI). Writing has also been used as an intervention to prevent self-mutilation (I, II) (Crowe & Bunclark 2000, Pawlicki & Gaumer 1993). By sending their descriptions, participants stated that they had understood the purpose of the study (I, II, V, VI) (see also Morse & Field 1996, Kylmä et al. 1999, Jokinen et al. 2002).The received e-mails were removed from e-mail inbox and saved on the computer. Participants participating by e-mail usually used a pseudonym in their e-mail

addresses. The participating adolescents' pseudonym e-mail addresses were collected, which was important in case the adolescents had something to ask about the study or if, based on my clinical competence, I considered it necessary to contact an informant by e-mail. Six adolescents were contacted in this way because their questions focused on receiving nursing care and confidentiality.

I conducted all the interviews (II, III, IV, V and VI) by myself. The open-ended personal and also focus-group interviews began by repeating the basic details of the study and signing of the consent forms (Munhall 2001). After the interviews I asked the interviewees (II, III, IV) about their emotions, how they felt about the conducted interview and whether they had anything to ask about the study they were participating in or anything else that was on their mind. I gave the participants my contact information in case they subsequently wanted to decline to participate in the study or to ask something about it (Laki lääketieteellisestä tutkimuksesta 488/1999).

6.1.3 Evaluation of the theory

The evaluation of a theory is very important because it helps to identify its strengths and limitations. The purpose in this case is to evaluate the theory's utility in clinical nursing. The evaluation process has been seen as a process that has one or multiple stages. In addition, multiple criteria of evaluation have been presented (Lauri & Kyngäs 2005). Here, the practice theory produced in this study is evaluated using Dudley-Brown's (1997) set of criteria for evaluating a theory, including accuracy, consistency, fruitfulness, simplicity/complexity, scope, acceptability and socio-cultural utility.

Accuracy. The accuracy of the present theory consists of the reality of nursing (Dudley-Brown 1997) and the truthfulness of descriptions. The participants' own descriptions have been used as a basis for this theory and they have been

written using language that is as concrete as possible, including all the viewpoints. First, I had an idea to use Kirkevolds' (1993) thoughts about practice theory as a basis for the interviews. However, the questions were found too theoretical and rejected by the participants, and so I gave up that idea.

Consistency. The consistency of a theory refers to its internal consistency, meaning consistency in the use of terms, principles and methods (Dudley-Brown 1997). In this theory, the terms used have been defined and their use has been explained. The used methods are consistent, because in each original study a qualitative descriptive approach was chosen, the data were analysed using the same methods, and in addition, metasynthesis was used in synthesising the findings, constructing a practice theory of the emerging knowledge.

Fruitfulness. Fruitfulness is another term for productiveness (Dudley-Brown 1997). The theory of helping adolescents who self-mutilate did not exist previously, and in addition, perceptions of helping adolescents who self-mutilate have not earlier been investigated. Self-mutilation as a phenomenon with its characteristics among Finnish adolescents was defined for the first time. This practice theory can therefore be considered very fruitful in increasing knowledge of self-mutilation and help for it not only among healthcare personnel but also in other organizations. In addition, this theory provides ideas for further research, for example the viewpoint of siblings of adolescents who self-mutilate.

Simplicity/complexity. Simplicity/complexity are both needed and they have their place, depending on the theory. If there are many concepts and relationships, the theory might be seen as complex, while if there are few concepts and few relationships, the theory can be seen as simple (Dudley-Brown 1997). The present theory consists of few concepts and their relationships are quite simple. This theory organises knowledge of self-mutilation and help for it in a new and original way.

Scope. Scope can be seen in two ways. A broad scope, including more concepts or a variety of facts, can lead to a more general theory, but a narrower scope considering more limited aspects of nursing can be seen as more realistic in theory development (Dudley-Brown 1997). Scope can also be conceptualised in relation to the level of the theory (Dudley-Brown 1997), as in the present practice theory. This theory is a synthesis of three different viewpoints that had a role in constructing it: the viewpoints of adolescents who self-mutilate, their parents and nurses who have cared for self-mutilating adolescents.

Acceptability. Acceptability includes the possibility to use a theory in other areas of nursing, which in addition to nursing practice include education, research and administration. Another term used instead of or under acceptability is usefulness (Dudley-Brown 1997). This practise theory of helping adolescents who self-mutilate can be used in nursing education because it includes guidelines for nursing that are needed in the nursing care of an adolescent who self-mutilates. In addition, these practical guidelines for care also present the structure of care, which is needed in administration. In addition, this practice theory can be used to define future research topics.

Socio-cultural utility. Socio-cultural utility means the possibility to use a theory in another culture, remembering to evaluate the theory's philosophical and theoretical relevance in the society or culture where it will be utilised (Dudley- Brown 1997). As Clarke and Whittaker (1998) stated, self-mutilation should be seen and known as a culturally defined phenomenon. The practice theory of helping adolescents who self-mutilate might be used, for example, in Western countries after evaluation of its philosophical and theoretical relevance to the society or culture where is it going to be used. Furthermore, when using this theory in practice the context and state in society have to be taken into account, in addition to the philosophical and theoretical relevance. (Im 2005.) At the time the data of the original studies were collected, Finland was enjoying a boom after the recession of the early 1990s, so the adolescent participants

might have been the victims of the reductions social and health care attendance in the 1990s.

6.2 Concept of self-mutilation and factors associated with it among Finnish adolescents

6.2.1 Definition of self-mutilation by the study participants

Self-mutilation can be defined as follows: self-mutilation includes all kinds of deliberate destructive acts towards one's own skin such as scratching, cutting, burning or self-injuring, conducted alone or together with someone else, on all parts of one's body excluding the head and back, with any tool that happens to be available and that causes a mark or a bleeding wound or wounds. Self-mutilation can also be used as way to commit suicide.

A new definition of self-mutilation is needed because as Messer and Fremouw (2008) recently suggested, there are still problems in defining self-mutilation. As a term, self-mutilation implies no intent to die (Messer & Fremouw 2008). However, Favazza's (1996) definition of pathological self-mutilation adds this idea of no intent to die in his definition, which is as follows: "Self-mutilation is a deliberate act to destroy one's own body tissue without a conscious intent to die." His definition is shorter and more general than that produced in this study. In addition, Hicks and Hinck (2008) have recently presented a theoretical definition of the concept of self-mutilation based on the existing literature prior to 2007. Their definition was: "Self-mutilation is the intentional act of tissue destruction with the purpose of shifting overwhelming emotional pain to a more acceptable physical pain" (Hicks & Hinck 2008, p 409). Their definition includes a purpose that is seen to be same for all the persons who self-mutilate, namely the shifting of overwhelming emotional pain to a more acceptable physical pain. Compared to the definition of the purposes of self-mutilation (see Figure 4 p. 55) based on the original studies (I, III, V), their definition is restricted because it presents only one purpose for self-mutilation. It is also notable that their

definition of self-mutilation has mainly been constructed through clinical case studies and literature reviews of studies mostly carried out among inpatients (Hicks & Hinck 2008).

6.2.2 Characteristics of the phenomenon of self-mutilation

In this study a large number of characteristics of self-mutilation were identified. Some of these had been mentioned in the previous literature, including self-mutilation as an old phenomenon (Clarke & Whittaker 1998), a typical phenomenon among adolescents (Derouin & Bravender 2004), a matter requiring intervention, (Derouin & Bravender 2004), contagious (Taiminen et al. 1998, Favazza 1998), compulsive (Cleaver 2007), a taboo subject (McAllister 2003a), interrelated with suicide, and a way to commit suicide or a completely unrelated act (Machoian 2001).

In addition, other characteristics of self-mutilation were identified that had not previously been reported, such as confusing, unshameful, difficult to perceive, having a blackish profile, crossing a certain line, manifested to different degrees, and a range of perceptions from self-mutilation being trendy disease to far from trendy, undiscussed to important to discuss, unknown to familiar, abnormal to possibly a part of youth culture, and an action that happens in public to one that takes place secretly. Some of these characteristics contrasted with each other, for example self-mutilation as unshameful and as a taboo subject. Some dimensions that were found reveal the lack of knowledge of self-mutilation as a phenomenon, including: unknown – familiar, abnormal – might be a part of youth culture, a trendy disease – far from trendy and an action happening in public – secretly. These have not been mentioned before.

The characteristic of secrecy has been mentioned in previous literature (Pawlicki & Gaumer 1993, Clarke & Whittaker 1998, McAllister 2003a), but not as a dimension. The perception of self-mutilation as a part of self-harm among

adolescents has been suggested by parents to be a fashion (Oldershaw et. al 2008), which is quite close the dimension of being a trendy disease – far from trendy. The huge variety of characteristics of self-mutilation demonstrates how multidimensional and multiform it really is and how it includes multiple meanings**.**

6.2.3 Factors contributing to self-mutilation

The factors contributing to self-mutilation were divided in this study into three levels: the individual adolescent level, the community level (especially the family community) and the society level.

Individual adolescent level. The factors contributing to self-mutilation were ongoing puberty, internal and experiential factors and changes, external factors and changes and gender, namely the commitment mainly to female gender. However, nurses told that they have also cared for boys. In previous studies, puberty as a term has not been highlighted, but self-mutilation has been seen as a typical phenomenon in adolescence (Klonsky et al. 2003), especially among female adolescents (De Leo & Heller 2004, Laukkanen et al. 2009). Among internal or experiential factors, the lack of awareness among adolescents of self-mutilation as a phenomenon can be seen as a reason for self-mutilation due to their belief that is it trendy to self-mutilate. These internal or experiential factors, together with attempts to appear older than their chronological age, were factors that had not been mentioned in earlier literature. In addition, hearing voices ordering one to cut oneself, which possibly reflected a psychotic disease, was a new finding that has not been mentioned in the cited references.

Fear of violence and a low self-esteem have both been mentioned in previous studies (Machoian 2001, Derouin & Bravender 2004). Several studies have reported the inability to cope alone with the surge of emotions in adolescence,

especially negative emotions (anger, rage and low mood), was found in this study and is a factor that has also been mentioned earlier (Suyemoto 1998, Gardner 2001, Machoian 2001, Hintikka et al. 2009). This is an important finding, because the inability to cope with emotions can be influenced by therapeutics acts.

External factors and changes contributing to self-mutilation mostly include negative factors and changes that have also been described in previous studies, such as the abuse of alcohol (Tolmunen et al. 2008) or changes in relationships with peers (Puskar et al. 2006). In addition, earlier unmentioned neutral changes, including changes in behaviour or concrete changes in life, such as moving away from the birthplace were found in this study. Interest in Satanism has not been mentioned in these executed literature searches. In some cases there were no conscious antecedents to self-mutilation.

Community level, especially in the family community. Among the family factors contributing to self-mutilation were possible differences in the upbringing of self-mutilating adolescents compared to other children and the level of competence of parenting, meaning inadequacies in parenthood and problems in the family. Possible differences in the upbringing of an adolescent who self-mutilates have not been mentioned in previous studies. Parents might reflect on whether they have raised this particular child somehow differently from the other children. This kind of reflection might be the parents' way to describe their feelings of guilt over an adolescent's self-mutilation. Furthermore, parents' acute reactions and responses to adolescent self-mutilation can influence whether the adolescent continues to self-mutilate (Yip et al. 2003). The level of competence in parenting and problems in the family are factors that have been found in this study and also described in previous literature, varying from quite typical problems in relationships or interactions with parents (Tulloch et al. 1997, Webb 2002, Yip et al. 2003) to any kind of traumatic experience such as violence in everyday life in childhood (Levenkron 1998, Derouin & Bravender 2004, Yip 2005).

Society level. At the society level, factors contributing to self-mutilation included violence, a lack of information on self-mutilation as a phenomenon and a requirement for adolescents to be more grown-up than they actually are. The lack of information on self-mutilation as a phenomenon is a factor that has not been described earlier, which might be because self-mutilation has been seen as a taboo subject (Clarke & Whittaker 1998, McAllister 2003a). Research on self-mutilation is still limited in Finland, although the number of publications has recently been growing (Taiminen et al. 1998, Rissanen et al 2006b, Rissanen et al.2008, Tolmunen et al. 2008, Laukkanen et al. 2009, Hintikka et al. 2009).

The requirement for adolescents to appear older than they are has not been mentioned in previous studies as a factor contributing to self-mutilation. This requirement might relate to the illusion that adolescents, especially girls, are more mature than they are because they have reached their pubertal maturity. Furthermore, in Finnish society and in Finnish culture, children are expected to mature and grow up quickly and take care of themselves, becoming independent as soon as possible. This includes separation and independence from the family as early as possible. It might even be considered by parents as an achievement to be proud of.

Violence is a factor contributing to self-mutilation in Finland and also discussed in previous literature (Pawlicki & Gaumer 1993, Ledray 1994, McLane 1996, Solomon & Farrand 1996, Batty 1998, Crowe & Bunclark 2000, Harris 2000, Gardner 2001, Cavanaugh 2002, Derouin & Bravender 2004, Yip 2005, Balch 2006). In Finland, the actual amount of violence is difficult to estimate in the light of existing research. In Finland, punishing children has been a crime since 1984. The number of victims of domestic violence in the whole country that have informed the police was 4109 in 2005, being 5% higher than in 2004 (Tilastokeskus 2006). As a part of the Marc Balticum survey (N = 1135) conducted in Helsinki in 2002, 57% of children at the age of 15 years had been victims of parental violent behaviour. In addition, police statistics for 2006

revealed that police had been informed of 2128 children under the age of 15 who were victims of violence. (Ellonen et al. 2007.)

6.2.4 Purposes of self-mutilation

The purposes of self-mutilation were divided into two categories: purposes relation to oneself and in relation to others.

Purposes relating to oneself. Purposes of self-mutilation reported by adolescents as relating to oneself were self-help, punishing oneself, having blips in everyday life, practising Satan worship and having no conscious purpose. Experiences of blips in everyday life and the lack of a conscious purpose have not previously been mentioned in connection with adolescent self-mutilation. They might be signs of problems, but they may also describe emptiness in an adolescent's emotional life. Practicing Satan worship has not been described in previous studies identified in the executed literature searches, but among Finnish adolescents it is one of the purposes of self-mutilation. Self-mutilation as means of self-help emerged very strongly in this study, as in the previous literature (Allen 1995, Favazza 1996, Kehrberg 1997, Favazza 1998, Sueymoto 1998, Gardner 2001, Machoian 2001, Derouin & Bravender 2004, Lloyd-Richardson et al. 2007, Moyer & Nelson 2007, Schoppmann et al. 2007).

Purposes in relating to others. Purposes of self-mutilation in relation to others included the act as a cry for help, being protective towards the mother, punishing or protesting by melodramatic behaviour directed at the mother, and a form of blood vengeance. A cry for help as a purpose of self-mutilation has been mentioned in previous literature (Spencer 1995, Sueymoto 1998, Machoian 2001, Derouin & Bravender 2004), but not the other purposes relating to others found in this study. Being protective towards the mother and punishing or protesting by melodramatic behaviour directed at the mother may reflect

problems in the relationship between the mother and daughter. In addition, an adolescent might be protective towards her mother, for example, because the mother has problems of her own and the adolescent does not want to burden her with her own difficulties. The daughter may to some extent act as a mother to her mother. The content of blood vengeance as a purpose of self-mutilation in relation to others remains unclear because it has not been described more widely.

6.2.5 Sequels of self-mutilation

The sequels of self-mutilation were divided into two categories: sequels on the individual level for the adolescent and sequels at the level of the community.

Sequels on the individual level for the adolescent. Sequels on the individual level for the adolescent included sequels on the emotional level, meanings related to blood and to pain, the concrete physical permanence of the results, such as scars, and suicide attempts. Concrete physical permanence, such as scars, has not been described earlier as a sequel of self mutilation, being a new finding. In previous studies, scars have been mentioned as something that have to be hidden (Murray et al. 2005) or something that exists and can be seen (Derouin & Bravender 2004), but not as sequels. Scars emerged in this study as both unwished and also wished for sequels.

Sequels on the emotional level presented in this study as well as in earlier studies have described how emotions can vary from positive (Derouin & Bravender 2004) to negative feelings (Woldorf 2005), and in addition how experiences can also be neutral, having no emotional content, as in this study. Addiction was described as an unwished for sequel (see also Winchel & Stanley 1991, Derouin & Bravender 2004, Puskar et al. 2006). Meanings and experiences related to blood and pain have been described in previous reports as well (Allen 1995, Favazza 1996, Solomon & Farrand 1996, Crowe &

Bunclark 2000, Harris 2000, Machoian 2001). Suicide attempts as possible sequels have also been reported previously (Machoian 2001), in addition to the higher risk of committing suicide among adolescents who self-mutilate than among those who do not (Stanley et al. 2001, Evans et al. 2005, Fortune 2006, Whitlock & Knox 2007).

Sequels at the community level. Sequels at the level of the community included concrete and emotional reactions, unresponsiveness, intervening in self-mutilation and unawareness of self-mutilation as a phenomenon. Concrete and emotional reactions included some that were known from previous studies, such as negative emotional reactions among significant others (Oldershaw et al. 2008, McDonald et al. 2007, Machoian 2001) and among health care staff (Sidley & Renton 1996, McAllister et al. 2002, McCann et al. 2007), but also positive emotional reactions and concrete actions. Negative emotional reactions among significant others included examples such as a mother yelling at her daughter or a friend being upset. Among health care staff, however, negative emotional reactions included some healthcare staff viewing self-mutilation as irrelevant. Examples of positive emotional reactions among significant others included the parents and daughter becoming closer (see also Oldershaw et al. 2008). Furthermore, concrete negative or positive reactions among significant others who have not previously been named included a boyfriend ending a relationship, a mother who gave her daughter a caning and parents who took their daughter to the hospital. As McDonald et al. (2007) suggested, the emotions aroused by self-mutilation often shape the reactions and responses of significant others, such as parents. However, this also happens among professionals. Ignorance of self-mutilation as a phenomenon emerged as an additional sequel, being a new finding. This might be understood as being because of the taboo characteristic of self-mutilation (McAllister 2003a), but it affects the responses and reactions of others at the level of the community. In the light of this, unresponsiveness among others, including healthcare staff, as an unwished for sequel, can be seen as a reaction to the taboo characteristic of self-mutilation. Self-mutilation can be seen in these cases as an unsuccessful

cry for help. One reason for this may be the lack of factual knowledge of self-mutilation among ordinary citizens in Finland.

Intervening in self-mutilation was one of the sequels, including interventions by peers and healthcare professionals, and can also be seen as a part of help. Healthcare professionals intervened by giving medical care, checking arms and hospitalizing an adolescent who self-mutilates, but sometimes had a fixed attitude concerning self-mutilation. These interventions seem to be quite technical ones, for example as if self-mutilation might be due to a lack of medical care or could be cured by medical care or by hospitalization. As a sequel, these kinds of intervention have quite a negative tone, but an intervention as a sequel is the first step to care. In previous studies, intervention has been reported to begin by taking care of the wounds (McDonald 2006), and inpatient hospitalization has only occurred in the case of life-threatening self-caused wounds, acute psychosis or suicidal intention (Favazza 1998).

6.2.6 Reflection on the concept of self-mutilation among Finnish adolescents

According to this study, self-mutilation among Finnish adolescents is a multifaceted and perhaps also a confusing phenomenon because of its many particular features. In real life, beliefs have a stronger impact than real facts on peoples' perceptions of self-mutilation, and therefore also on attitudes towards adolescents who self-mutilate. The realisation that self-mutilation among adolescents is both a familiar and an unknown phenomenon at the same time tells a great deal about the lack of knowledge of self-mutilation among people in general. This means that the level of knowledge of self-mutilation varies and it would therefore be very important to recognize those who do not have factual knowledge of self-mutilation as a phenomenon and tell them about it.

In addition, reflection on the finding that adolescents have a range of views on self-mutilation from it being a trendy disease to one that is far from trendy

challenges us to rethink the limits of normal and abnormal. If we see self-mutilation as a part of an adolescent's life or we consider it is as something like having tattoos, we may be in danger of losing our conceptions of reality. This study is a good beginning in examining the concept of self-mutilation among Finnish adolescents. However**,** because of the multifaceted appearance of this phenomenon, further research considering self-mutilation in Finland is needed. As the multifaceted characteristics of self-mutilation and sequels at the community level pointed out, a lack of awareness of self-mutilation also exists among healthcare staff. This means that knowledge concerning self-mutilation has to be included in professional education in social and health care.

6.3 Concept of an adolescent who self-mutilates

The definition of an adolescent who self-mutilates included the concept of a female (see also Murray 2005, Laukkanen et al. 2009) who looks great; a girl who is conscientious and takes care of her significant others if they are in trouble or in any kind of difficulty. These positive characteristics have not previously been mentioned in the literature. Together with the concept that the female adolescent is hiding her real feelings, there may be the reasons why an adolescent becomes mistreated by others because of her self-mutilation. Internally, she is very sensitive, having a low self-esteem (see also Derouin & Bravender 2004); she considers herself inferior to others. She feels lonely and ashamed of her self-mutilation. According to this definition, self-mutilation and factors contributing to it cannot be observed without a real interaction with the adolescent. If nobody recognizes self-mutilation or tries to find out what is going on by real interaction with the adolescent who self-mutilates, then she will be left alone with her inferiority hidden behind her appearance. And when she looks great and grown-up, others cannot imagine how lonely or how inferior compared to others she really feels. Although this definition made, self-mutilation is mainly a phenomenon of adolescent girls (see also Laukkanen et al.2009) but also adolescent boys self-mutilate (Hintikka et al. 2009). Many of these characteristics describing an adolescent who self-mutilates might be suitable for boys too.

6.4 The concept of help for adolescent self-mutilation

The concept of help included all kinds of help and nursing care for an adolescent who self-mutilates provided by the adolescent her/himself and other helpers. Helpers included all persons who can be of help and were described by the informants in their own words. Helping in this context referred to the help and care provided by persons other than healthcare personnel, while nursing care included care provided by healthcare personnel.

6.4.1 Helpers

According to the participants, “any person who knows about self-mutilation can be a helper.” This sentence told how the responsibility concerning help for self-mutilation should be shared. There were no limitations according to whether these persons were healthcare professionals or not. The detailed demands towards helpers differed depending on whether the helpers were peers, parents, unknown adults, social or healthcare personnel or teachers, but the core of helping was the same.

6.4.2 Helping

Help from other people than healthcare personnel consisted of three categories: self-help by adolescents, another as a helper, i.e. the existence of safe and trusting human relationship with someone as a help, and society as a source of help. Each of these elements is needed to achieve a good outcome from intervention.

Adolescent self-help. A considerable amount of new knowledge emerged concerning self-help by self-mutilating adolescents. Adolescent self-help was based on their factual knowledge of self-mutilation as a phenomenon and help for it. This was needed before an adolescent who self-mutilates could become

aware that she/he needed help. The existence of a caring environment, including all kinds of support from significant others, was needed in seeking help. Previous literature has pointed out that an adolescent who self-mutilates is often unable or unwilling to ask for or verbally seek help (McLane 1996, Isacsson & Rich 2001, Derouin & Bravender 2004). This study provides a possible explanation for this inability or unwillingness to seek help; if an adolescent does not know the facts of self-mutilation and where she can get help from, help-seeking will be at very low level. In addition, there is variation in both the level of the caring attitude in environments where adolescents live and support from significant others.

Adolescent self-help also included a large range of individual activities, both constructive and destructive, that were done alone to keep thoughts of self-mutilation under control. These activities highlighted that discussion alone is not the only way of keeping thoughts of self-mutilation under control, but discussion is a way to handle factors contributing to self-mutilation. As reported previously (McLane 1996, Skegg 2005), expressing the need for help explicitly or implicitly to others, including self-mutilation itself, encompassed a large variety of signs and activities that might be recognized by significant others and other persons. Recognition of these signs is only possible if the environment is caring.

Another as a helper: the existence of a safe and trusting human relationship with someone as a source of help. These human relationships were relationships with adults and with age-mates. Adults as helpers included parents, adult siblings and school personnel.

Parents. Parents were described as the principal helpers, but their abilities were limited because they did not have factual knowledge of self-mutilation (also Mc Donald et al. 2007, Oldshaw et al. 2008) or how and where to get help for it. In addition, someone in the family may have a previous history of self-mutilation, and this might prevent them from interfering in their child's self-mutilation. The main content of help was being an authentic, supporting parent (also Yip 2005)

who has factual knowledge of self-mutilation as a phenomenon. The content of parenthood included knowledge of the development from childhood to adulthood. In addition, the content of help provided by parents included support and acute help when needed by society (also Oldershaw et al. 2008), which appeared to be inadequate.

Adult siblings. A new finding in this study was that adult siblings may also be helpers for adolescents who self mutilate. Adult siblings as helpers were described as listeners and persons with whom an adolescent could discuss self-mutilation and associated factors. Discussion with an adult sibling was found to be easier than with the parents.

School personnel. The significance of the expected role of school personnel in helping emerged as a new finding, being based in the notion that it was easier to perceive self-mutilation at school than at home, because adolescents spent a large amount of time there. According to the participants, helping consisted of preventing self-mutilation and interfering in it (also White et al. 2002), but the abilities of school personnel were seen as limited because of their lack of factual knowledge of self-mutilation as a phenomenon (see also Carlson et al. 2005) and help for it. This might have caused difficulties among school personnel in discussing self-mutilation with adolescents and perhaps affected co-operation with parents. Prevention of self-mutilation did not take place, but self-mutilation should have been recognized and responded to by an authentic caring attitude in all school practices, particularly when the parents and family could not help.

Interfering in self-mutilation on an individual level can occur by noticing and asking about it. At the community level, interfering in self-mutilation can include telling about self-mutilation as a phenomenon to parents. However, this can only be possible once school personnel themselves have received information about self-mutilation as a phenomenon in order to understand it (Moyer & Nelson 2007). Furthermore, the lack of awareness of the demands of society on

parents, for example work tasks taking more time than earlier, and the lack of knowledge of the growing number of psychic problems among adolescents were described factors limiting the ability of school personnel to help.

Age-mates. Age-mates could be helpers simply through the existence, by intervening in self-mutilation, as well as by providing all kinds of support and authentic care. On the other hand, the influence of age-mates as a source of traumatic experiences for at least some adolescents (also Yip 2005, Puskar et al. 2006) is a claim that might be worth noting.

Society as a source of help. The role of society as a source of help was two-fold: firstly through prevention, including enabling early and practical intervention for all kinds of adolescent problems, and secondly by enabling support and acute help for parents and the whole family of an adolescent who self-mutilates when needed (see also Yip 2005). Unfortunately, according to the participants, society could not fulfil these expectations. One reason might be the lack of factual knowledge concerning self-mutilation, and another reason might be that the violent act of an adolescent who self-mutilates does not threaten the well-being of others.

6.4.3 Nursing care

Nursing care referred in this context to care provided by healthcare personnel. Nursing care included four categories: the basis of care, aims of care, content of care in relation to an adolescent and content of care in helping the parents and the whole family. These factors constructed the content of good care, including care received and care wished for.

Basis of care. The basis of care included a professional, genuine caring attitude, professional skills that include knowledge of self-mutilation as a phenomenon and pertinent, explicit and realistic co-operation with an adolescent and with the whole family. All these factors that constructed the

basis of care require knowledge of self-mutilation as a phenomenon and were considered by the participants partly to be lacking (see Table 14). According to Cooper and Glasper (2001), belief systems considering self-harm have an effect on nurses' practices in relation to child and adolescent patients. In conclusion, there is a special need for education among all health and social care personnel who work with persons who self-mutilate (Mc Donald 2006, Allen 2007). Table 14 presents detailed factors that should include a professional caring attitude towards any patient if the core of care is to alleviate human suffering (Eriksson 1992), as it should be. However, as Toivanen (2009) recently suggested, caring can cause unnecessary suffering due to the unprofessional attitudes of professionals.

Aims of care. The aims of care included soothing the situation, avoiding extra traumatization, providing and keeping up hope and enabling change. These aims can be achieved after gaining an understanding and knowledge of self-mutilation. However, these aims are common in clinical nursing and can be achieved by means of a professional, genuine caring attitude.

Content of care in relation to an adolescent. The content of care in relation to an adolescent was dived into three categories: the emotional level of care, concrete acts of care and therapeutic discussion. The detailed content of each category can be used as guidelines for nursing practice. For example, the emotional level of care describes the emotions that are needed in caring for an adolescent who self-mutilates and, in addition, emotions with which a nurse may have to struggle when caring for an adolescent who self-mutilates (Woldorf 2005). Concrete acts of care are acts that can be included in the care of an adolescent who self-mutilates, not all of them but the acts that are needed. The category of therapeutic discussion lists important acts and topics to discuss with an adolescent who self-mutilates (Woldorf 2005).

Content of care in helping the parents and the whole family. The content of care in helping the parents and the whole family included acute therapeutic discussion, a possibility to get acute support from other parents who have had

the same experiences of their child's self-mutilation, and acute concrete acts such as organizing a supporting family, as well as other official support as a substitute for personal support and these aspects have also been reported by Yip (2005). It is very important to help the whole family when one member of it is suffering and in need of acute care. In addition, the importance is more significant when the one in need of acute care is a child or an adolescent.

6.4.4 Reflection on the concept of help for adolescent self-mutilation

According to the participants, anyone knowing about self-mutilation can be a helper. This can be interpreted as meaning that help means caring. It can be seen as everyone's internal ability and desire to take care others. According to Eriksson (2002), care is the core of caring. Caring is more than nursing, because it is something primordial and natural that simply exists and is not dependent on a person's profession (see also Lavoie et al. 2006). Caring science is basically humanistic in nature, with its leading idea of caring and the idea of love and compassion. In caring science, the basic question that is foremost in the search for knowledge is "what". This means, for example, what is help? (Eriksson 2002.)

Help includes helping and nursing care. Helping consists of a caring attitude and all the activities carried out by adolescent themselves or others that can be of help in preventing or ending their self-mutilating. Nursing care includes a professional caring attitude and skills that have been taught and learned in professional education, in addition to the existing natural and primordial desire to take care of others (Eriksson 2002). Learning to alleviate suffering is one of the aims in clinical nursing as a part of professional competence (Curriculum of Registered Nurse, Curriculum of Vocational Qualification in Social and Health Care; practical nurse), and the alleviation of suffering was also suggested by Eriksson (1992) to be the core of care.

The lack of a professional caring attitude and the lack of professional skills in caring for adolescents who self-mutilate are very regrettable. When caring is something primordial and natural, why it is not largely found among professional educated nurses if there are persons who can be of help without a professional education? Herdman (2004) suggested that in nursing there has also been a separation of emotion from action, and in addition, nurses have negative attitudes towards disadvantaged groups such as suicidal persons. According to Fletcher (2000), caring is unimportant or subordinate in nursing when technical management seems to be workable. She warned us not to believe that professionalization itself guarantees care, and suggested that nurses need re-education to care. (Fletcher 2000.) In addition, Toivanen (2009) recently suggested how nurses and nursing can cause unnecessary suffering among all patients. Nursing as a concept denotes that it is a question of a professional touch. It creates a demand for the responsibility of an expert, and all the specialized knowledge produced in nursing science should therefore be added to the dimensions of care: the moral obligation, the relation with the other, the feeling of affection and the interventions (Lavoie et al. 2006).

Help for an adolescent who self-mutilates can also be provided by an uneducated person who really cares and is authentically present (Lindström et al. 2006), and who has enough factual information concerning self-mutilation as a phenomenon. Helping includes interfering and, after the first step, more long-term help will be possible. Knowing and caring can together mean interfering, and this will be of help. Long-term help such as a therapeutic relationship with a nurse in inpatient care or outpatient care also includes other elements, depending on the helping organization.

6.5 Conclusions

1. Self-mutilation comprises all kinds of destructive acts towards one's own skin, such as scratching, cutting, burning or self-injuring, alone or together with

someone else, involving all parts of one's body excluding the head and back, using any tool that happens to be available and that leaves a mark or a bleeding wound or wounds. Self-mutilation can also be used as way to commit suicide. Self-mutilation is a multifaceted phenomenon having a considerable range of characteristics.

2. The factors contributing to self-mutilation, the purposes of self-mutilation and the sequels of self-mutilation are associated with self-mutilation. The factors contributing to self-mutilation can be divided into three levels: the level of the adolescent, of the family community and of society. The purposes of self-mutilation include purposes relating to oneself and relating to others. The sequels of self-mutilation can be divided into sequels at the individual level for the adolescent and sequels at the level of the community.

3. An adolescent who self-mutilates looks externally good and is conscientious and takes care of significant others, especially if they are in trouble or in any kind of difficulty. However, internally she/he is very sensitive, having a low self-esteem: she/he considers her/himself inferior to others. She/he feels lonely and is ashamed of her/his self-mutilation. In addition, she/he is the one who will become mistreated by others because of her/his self-mutilation.

4. Help includes all kinds of help and nursing care for an adolescent who self-mutilates provided by the adolescent herself and by other people. Anyone who knows about self-mutilation can be of help. Help consists of knowing, caring and interfering.

6.6 Implications

6.6.1 Nursing practice

This practice theory of helping adolescents who self-mutilate provides nurses with practical guidelines for helping adolescents. In addition, knowledge of

adolescent self-mutilation as a phenomenon and help for it has been broadly organized into this theory. The phenomenon of self-mutilation has been approached from different viewpoints and has been defined in our culture, as Clarke and Whittaker (1998) stated that self-mutilation should be seen and known as a culturally defined phenomenon. In addition, when using this theory in practice the context and the state in society have to be taken into account.

Factors contributing to self-mutilation have been described at individual, community and society levels. At the individual and community level, nurses can prevent self-mutilation by promoting the mental health of an adolescent and also the mental health and wellbeing of the whole family. At the society level, nurses can and should influence the structure of health and social care organizations, for example by taking part in politics and writing to newspapers.

The purposes of self-mutilation have been described in relation to adolescents themselves and in relation to other individuals. These purposes include a cry for help by an adolescent, who may feel helpless despite appearing to feel fine. This means that in nursing practice we have to allow more time in clinical work for caring and acting as a voice for vulnerable and suffering adolescents. For example, school nurses need more knowledge of self-mutilation and possibilities to discuss with pupils or students.

For nursing practices, the following guidelines can be provided:

1. Find out about and acquire factual knowledge of self-mutilation as a phenomenon.
2. Face individually every adolescent who self-mutilates: there is no stereotypical group of “self-mutilators”.
3. Find out an adolescent’s individual situation-specific antecedences, purposes and sequels for self-mutilation. In addition, ask about methods of self-mutilation and where she or he has self-mutilated.

4. Nursing care consists of a caring attitude and professional skills, including factual knowledge of self-mutilation and interfering by asking about an adolescent's and her/his family's situation.
5. Remember to take care of the significant others, such as family members.
6. Remember to take care of yourself as a nurse by discussing self-mutilation with your colleagues and use clinical supervision to develop your professional skills.

6.6.2 Nursing science: research and theory

This theory adds to our understanding of the phenomenon of self-mutilation and organizes knowledge on the phenomenon. The produced knowledge can be used in clinical mental health nursing. Research is very important for all nursing practices, particularly on unstudied and relevant topics. This study can be seen as a foundation for deeper research on self-mutilation. More research is needed, for example, on the viewpoint of siblings. In addition, it would be very important to know male adolescents viewpoint on help for self-mutilation. Furthermore, it would be important to know what school personnel think about self-mutilation and help for it. Moreover, it would be very important to determine what would happen if an adolescent who self-mutilates does not receive help from others; how would she or he be able to end self-mutilation completely**,** or would she or he? What consequences might self-mutilation in adolescence have during ones' life? For example, what are the consequences for education, getting a job or attending health services? In addition, does self-mutilation in adolescence have an influence on ones' ability to be a parent? In addition, the experiences of care and help of those adults who have self-mutilated as adolescents or continue to self-mutilate should also be investigated.

This practice theory of help for adolescents who self-mutilate is the first theory to produce definitions of the phenomenon of self-mutilation, of an adolescent

who self-mutilates and of help for adolescents who self-mutilate. In addition, these definitions have been inductively constructed based on participants' descriptions. This practice theory could be useful in the current socio-political situation, but it will need to be developed further once the socio-political situation changes, because a situation-specific theory is limited to the context in which it is produced (Im 2005).

The findings of all the original studies including adolescent's descriptions of self-mutilation (Laukkanen et al. 2004) can also form a basis for constructing questionnaires for further quantitative research.

6.6.3 Nursing education

This study might induce the question of why adolescents and their parents feel that they are not heard. Is there something that can be done otherwise in education, for example paying more attention to learning basic nursing skills such as listening and hearing at different levels and forming real co-operation with families and parents?

Persons who self-harm are often encountered in clinical nursing, so self-harm with its many forms and especially self-mutilation as a phenomenon and help for it should be taught at every level of professional nursing education**.** It might be important to be a part of basic nursing education, and is also suitable for supplementary education. The content might include basic information on self-mutilation as a phenomenon, open reflection on experiences with others and learning to process one's own emotions. Furthermore, the places where self-mutilating adolescents live and can get professional or non-professional help might be good to be named.

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Appendix 1. The advertisement about the study published in magazines targeting adolescents, on magazine websites and on the researchers' own website aimed at adolescents who self-mutilate.

Hei !

Olen psykiatriaan erikoistunut sairaanhoitaja Marja-Liisa Rissanen ja opiskelen nyt Kuopion yliopistossa terveystieteiden opettajaksi. Teen graduani varten tutkimusta nuorten itsensä viiltelystä tai polttamisesta ja tarvitsen siinä Sinun apuasi. Jos Sinulla on omakohtaista kokemusta itsesi viiltelystä tai polttamisesta, kertoisitko siitä minulle omin sanoin kirjeen tai muun kirjoitelman muodossa. Voit kirjoittaa nimettömänä, mutta liitäthän mukaan tiedon sukupuolestasi ja iästäsi. Saamani kuvaukset luen vain minä. Tutkimustuloksia hyödynnetään itseään viiltäneiden tai polttaneiden nuorten hoidon kehittämisessä ja hoitotyön opettamisessa. Postitathan kuvauksesi alla olevaan osoitteeseen, voit käyttää myös sähköpostia. Kiitos!

Marja-Liisa Rissanen
Kuopion yliopisto
Hoitotieteen laitos
PL 1627
70211 KUOPIO

mlrissan@hytti.uku.fi

Appendix 2. The letter of invitation concerning the study focusing on adolescents' conceptions and experiences of help.

Hyvä nuori,

Olen Marja-Liisa Rissanen, sairaanhoitaja. Olen työssäni kohdannut ja hoitanut itseään viiltäneitä nuoria. Minulla on myös tutkijan koulutus ja teen väitöskirjatutkimusta itseään viiltävien (tai itseään viiltäneiden) nuorten hoitamisesta ja tarvitsen siinä Sinun apuasi.

Olet osallistunut "Nuorten psyykkinen hyvinvointi ja siihen yhteydessä olevat tekijät" -tutkimuksen ensimmäiseen vaiheeseen syksyllä 2004 tai alkuvuodesta 2005. Olen ollut tässä tutkimuksessa mukana toteuttamassa sitä luokissa tai kertonut siitä opettajille, jotka ovat sitten kyselyn kouluilla toteuttaneet. Olen mukana tutkimuksen teossa myös siksi, että olen sairaanhoitajana kohdannut itseään viiltäneitä nuoria ja haluaisin kehittää heidän hoitoaan.

Kyselyymme vastasi todella paljon nuoria. Olen käynyt kaikkien vastanneiden nuorten kyselylomakkeet läpi katsoen ketkä ovat vastanneet kyllä itsensä viiltämistä koskevaan kysymykseen. Myönteisesti vastanneista olen valinnut sellaisia nuoria, joilla on kokemusta toiselta saadusta avusta ja tuesta. Olet yksi heistä ja toivoisin, että tulisit kertomaan minulle kokemuksistasi saamastasi avusta. Esimerkiksi; mikä auttoi vai auttoiko, keneltä olisit apua halunnut, mitä olisit toivonut ja mitä itse asiassa ajattelet avun tarpeellisuudesta?

Pyydän sinua siis tulemaan haastatteluun. Haastattelu on luottamuksellinen ja minua koskee pysyvä salassapitovelvollisuus. Haastattelu nauhoitetaan ja saat sen luettavaksesi, mikäli niin haluat, kunhan se on puhtaaksi kirjoitettu. Haastatteluaineisto on nimetöntä ja nauhat hävitetään tutkimuksen valmistuttua.

Haastattelusi on päivänä kuuta 2005 kello Sihti-hankkeen tiloissa osoitteessa Vuorikatu 34, 2. kerros, huoneisto 4. Sinun kannattaa varata haastattelua varten aikaa tuntia.

Mikäli haluat lisätietoa tutkimushaastattelusta, niin ota yhteyttä p XXXXXXX

Ystävällisin terveisin

Marja-Liisa Rissanen
Tutkijasairaanhoitaja, KYS

Appendix 3. Adolescent's informed consent to participate in the study.

NUOREN TIETOISEN SUOSTUMUKSEN LOMAKE

Olen saanut tutkimuksesta riittävästi tietoa ja haluan osallistua TtM Marja-Liisa Rissasen itseään viiltävän nuoren hoitoa koskevaan tutkimukseen sekä antaa äänitetyn tutkimusaineiston tutkijan käyttöön. Tutkija voi tarvittaessa ottaa minuun uudelleen yhteyttä asioiden tarkistamista varten. Olen saanut myös tutkijan yhteystiedot.

Päivämäärä:

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tiedonantajan nimi

Appendix 4. Adolescent's informed consent for inviting parents to participate in the study focusing on parents' conceptions of self-mutilation and help for it.

LUPA

Annan Marja-Liisa Rissaselle luvan ottaa yhteyttä _____

heidän / hänen pyytämiseksi osallistumaan vanhemmille kohdennettuun

haastattelututkimukseen. Vanhempani tietävät että olen vahingoittanut itseäni viiltämällä.

Päivämäärä:

_____

nuoren allekirjoitus

Appendix 5. The advertisement aimed at parents concerning the study focusing on parents' conceptions of self-mutilation and help for it.

Hyvä vanhempi,

Peruskoululaisen ja nuoren opiskelijan elämä on muutoksen aikaa. Nuori itsenäistyy ja etsii omaa elämäntapaansa ja viettää entistä enemmän aikaa kavereidensa kanssa. Aikuisten maailmaan liittyvät asiat kiinnostavat, mutta saattavat aiheuttaa myös epävarmuutta ja ahdistusta. Nuoret omaksuvat erilaisia keinoja, miten selvitä vaikeiden olojen kanssa. Osa näistä keinoista on rakentavia ja kehitystä eteenpäin vieviä, osa taas saattaa vahingoittaa nuorta itseään ja vaarantaa nuoren terveyttä.

Olette antaneet suostumuksenne siihen, että nuorenne osallistuu tähän tutkimukseen, jonka kohderyhmänä ovat Kuopiossa tutkimushetkellä opiskelevat 13–17-vuotiaat nuoret. Kuten muistanette, tutkimus liittyy tieteelliseen jatkokoulutukseen ja tutkimuksen johtajana toimii professori Eila Laukkanen Kuopion yliopistollisen sairaalan nuorisopsykiatrian poliklinikalta. Tutkimuksen tarkoituksena on selvittää, miten kuopiolaiset nuoret tällä hetkellä voivat, ja miten he selviytyvät nuoruusikään liittyvien muutosten ja niihin mahdollisesti liittyvien ahdistusoireiden kanssa. Pyrkimyksenä on myös kartoittaa mahdollista päihteiden käyttöä sekä itseä vaarantavaa käytöstä, kuten viiltelyä tai muunlaista itsensä vahingoittamiskäyttäytymistä.

Ensimmäisessä vaiheessa nuori täytti kyselylomakkeen, jonka kysymykset liittyvät koulunkäyntiin, harrastuksiin, tunteisiin, mahdolliseen viiltelyyn tai muuhun itsensä vahingoittamiseen sekä päihteisiin. Osa nuorista on kutsuttu myöhemmin haastatteluun, jossa kysymyksiä on tarkennettu. Teidän nuorenne kuuluu tähän joukkoon. Nuorenne on antanut suostumuksen siihen, että voin lähettää tämän kirjeen hänen mukanaan teille, ja pyytää teitä osallistumaan jatkotutkimukseen. Jatkotutkimus on osa allekirjoittaneen väitöskirjatutkimusta, jonka tavoitteena on muodostaa käytännön teoria itseään viiltävän nuoren hoitamisesta. Tutkimuksessa noudatetaan ehdotonta vaitiolovelvollisuutta. Tutkimukselle on haettu Kuopion yliopiston ja Kuopion yliopistosairaalan tutkimuseettisen toimikunnan hyväksyntä.

Nuorenne on kertonut minulle, että tiedätte hänen itsensä viiltelystään ja että voin pyytää teitä haastatteluun, mikäli te siihen suostutte. Tarkoituksenani on keskustella kanssanne nuorenne tilanteesta, ja siitä mitä ajatuksia tai tunteita se on teissä herättänyt. Olisi tärkeää kuulla myös ajatuksianne nuorten avunsaantimahdollisuuksista ja mahdollisista kokemuksistanne niistä. Nuorenne kanssa on sovittu, että n. viikon sisällä soitan teille ja sovin mahdollisesti haastatteluajasta kanssanne, mikäli te suostutte osallistumaan tähän jatkotutkimukseen.

Yhteistyöstä kiittäen

Marja-Liisa Rissanen
Terveystieteiden maisteri
Tutkijasairaanhoitaja, KYS

Eila Laukkanen
Nuorisopsykiatrian
ylilääkäri, KYS

Appendix 6. Parent's informed consent to participate in the study.

VANHEMMAN / VANHEMPIEN TIETOISEN SUOSTUMUKSEN LOMAKE

Olen saanut /olemme saaneet tutkimuksesta riittävästi tietoa ja haluan/haluamme osallistua TtM Marja-Liisa Rissasen itseään viiltävän nuoren hoitoa koskevaan tutkimukseen sekä antaa äänitetyn tutkimusaineiston tutkijan käyttöön. Tutkija voi tarvittaessa ottaa minuun / meihin uudelleen yhteyttä asioiden tarkistamista varten. Olen saanut / olemme saaneet myös tutkijan yhteystiedot.

Kuopiossa / 2005

_____

Appendix 7. The advertisement about the study aimed at nurses caring for adolescents who self-mutilate.

Hei Sinä nuoria hoitava hoitaja! 27.1.2005

Olen Marja-Liisa Rissanen, sairaanhoitaja ja TtM. Olen tekemässä tutkimusta itseään viiltävän tai itseään viiltäneen nuorten hoitamisesta ja tarvitsen siinä Sinun apuasi. Olen saanut luvan tutkimuksen toteuttamiseen tutkimuseettiseltä toimikunnalta.

Tiedot nuoren itsensä viiltelyn esiintyvyydestä vaihtelevat kansainvälisesti 2-14 % (Hirvonen ym. 2004). Suomalainen nuorten itsensä viiltämistä ja mm. sen esiintyvyyttä koskeva tutkimus on tekeillä ja alustavasti voidaan sanoa, että itsensä viiltämisen esiintyvyys on lähempänä kansainvälisten tutkimusten ylä- kuin alarajaa. Voidaksemme hoitaa näitä nuoria parhaalla mahdollisella tavalla tarvitaan tietoa vallitsevista hoitokäytännöistä sekä siitä, miten itsensä viiltely ilmiönä ymmärretään hoitohenkilöstön keskuudessa. Mikäli olet kohdannut ja/tai hoitanut itseään viiltävää tai itseään viiltänyttä nuorta, olet tervetullut mukaan tähän tutkimukseen!

Tiedon keruu toteutuu ryhmähaastattelujen avulla siten, että ryhmä muodostuu 3-4 hoitajasta. Haastattelut nauhoitetaan, ja sitä varten tarvitsen Sinulta kirjallisen suostumuksen. Käytän analyysivaiheessa koodinimiä, joten nimesi ei tule paljastumaan kenellekään muille kuin ryhmän jäsenille ja minulle. Kukin ryhmä kokoontuu 1-3 kertaa. Tarkemmat paikat ja ajat sovitaan sitten kun ryhmien kokoonpanot ovat selvillä.

Käytän ryhmähaastattelussa Kirkevoldin (1993) ajattelua haastatteluteemojen taustana. Teemat ovat seuraavat:

- Miten sinä hoitajana määrittelet itsensä viiltämisen?
- Mistä itsensä viiltelyssä sinun mielestäsi on kysymys?
- Mitkä arvot ohjaavat toimintojasi ja hoitomuotojen valintoja?
- Mihin sinä hoidolla pyrit?
- Miten sinä hoitajana määrität hoidon kontekstin; missä hoidetaan, kuka hoitaa ja miten?

(Kirkevold 1993.)

Toivon, että otat minuun yhteyttä mahdollisimman pian.

Ystävällisin terveisin

Marja-Liisa Rissanen
Tutkija, sairaanhoitaja, terveystieteiden maisteri
KYS / Psykiatrian tutkimus- ja kehittämisyksikkö
Vuorikatu 34 A4
70100 KUOPIO

Appendix 8. Nurses' informed consent to participate in the study focusing on nurses caring for adolescents who self-mutilate.

HOITAJAN TIETOISEN SUOSTUMUKSEN LOMAKE

Olen saanut tutkimuksesta riittävästi tietoa ja haluan osallistua TtM Marja-Liisa Rissasen itseään viiltävän nuoren hoitoa koskevaan tutkimukseen sekä antaa äänitetyn tutkimusaineiston tutkijan käyttöön. Tutkija voi tarvittaessa ottaa minuun uudelleen yhteyttä asioiden tarkistamista varten. Olen saanut myös tutkijan yhteystiedot.

Päivämäärä:

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tiedonantajan nimi

Appendix 9. The advertisement about the study published in magazines targeted at health care professionals.

Hyvä nuorten parissa työskentelevä hoitaja!

Olen tutkijasairaanhoitaja Marja-Liisa Rissanen Kuopion yliopistollisesta sairaalasta. Teen väitöskirjatutkimusta itseään viiltävän tai itseään viiltäneen nuoren hoitamisesta ja tarvitsen siinä Sinun apuasi. Tutkimustani ohjaavat dosentti Jari Kylmä ja dosentti Eila Laukkanen.

Tiedot itsensä viiltelyn esiintyvyydestä vaihtelevat kansainvälisesti 2-14 % (Hirvonen ym. 2004). Vireillä olevan suomalaisen tutkimuksen mukaan voidaan todeta, että itsensä viiltämisen esiintyvyys on lähempänä kansainvälisten tutkimusten ylä- kun alarajaa. Voidaksemme hoitaa näitä nuoria parhaalla mahdollisella tavalla tarvitsemme tietoa nuorten itsensä viiltelystä sekä vallitsevista hoitokäytännöistä hoitajien näkökulmasta. Mikäli olet työssäsi hoitanut ja / tai kohdannut itseään viiltävää tai itseään viiltänyttä nuorta, olet tervetullut mukaan tähän tutkimukseen!

Pyydän Sinua kirjoittamaan minulle vapaamuotoisesti ja nimettömänä. Toivon, että kirjoitelmastasi löytyisi vastauksia seuraaviin kysymyksiin: Miten hoitajana määrittelet viiltämisen? Mistä itsensä viiltelyssä on mielestäsi kysymys? Miltä sinusta tuntuu kohdata/hoitaa itseään viiltänyttä nuorta? Mitkä arvot ohjaavat toimintojasi ja hoitomuotojen valintoja? Mitä konkreettisesti teet hoitotilanteessa? Mihin hoidolla pyrit? Miten määrität hoidon kontekstin eli missä hoidetaan, kuka hoitaa ja miten?

Mainitsethan myös sukupuolesi, koulutustaustasi, työkokemuksesi vuosina, kauanko olet hoitanut itseään viiltäneitä nuoria ja millaisessa yksikössä työskentelet. Lähetä minulle kirjoitelmasi joko postitse tai sähköisesti.

Mikäli haluat lisätietoja tutkimuksestani, niin ota yhteyttä. Vastaan mielelläni!

Ystävällisin terveisin ja kiittäen

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