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Reid Lantto

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DOCTORAL DISSERTATION

Doctoral dissertation for the degree of Doctor of Philosophy (PhD) at the Faculty of Medicine at Lund University to be publicly defended on the 16th of December at 09.00 in Agardhsalen, Clinical Research Center, Jan Waldenströms gata 35, Malmö, Sweden

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The parental experience of adolescent BAs was inherently relational, implying that recovery wasn't separate for the adolescent versus surrounding family members, but one mutual process. Family members related to involvement and responsibilities in a multitude of ways, where some were happy to remain on the sidelines or exclusively in supportive roles, mainly expressing gratitude that BA was available to adolescents. Others felt under-involved or altogether abandoned by CAP and forced to shoulder responsibilities that weren't theirs, which was perceived to violate adolescents' right to health.

The perspectives of human rights and relational recovery divorce from traditional understandings of psychiatry and recovery. This dissertation demonstrates the crucial potential of these frameworks to further improve the BA method and truly transform psychiatric care for people who self-harm.

Key words: Brief Admission by self-referral; self-harm; suicidal behaviour; crisis management; prevention; human rights; relational recovery; attitudes; family; healthcare providers

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MADE IN SWEDEN

To all the kids, adults, and families who might resonate with this.
To my past self and the loved ones in my present.

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Acknowledgements

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Abstract

People who self-harm have historically not had much say in their healthcare processes. When seeking psychiatric emergency care, people who self-harm have frequently been turned away, or admitted for lengthy hospitalisations that may aggravate self-harm. The attitudes of psychiatric clinicians toward people who self-harm are important to healthcare users' experience of care, affecting quality and access.

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The perspectives of human rights and relational recovery divorce from traditional understandings of psychiatry and recovery. This dissertation demonstrates the crucial potential of these frameworks to further improve the BA method and truly transform psychiatric care for people who self-harm.

Populärvetenskaplig sammanfattning

Personer som självskadar har historiskt sett inte haft så mycket att säga till om i sina egna vårdprocesser. När de har sökt psykiatrisk vård akut, ofta för att de upplevt akut svåra tankar och impulser att skada sig själva och kanske har planerat göra suicidförsök, har personer som självskadar ofta blivit hemskickade utan hjälp, eller så har de blivit inlagda för långvarig psykiatrisk vård som faktiskt kan förvärra självskadebeteendet. Psykiatripersonalens attityder mot personer som självskadar kan spela stor roll för hur vårdanvändare som självskadar upplever vården. Det kan påverka såväl vårdens kvalitet som hur tillgänglig den är.

Brukarstyrda inläggningar (BI) är en metod inom den psykiatriska heldygnsvården som syftar till att förebygga självskada genom att ge vårdanvändare makten att själva bestämma över sina inläggningar, så att de kan lägga in sig innan det blir kris. Inläggningar med BI är korta och gjorda för att störa så lite som möjligt i användarens vardagsliv. Personer på BI får komma och gå som de vill från den psykiatriska avdelningen medan de är inlagda, så att en till exempel kan hålla kontakten med vänner och familj, gå på fritidsaktiviteter eller fortsätta gå till skolan eller jobbet medan en är inlagd. BI började erbjudas för vuxna i Sverige år 2015, men sedan dess har metoden också anpassats och börjat erbjudas för tonåringar och deras familjer inom barn- och ungdomspsykiatrins, Bups, heldygnsvård. I Skåne har BI erbjudits på Bup sedan 2018.

Den här avhandlingen utforskar psykiatripersonals attityder gentemot personer som självskadar och familjeperspektiv på BI inom Bup. Avhandlingen består av fyra studier: en som validerar ett frågeformulär om vårdpersonals attityder, en som tittar på resultaten från det här frågeformuläret och vilka faktorer som verkar hänga samman med psykiatripersonalens attityder till personer som självskadar, en som utforskar förälderns levda erfarenhet av att ens tonåring lägger in sig med BI, och en som utforskar hur vuxna familjemedlemmar pratar om inkludering och ansvar i relation till BI på Bup. Studiernas resultat tolkas och diskuteras med hjälp av teori om mänskliga rättigheter och relationell återhämtning.

Frågeformuläret om attityder, SHAS-SR, visade sig vara giltigt och trovärdigt att använda som självskattningsformulär för svensk psykiatripersonal. Den slutliga versionen innehöll dock bara ett fåtal frågor som skulle kunna tolkas beskriva självskada och återhämtning som relationella fenomen. Formuläret innehöll till slut inga uttalanden alls om att vårdanvändare som självskadade hade rättigheter. De flesta bland psykiatripersonalen besvarade formuläret på ett sympatiskt sätt, men en mindre grupp svarade på sätt som antydde att de var något motvilligt inställda till personer som självskadar. Några ytterligare minoriteter hade svarsmönster som var mer dömande eller fientliga.

Förälderns upplevelse av tonåringens inläggningar med BI var relationell i sig, det vill säga att den berodde på vad som hände mellan föräldern, tonåringen som var

inlagd, resten av familjen, och vårdpersonalen som arbetade med BI. Resultaten antydde att återhämtning inte var ett separat fenomen för tonåringen respektive övriga familjemedlemmar, utan återhämtning var en enda gemensam process. Familjemedlemmar relaterade till inkludering och ansvar på flera olika sätt, där en del var nöjda med att inte ha så mycket med BI att göra och uttryckte främst att de var tacksamma för att BI fanns tillgängligt för tonåringen. Andra kände sig inte tillräckligt inkluderade; vissa kände sig till och med övergivna av Bup och tvingade att ta ansvar för sådant som inte borde ligga på dem egentligen. Sådana erfarenheter kan anses bryta mot tonåringarnas mänskliga rättigheter, framför allt rätten till bästa möjliga hälsa.

Perspektiven på mänskliga rättigheter och relationell återhämtning skiljer sig från traditionella, kliniska idéer om vad psykiatri, sjukdom och återhämtning betyder. På så sätt har de här perspektiven en unik och avgörande potential att fortsätta förbättra BI-metoden, och att verkligen transformera psykiatrin för personer som självskadar.

List of papers

Paper I

Lantto, R., Jungert, T., Nilsson, M., Probert-Lindström, S., & Westling, S. (2020). Revising the self-harm antipathy scale: validation among staff in psychiatric healthcare in Sweden. *Nordic Journal of Psychiatry*, *74*(6), 429–438. https://doi.org/10.1080/08039488.2020.1733657

Paper II

Lantto, R., Jungert, T., Lindström, S., Nilsson, M., & Westling, S. (2025). Profiling attitudes toward individuals who self-harm among mental health workers in Sweden: a cross-sectional study. *Issues in mental health nursing*, *46*(8), 782-791. https://doi.org/10.1080/01612840.2025.2506475

Paper III

Lantto, R., Lindkvist, R-M., Jungert, T., Westling, S. & Landgren, K. (2023). Receiving a gift and feeling robbed: a phenomenological study on parents' experiences of Brief Admissions for teenagers who self-harm at risk for suicide. *Child and Adolescent Psychiatry and Mental Health*, *17*(127). https://doi.org/10.1186/s13034-023-00675-y

Paper IV

Lantto, R., Landgren, K., Eberhard, S., Johansson, B. A., Rask, O., & Westling, S. (2025). Brief Admission by self-referral for adolescents who self-harm: discourses on involvement and responsibility among parents and other significant adults. *Child and Adolescent Psychiatry and Mental Health*, *19*(102). https://doi.org/10.1186/s13034-025-00948-8

Abbreviations

BA	Brief Admission by self-referral
BASRCT	Brief Admission Skåne Randomized Controlled Trial
BPD	Borderline Personality Disorder
BUCA	Brief User-Controlled Admission
CAP	Child and Adolescent Psychiatry
CBT	Cognitive Behavioural Therapy
DBT	Dialectical Behaviour Therapy
ERGT	Emotion Regulation Group Therapy
DSH	Deliberate Self-Harm
GPM	General (or Good) Psychiatric Management
MBT	Mentalisation-Based Therapy
NSSI	Non-Suicidal Self-Injury
OHCHR	United Nations Office of the High Commissioner on Human Rights
PCA	Patient-Controlled Admission
PIBA	Patient-Initiated Brief Admission
SA	Suicide Attempt
SHAS	Self-Harm Antipathy Scale
SHAS-SR	Self-Harm Antipathy Scale – Swedish Revised
SI	Suicidal Ideation
SIB	Self-Injurious Behaviour
SITB	Self-Injurious Thoughts and Behaviour
SRIT	Self-Referral to Inpatient Treatment
UDHR	United Nations Universal Declaration of Human Rights
UNCRC	United Nations Convention on the Rights of the Child
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organization
WHODAS	World Health Organization Disability Assessment Schedule

Chapter 1. Purpose, positionality, and philosophical underpinnings

> *Oh no, you're a psychologist.* (Clinical psychologist interviewing me in my capacity as loving supporter)

Purpose and structural statement

In this dissertation, I will synthesise a body of research on clinicians' attitudes toward people who self-harm, and family perspectives on Brief Admission by self-referral (BA) for adolescents who self-harm.

The four papers that make up the foundation of this dissertation have the following specific aims:

1. To revise and adapt the Self-Harm Antipathy Scale (SHAS) for use in Swedish healthcare settings and to evaluate the psychometric properties of this Swedish version (the SHAS-SR) on a sample of psychiatric workers (Paper I)
2. To examine psychiatric workers' responses across the SHAS-SR and explore the roles of various intrapersonal and contextual factors in predicting attitudes toward people who self-harm (Paper II)
3. To explore the lived experience of parents as their teenagers, who recurrently self-harm and experience suicidal thoughts, self-admit using BA (Paper III)
4. To explore how parents and other significant adults speak of their care involvement and responsibilities in relation to children's access to BA in child and adolescent psychiatry (CAP) in Sweden (Paper IV)

I will synthesise these papers using the overarching perspective of human rights as well as the specific theoretical framework of relational recovery. Human rights have direct implications for mental healthcare and psychiatry at large, and I would argue, especially for people who self-harm, who may become subject to legally mandated coercion in psychiatric settings. Relational recovery compels us to consider the

social context of healthcare users and their families, marrying into the human rights framework in going beyond individual-level pathology. These perspectives are seldom recognised or applied in psychiatry, and their combination fills a pressing void in the field of self-harm research.

In the rest of this chapter, I will explicate my positionality in writing this dissertation as well as the research philosophical underpinnings of this piece of work. In chapter 2, I will define what I mean by self-harm and further clarify the scope of this dissertation. Next, I will provide an overview of the field of self-harm in terms of my chosen theoretical frameworks (chapter 3). I will then contextualise the emergence of BA in Sweden and summarise the distinctive features of the method as well as the existing body of research on BA and other brief, user-controlled admissions (chapter 4). Against this backdrop, I will focus attention onto the body of research by my coauthors and myself, describing the methods used to conduct the four papers included in this dissertation (chapter 5), summarising their results in terms of my chosen theoretical frameworks (chapter 6), and discussing what we can learn from this, as well as the limitations of the current research (chapter 7).

Positionality: from where I come into research

I have been internally debating what I want to include in this section. I believe that reflecting on one's positionality is crucial to doing *any* form of research. One's transparency about it is a different question, as demands for personal self-disclosure could put socially marginalised people in a position of risking repercussions (Levitt, 2024). For this reason, I want to be clear that my intention with the following text is not to feed into an idea that self-disclosure is mandatory. I have carefully chosen, and omitted, many aspects of my social, personal, and professional experiences in this section. I don't wish to be read as prescriptive and I firmly believe that there are many other ways to demonstrate reflexivity, knowingness, and social awareness, beyond a positionality statement.

That being said, I want to acknowledge that my road into research in this field – and indeed, what made me want to become a clinical psychologist long before that – has been directly shaped by my own lived experience with self-harm and suicidal thoughts, and my life of knowing, loving, caring and connecting with others who also share those experiences.

My educational background is in psychology. At the time of writing, I have worked clinically for five years with children, adolescents, and their families, mainly focused on those affected by self-harm and suicidality, as well as trauma. Though, the crucial lessons of learning to calmly sit with people's hurt, remain unconditionally compassionate and empathetically engaged, and to keep seeing whole, complex human beings who need to prove themselves to no-one – those

lessons came from living, rather than my clinical training or research role. At times, I have felt that working in psychiatry and researching this field has made me more distant and prone to generalise about people, which makes me profoundly thankful that I have my lived experience to guide who and how I want to be.

What I want to say with this is that my own lived experience, and being close to others with similar experiences, is the inseparable bottom layer to any understanding I have of these issues. However, inhabiting multiple roles and knowledge bases does not always seem to be appreciated in the clinical nor academic realm, which is what I wanted to illustrate with the opening quote of this chapter.

The quote is from years ago, in a phone interview with a clinical psychologist doing a diagnostic assessment of someone dear to me, who was in regular contact with psychiatry at the time. The psychologist was interviewing me in my capacity as loving supporter of this person, with intimate knowledge of how they presented, felt, and acted in everyday life. 'Oh no' was literally her response upon learning that I, too, was a clinical psychologist. She then proceeded to question my descriptions whenever they did not fit with the diagnostic criteria she had in mind. 'Are you sure?', 'Could it be that…?' As I stood by my statements, the psychologist sighed and said that from the moment she learned I was a psychologist, she had known it would be difficult to get information out of me. I remember being baffled. Her response suggested that my inhabiting multiple knowledge bases was somehow inconvenient, getting in the way of her doing her job.

Over the years, I have had similar experiences on a number of occasions where I have gotten the sense that my experiential knowledge of self-harm inconvenienced fellow academics and clinicians in the field, begging the question: what am I getting in the way of? I believe that the slightly uneasy mood stemmed from a perceived threat to their epistemic authority and the superiority of their knowledge claims. Most of all, my presence from multiple knowledge bases threatened the status quo of the psychiatric system, making it that much harder to subscribe to coercive practices and paternalistic convictions of another's best interest (Hahn et al., 2024; Stastny et al., 2020; United Nations Human Rights Council, 2017; United Nations Human Rights Council, 2020).

These experiences did make me hesitant to disclose my experiential knowledge of self-harm in this dissertation. It didn't help that I am operating in a research field globally dominated by biomedical understandings and positivist/post-positivist values of objectivity, where lived experience is largely not recognised as a legitimate knowledge base or, if so, firmly subordinated to the position of the researcher-clinician coming at these issues 'from above' (Faulkner, 2017; Harding, 2015). I am delighted to see a growing body of research calling for lived experience to be valued as a legitimate knowledge base and for people with experiential knowledge to assume central roles in healthcare services and research (Faulkner, 2017; Friesen, 2022; Grim et al., 2022; Grim et al., 2019; Moran et al., 2024; Norton,

2023; Rose, 2017), recently backed up by the World Health Organization (WHO; 2025). Still, my impression of my current psychiatric research setting within a medical faculty is that the dual position of researcher with lived experience is still considered quite suspicious. I want to stress, though, that I have always perceived my experiential knowledge to be valued within my closest, multidisciplinary research team.

At this point, I feel it is highly relevant to point out some experiences I *don't* have. I have never personally been subjected to coercion in a healthcare setting. In fact, I have never been admitted to hospital, neither in somatic nor psychiatric settings. Coupled with the fact that I am white, able-bodied, middle-class, and that I've always been encouraged to study (though my closest bio-family never graduated high school), I have often had quite a lot of influence in healthcare interactions as a user or supporter of my loved ones. When clinicians would start to problematise self-harm, I would ask them to leave it alone, and they mostly did.

This highlights the important point that 'lived experience' can mean many things. In this dissertation, my blend of lived/personal, academic, and clinical perspectives varies depending on the specific topic. Where I lack experiential knowledge, or where it may be dated, I have tried to tap into the lived experiences among my loved ones and the greater communities. As such, I don't believe I fit neatly within the binary 'insider/outsider' perspectives in research (Gair, 2012).

Lastly, I want to address that the critical perspectives I apply in this dissertation also stem from my experiences with being a queer, non-binary trans person assigned female at birth. My own critical consciousness is very much a result of having lived, known and spoken out about these identities and related social injustices from early adolescence. Growing up in a queerphobic, transphobic bio-family who repeatedly asserted that I shouldn't expect to enjoy human rights has undoubtedly shaped my social awareness. Connecting with diverse communities, and living in today's global political climate, has defined my critical perspectives. These critical perspectives are inextricable from my clinical and academic perspectives and make up the central unifier of this dissertation.

Philosophical underpinnings: on axiology, ontology, epistemology, and methodology

All research projects are conducted on the basis of some underlying philosophical assumptions (whether or not the researcher recognises them) about reality, the role of the researcher, and how topics of interest should be studied.

Axiology is about the values that underpin the research process, how ethical issues should be addressed and what defines ethical conduct in research. Ontology is about

our perception of the nature of reality and what is true or real. Epistemology is about our relation to reality as knowers, what we believe we can know and what our role is as knowledge-producers. Methodology is the framework derived from our ontological and epistemological assumptions to clarify how research should be carried out (Mertens, 2007, 2017). Of note, methods are more concrete delineations of *what* to do, like specific instruction manuals describing certain procedures, while methodologies are intimately connected to the broader research-philosophical questions, grounded in certain values reminding us of the overarching plan, *how* things should be done and *why* we should do it in that way.

Though axiological, ontological and epistemological assumptions form the basis of researchers' methodological stances and precede choices of methods, for the sake of readability I will clarify my position on these matters in a backwards order.

Using multiple methods: recognising the merit of qualitative and quantitative methods

First, for this dissertation I have utilised both qualitative and quantitative methods. I recognise that there is merit to different approaches depending on the type of research question one seeks to answer, and that we can gain useful insights from combining qualitative and quantitative methods. Such an outlook may seem rather straightforward and uncontentious, though it is debated in academia. This is because qualitative and quantitative methods tend to be applied from very different philosophical positions.

With exceptions, quantitative methods are often applied based on realist/positivist ontological and epistemological assumptions: that a real world exists objectively 'out there', independently of human beings, and that the role of the researcher is to discover it. This perspective seeks to mimic the natural science approach, even when applied to social issues in psychiatry or psychology (Burr, 2015; Willig & Stainton-Rogers, 2017).

Conversely, qualitative methods tend to reject the (purely) realist stance, assuming to some extent that the reality we experience isn't fixed or universal but depends on context. One example is social constructionism which assumes that the way we understand reality is socially constructed, i.e. that we create meaning as human beings in social interactions, through language and culture, and this meaning is specific to certain settings and times. The role of the researcher is to (de)construct meaning out of people's experiences; that is, the researcher is actively shaping meaning and knowledge (Burr, 2015).

Phenomenology is another form of qualitative research, striving to uncover rich meanings in human experience to understand phenomena as they appear in our immediate lived experience. The researcher needs to explicate these phenomena, peel them down, if you will, to their essential meaning structure, allowing

phenomena to show themselves as they truly are. Phenomenology thus assumes there is some kind of truth about phenomena in the world, but each person perceives phenomena idiosyncratically (subjectively, individually). The role of the researcher is to move from idiosyncratic to nomothetic (generalised) understandings of phenomena (Churchill, 2022; Davidson, 2003; Englander & Morley, 2023).

These widely different qualitative and quantitative paradigms, with different views on reality, knowledge and research are indeed complicated and contentious to combine. Pragmatism has become a popularised stance in mixed methods research, proposing to reconcile paradigm trouble by taking the position that design decisions and knowledge claims should be based on practical value and contextual responsiveness – i.e. doing what works in a given situation (Creswell & Plano Clark, 2017; Hampson & McKinley, 2023).

However, pragmatism has been criticised for being convenient and consequential rather than philosophically and methodologically grounded, offering a watered-down middle position providing little guidance for researchers (Hampson & McKinley, 2023). Some have even suggested that pragmatism, if applied without careful reflection, may effectively reproduce positivism in disguise (Gobo, 2023).

My intention in this dissertation has not been to adopt pragmatism as a research paradigm. To be clear, my coauthors and I have not conducted a *mixed methods* project in the sense of integrating results from qualitative and quantitative methods within our published research articles. Rather, I am combining our use of *multiple methods* in this dissertation. Within the research team, we have based methodological and methods decisions on the specific research topics of interest, with an overarching interest in looking into social justice issues in psychiatry and the field of self-harm. Importantly, even as we employed quantitative methods in papers I and II, we didn't do so from a positivist understanding of reality. Rather, this dissertation has been guided by an overarching transformative aim, as well as a foundation in standpoint theory.

A transformative paradigm: research as a vehicle for social justice

Transformative research (Mertens, 2007, 2017) sets out to achieve social change. Power issues are both the focal points of research and are interrogated at every stage throughout the research process. The transformative research paradigm assumes that reality is multiple and socially constructed, and that societal values and power relations determine what realities should be targeted for social transformation. The researcher 'is a bit of a provocateur with overtones of humility […] who possesses a shared sense of responsibility' and whose role it is to '[recognize] inequalities and injustices in society and [strive] to challenge the status quo' (Mertens, 2007, p. 212). The researcher needs to be aware of power relations, respectful of culture, and mindful of building trust with the community members involved. The

transformative paradigm critically examines and (re)defines the ethical principles of beneficence, respect, and justice in terms of promoting human rights, respecting the cultural norms of the researched communities, and explicating how the research project can further social justice.

The researcher may utilise qualitative, quantitative, or mixed methods to explicate issues of power, discrimination, and oppression, though 'there should be an interactive link between the researcher and the participants in the definition of the problem' (Mertens, 2007, p. 216). Mertens (2007) further argues that mixed methods have a unique potential in transformative research, as qualitative methods can highlight the perspectives of marginalised communities on the impact of social injustice, which social justice issues need to be addressed, and possibly how, while quantitative methods can yield results that validate marginalised people's experiences and are important to other stakeholders as per the social justice agenda. Different types of data can be collected for different purposes; the key is to match these strategies to the needs of the communities implicated.

I have been guided by the transformative research paradigm in centralising power issues in this dissertation and exploring theoretical angles that I believe to be beneficial in furthering social justice and human rights in psychiatry, specifically as concerns people who self-harm.

Standpoint epistemology: marginalised experiences as a more complete knowledge base

Feminist standpoint theory (Haraway, 1988; Harding, 1992) is an epistemological position that scrutinises how power relations are involved in knowledge production, to decentre it. The theory essentially posits that people who are marginalised have a unique potential for more complete knowledge and understanding of the (social) world (Faulkner, 2017; Friesen, 2022).

According to standpoint theory, knowledge is socially situated (Haraway, 1988), i.e. shaped and limited by people's social conditions and the power relations that create and maintain them. Power relations enable and limit the experiences that are available to individuals and hence, what they are able to know. Power relations are also integral to what is held to be true in a society at large, as dominant social groups tend to lead the production of knowledge, establishing their values and ideas of reality as facts, culture, and social norms that we all tend to live by. People who are marginalised by such social norms and ideas have a unique potential to spot problematic assumptions and errors in the dominant way of thinking, while those who are privileged by these ideas tend to be invested in upholding them (Friesen, 2022).

This epistemic potential is realised when marginalised people achieve *standpoints*, from the collective political effort of engaging in critical examination of the power

structures and material and social conditions involved at a certain point of knowledge production (Friesen, 2022; Rose, 2017).[1] The epistemic advantage garnered is multiple: as mentioned, one is able to identify problematic assumptions and underlying values of certain knowledge claims. This may, in turn, spur new, alternative ideas, hypotheses, and research objectives and methodologies (Friesen, 2022). Interestingly, standpoint theorists have challenged traditional views of objectivity as arising by virtue of, among other things, being value-free and distanced from what is being studied (Rose, 2017). Instead, they argue that the reflexive outcome of insight into the underlying values that tend to be denied and unexamined by distanced researchers, is precisely what generates 'strong objectivity' (Friesen, 2022; Harding, 1992). As Donna Haraway puts it:

> The standpoints of the subjugated […] are preferred because in principle they are least likely to allow denial of the critical and interpretive core of all knowledge. They are knowledgeable of […] ways of being nowhere while claiming to see comprehensively. […] "Subjugated" standpoints are preferred because they seem to promise more *adequate, sustained, objective, transforming* accounts of the world. (Haraway, 1988, p. 584, emphasis added)

I believe this epistemological position to be relevant – indeed, crucial – in a psychiatric context, where power asymmetries between clinicians and healthcare users frequently expose users to forms of epistemic injustice: unfair treatment in terms of being invalidated as knowers, being silenced, having their own experiences and understandings overwritten, being stereotyped, and being paternalised as clinicians define users' best interests (Faissner et al., 2025; Fricker, 2007; Moberg & Schön, 2022; Scrutton, 2017).

One might reasonably think that it is odd for me to argue for this orientation in a dissertation summarising a body of research which does not directly involve the healthcare users in question, i.e. people with lived experience of self-harm. However, in my view, grounding my research in standpoint epistemology was even more important for this very reason, reminding me to at the very least have this project be guided by the accumulated, collective knowledge of users/survivors who self-harm. To me, this dovetails with my transformative approach.

Hopefully, this makes it excessively clear that I consider multiple knowledge bases as a resource rather than a problem. I believe researchers and clinicians with their own lived experience of the matter at hand may attain unique standpoints from which to enact change and contribute to a more equitable and just healthcare system.

[1] Standpoint-theoretical ideas of critical engagement and the potential of marginalized social locations share some common ground with Freire's (1972) idea of critical consciousness, both Marxist-rooted.

Chapter 2. Definitions and scope

> We must continue to use our lived experience to rewrite the narrative of those that try to erase us. (Jay, 2025; blog post for the U.K. National Survivor User Network)

Terminology in the field of self-harm research

From the first mention of self-harm in academic literature in the early 1900s through today, terminology has varied along with central understandings of what it means to self-harm. Some of the earliest mentions spoke of *self-mutilation* (Emerson, 1913; Favazza, 1998; Menninger, 1935, 1938; Shaw, 2002), a term that persists in contemporary literature. More common terms today are *self-harm*, *deliberate self-harm* (DSH), *self-injury*, *self-injurious acts*, *self-injurious behaviour* (SIB), and *self-injurious thoughts and behaviour* (SITB), which may all be used to refer to a range of behaviours irrespective of intention. Other frequently used terms clearly distinguish between suicidal and non-suicidal intention, including *non-suicidal self-injury* (NSSI), *suicidal ideation* (SI), *suicidal behaviour*, and *suicide attempt* (SA).

Terminology varies with traditions in different geographical regions, where DSH and later self-harm has been more commonly seen in British literature whereas NSSI is more commonly used in North America (Kapur et al., 2013; Wilson & Ougrin, 2021). Appropriate language use has also been discussed in terms of stigmatising or derogatory tones of certain terms, including suggestion of deliberateness and choice (Adler & Adler, 2007; Lewis & Hasking, 2021; Wilson & Ougrin, 2021).

Three commonly discussed aspects when defining self-harm are intention (in terms of lethality), directness, and sociocultural context (International Society for the Study of Self-Injury, 2024). In the following, I will briefly outline how various definitions of self-harm assume different positions in these regards and clarify my own reasoning when I use the term self-harm in this dissertation.

The relation between self-harm and suicide and the complexity in defining lethal intention

There is an undeniable relationship between self-harm and suicide. Suicidal ideation and attempts are common among people who also self-harm in non-suicidal ways,

and vice versa (Gillies et al., 2018; Hamza et al., 2012; Kapur et al., 2013; Laye-Gindhu & Schonert-Reichl, 2005; Zhiyu et al., 2022). The association between self-harm and future suicide attempts is well-documented, though its predictive value is contested (Ammerman et al., 2025; Castellví et al., 2017; Ribeiro et al., 2016).

The term *non-suicidal* self-injury originated as an effort to clarify that self-harm is not inherently suicidal or self-destructive, nor exclusively seen in people with borderline personality disorder (BPD), with researchers calling for further theoretical and clinical development and refinement (Kapur et al., 2013; Klonsky & Muehlenkamp, 2007; Laye-Gindhu & Schonert-Reichl, 2005; Muehlenkamp, 2005). When e.g. exploring self-preserving functions of self-harm, considering people who self-harm but do not experience suicidal ideation, or researching treatment for people who exclusively self-harm in non-suicidal ways, I believe a specific non-suicidal focus makes sense.

However, dichotomising the complexity and nuance of human experience can also be limiting. For instance, people might be ambivalent about their intentions, might change their minds or may not be able to account for their intentions in the moment. A sense of self-preservation is not always clearly felt to be present or absent; someone might not engage in a certain behaviour for primarily suicidal reasons but may simultaneously not care about risks of lethal outcome (Kapur et al., 2013; Liljedahl, Daukantaitė, et al., 2023; Marzetti et al., 2023; Wilson & Ougrin, 2021). In my clinical work with adolescents, I have heard them describe a strong sense of shame following non-suicidal acts of self-harm, which increased their suicidal thoughts. Occasionally, I have also heard descriptions of coming out of self-harm with an increased sense of self-compassion and self-preservation.

Additionally, the argument about needing specific treatment interventions is equally relevant in the case of non-suicidal self-harm co-occurring with suicidal thoughts and behaviours. Coincidentally, this has been a strong argument for conducting research on BA in the first place. BA, as offered in the psychiatric context of this dissertation, is not limited to self-harm as per the NSSI definition.

In all papers included in my dissertation, self-harm has been used as an inclusive term not specifying intention. Participants in papers III and IV often spoke of self-harm and adolescent suicidal behaviour interchangeably, though sometimes drawing clearer distinctions between them.

For the above reasons, in this dissertation I purposely refrain from using terminology that defines self-harm as decidedly suicidal or non-suicidal.

(In)directness and behaviours less talked about

Another key aspect in various definitions of self-harm is the directness of the behaviour, i.e. the extent to which it has an immediate impact on the body.

NSSI and some definitions of self-injury are commonly limited to immediate physical injury to the body (International Society for the Study of Self-Injury, 2024; Muehlenkamp & Owens, 2023; Zetterqvist, 2015). Self-harm, in contrast, is one of the broadest umbrella terms for various harmful behaviours, which may encompass self-poisoning or injury (National Institute for Health and Care Excellence, 2022) as well as more indirect risky behaviours (Lewis & Hasking, 2023).

A common objection to including indirectly harmful behaviours is that the definition may be too imprecise, capturing e.g. excessive drinking or reckless behaviour such as not wearing a seatbelt while riding a car (International Society for the Study of Self-Injury, 2024; Lewis & Hasking, 2023).

On the other hand, considering only immediately physically harmful behaviours will exclude certain behaviours that people with lived experience will relate to as intentionally self-harmful, such as sexual self-harm or putting oneself in harm's way. These behaviours may fill the same functions as direct self-harm, may or may not co-occur with direct self-harm, and people may find them just as, or even more, relevant as treatment targets (Fredlund et al., 2017; Jonsson et al., 2015; St. Germain & Hooley, 2012; Svensson et al., 2013; Weiss et al., 2015). Additionally, there may be social, including gendered, components driving self-harm behavioural expressions, meaning that stricter definitions of immediate physical injury risk under-detecting forms of self-harm in certain populations (Bo et al., 2014; Chandler et al., 2011; Fredlund et al., 2017; Green et al., 2017).

In this dissertation, I have been inspired by the Unified Model for consolidating and querying various forms of self-harm (Liljedahl & Westling, 2014). This model posits five behaviour groupings of self-harm, conceptualised along the dimensions of lethality and directness. In this model, self-harm spans from NSSI to direct suicide attempts, with a range of indirect behaviours in between, including harmful self-neglect (such as purposefully not taking one's prescribed medication), sexual self-harm or self-exploitation, or exposing oneself to risk of harm (such as going into physical settings known to be unsafe). This conceptualisation recognises that multiple, direct or indirect behaviours might be perceived as self-harm to the person engaging in them, reminding us to also consider behaviours that commonly go undetected in research and clinical settings (Liljedahl, Daukantaitė, et al., 2023).

The precedence of self-definition over sociocultural sanctions

Lastly, most definitions of self-harm exclude behaviours that are socially and/or culturally sanctioned. This is to avoid being over-inclusive on a technicality. For example, definitions of self-harm generally exclude piercings, tattoos and other socially accepted forms of body modification, as well as self-flagellation in a religious or spiritual context (International Society for the Study of Self-Injury, 2024; Lewis & Hasking, 2023).

It is certainly necessary to consider context, meaning, and functions of behaviours. The issue, however, is that there isn't a definitive line between what is and isn't sanctioned across various contexts, and sociocultural forces are very much involved in shaping the engagement, expressions, and meanings of such behaviours that *would* be classified as self-harm as per most definitions. In a Western context, self-harm has historically been thought of as a 'feminine' behaviour rather than an aggressive one; it might even be considered a more socially appropriate expression of aggression for girls and (young) women in the public eye (Chandler et al., 2011). Simultaneously, gendered social norms about aggressive behaviour, emotional control and self-reliance appear to be positively associated with suicidal thoughts and behaviours in men, and negatively associated with help-seeking (Dempsey et al., 2023). Further, *not* conforming to gender and sexuality norms is often cited as a driver of self-harm among lesbian, gay, bisexual, trans, queer, intersex, and asexual (LGBTQIA) populations (Coleman et al., 2025; McDermott, 2015; McDermott & Roen, 2016; Muehlenkamp & Nagy, 2025; Rogers & Taliaferro, 2020; Taliaferro & Muehlenkamp, 2017). Such gendered relations, if left unproblematised, lend themselves to essentialist interpretations (Dempsey et al., 2023; Dunlop et al., 2020; Liu et al., 2019; Shadravan & Barceló, 2021).

Crucially, what is socially or culturally accepted varies with time and place, and relying on social (non-)acceptance to classify self-harm may be detrimental. For instance, researchers and clinicians erroneously but commonly judge practices of bondage/discipline, dominance/submission, and/or sadism/masochism (BDSM) to be forms of self-harm (Lantto & Lundberg, 2022; Shahbaz & Chirinos, 2017), even though people may engage in BDSM for identity, social connectedness, recreation, intimacy and pleasure, in the absence of distress. One's temptation to pathologise certain subcultural expressions may have little to do with the behaviours themselves causing inherent harm or suffering, and more to do with stigma against subcultures (Adler & Adler, 2007; Dunkley & Brotto, 2018; Lantto & Lundberg, 2022).

Probably unsurprisingly at this point, my position when talking about self-harm favours self-definition: what *feels* like self-harm to the person, is self-harm. This implies that context is always relevant. Perhaps somewhat controversially, there are no acts that I would inherently regard as self-harm, irrespective of context. This position makes socially marginalised populations less vulnerable to pathologisation, or to clinicians deciding that ceasing this or that behaviour must be a treatment goal.

Granted, this also means that perspectives on what is or isn't, was or wasn't self-harm, as well as its salience and importance, may vary between people and change over time (Claréus, 2023). Imprecision or dissensus is often treated as a problem in research but could also be treated as potential for enriched understandings and innovation (Speyer & Ustrup, 2025). Most importantly, I believe variation in perspectives and experiences is a given when dealing with human phenomena. Basing the most central definition of this dissertation on anything other than the

self-definitions of the people affected would be discordant with my transformative and standpoint-theoretical research orientations.

Summary of my use of terminology

What I mean by self-harm

In this dissertation, unless otherwise specified, I will use the term self-harm to signify any behaviour, irrespective of directness or intended lethality, that is felt to be self-harm from within the contextual experience of people engaging in them. Those with lived experience of self-harm have definitional primacy over those having close relationships with people with such experiences, who in turn have primacy over people who come from removed clinical or academic perspectives.

This means that throughout the research studies of this dissertation, focused on family and clinical perspectives, I have treated participants' definitions of self-harm by continuously asking (usually self-directed) reflective questions about what people with lived experience of self-harm might feel about certain statements and where and how their own definitions and perspectives might have differed from those raised in the moment in research interactions.

To be clear, we did not pre-define self-harm in neither of the four papers included in this dissertation, leaving the concept open to interpretation. In communication with participants across all four studies (i.e. clinicians in papers I and II, and family members in papers III and IV), we used the Swedish term *självskadebeteende*, which is broad and inclusive of direct and indirect, suicidal and non-suicidal behaviours. Of note, when referring to specific studies, I will occasionally adopt the terminology used by the original authors, for the sake of clarity.

Other relevant terminology

Relatedly, the term *individual* is frequently used in research, for instance in the sense of 'individuals who self-harm' or 'individuals with lived experience'. This term may be considered respectful, bringing attention to the fact that each person is indeed an individual human being with self-worth and their own unique experiences. However, as I will elaborate on shortly, I believe that an individualised focus may also distract from collective experiences shared among many people with lived experiences of self-harm and psychiatric care, and obscure structural issues within the psychiatric system and society at large. For this reason, unless I want to emphasise reference to single individuals, I prefer the terms *people*, *healthcare users*, and in some cases *survivors* and/or *mad-identified people*.

Relatedly, in general when I use the term *lived experience* in this dissertation (apart from when discussing paper III), I intend it in a broad sense, not limited to the phenomenological conceptualisation of the primal, pre-reflective, instant moment (van Manen, 2017). I intend it to mean having any form of first-hand experience of the matter at hand. Sometimes in mental health literature, a distinction is made between *lived* and *living* experience, where the latter is meant to signify that a person is still currently experiencing certain things (usually struggling with some form of mental health issue), while the former is taken to mean that such experiences are not current but part of the person's life history (Bergmans et al., 2025; Sayani et al., 2025). While, at times, I find it meaningful to emphasise that someone is currently dealing with something, one problem with the present use of such distinctions is that they are commonly a shorthand for ideas of recovery, as in whether or not someone may be considered 'recovered' or being 'in recovery' (Askew & Ritter, 2023; WHO, 2025). I will go further into some issues with contemporary circulations of such ideas in the next chapter. For now, I simply want to clarify that I will use the term lived experience broadly to encompass current *and* previous direct experiences in a person's life, without making any assumptions about recovery.

Lastly, I occasionally use *personal experience* to signify second-person experiences that are deeply felt on a personal (rather than professional) level, such as the experiences of people who may describe themselves as family, significant others, informal carers, or loving supporters. For instance, I would suggest that family members who live together with someone who self-harms have *personal* experience with self-harm and *lived* experience of sharing a life with someone who self-harms.

A note on what I will and will not be discussing in this dissertation

Having received little attention since its appearance in the research community in the early 1900's, publications on self-harm started becoming more common in the 1990's. In the last two decades, research on self-harm has virtually exploded and it is no longer possible to stay up to date with every new publication in the field. Knowing this, I would like to briefly note my focus in the present dissertation and, consequently, what I will not be discussing.

As mentioned, the theoretical frameworks I have opted to use in this piece of work are the human rights perspective and the concept of relational recovery. I find that these frameworks are relatively rarely applied in psychiatric research, though I believe the psychiatric healthcare system stands to benefit from these lenses.

For context, I *will* briefly mention here that in Swedish public psychiatric care where my research is based, availability of treatment interventions for people who self-

harm varies on national and regional levels. In Region Skåne at the time of writing, some may receive Dialectical behaviour therapy (DBT; Linehan, 1993; Linehan, 2015), Mentalisation-based therapy (MBT; Bateman & Fonagy, 2006), Emotion regulation group therapy (ERGT; Gratz, n.d.; Gratz & Gunderson, 2006; Sahlin et al., 2017), or General psychiatric management (GPM; Gunderson & Links, 2014). All these treatment methods or frameworks have also been adapted specifically for adolescents (Bjureberg et al., 2023; Bjureberg et al., 2018; Choi-Kain & Sharp, 2022; Ilagan & Choi-Kain, 2021; Miller et al., 2007; Rathus & Miller, 2014; Rossouw et al., 2021; Rossouw & Fonagy, 2012). Others may receive a general, 'DBT-inspired' cognitive behavioural therapy (CBT) with an emphasis on skills training. Still others may only receive pharmacological treatment, or they might not receive any form of treatment at all, remaining on waitlists with perhaps the occasional follow-up phone call or visit to the outpatient clinic. Treatment interventions offered also vary depending on healthcare setting (outpatient care, mid-level care, inpatient care).

That being said, for the purpose of this dissertation I will not go further into detail on the evidence for various forms of treatment for self-harm. I will not go into matters such as primary prevention, nor intraindividual factors supporting the cessation of (or living well with) self-harm behaviour. I also won't be summarising models to understand the aetiology or maintenance of self-harm behaviour (why a person may start or continue to self-harm). In this dissertation, my interest is self-harm and psychiatry from a social justice perspective.

Chapter 3. Self-harm, human rights, and recovery

> You've no need to fear that I will crumble
> In front of you.
> Your eyes tell me
> That you don't really want to know.
> So why should I make myself
> That vulnerable?
> - Never.
> (Diane Harrison in her poem *See me*; published in Pembroke, 1994)

In the following chapter, I will clarify the theoretical grounding of this dissertation. I will start out by summarising some key features of the human rights perspective that are especially relevant to this field. Then, I will summarise different understandings of recovery and how the field of self-harm research ties into these, leading up to the notion of relational recovery. Finally, I will apply these theoretical perspectives to a brief review of previous research on clinicians' attitudes toward people who self-harm.

Self-harm and human rights

Human rights are defined by the *Universal Declaration of Human Rights* (UDHR; United Nations General Assembly, 1948). The rights of children below 18 years of age are especially regulated by the UN *Convention on the Rights of the Child* (UNCRC; United Nations General Assembly, 1989), emphasising that children are human beings and rights-holders, too, in need of special protection due to their dependency on adults. Another relevant convention in the context of this dissertation is the UN *Convention on the Rights of Persons with Disabilities* (UNCRPD; United Nations General Assembly, 2006). Both the UNCRC and the UNCRPD are legally binding in Sweden and many other countries around the world.

Getting an overview of human rights perspectives in self-harm research proved to be quite challenging; as I soon discovered when running literature searches using the search term 'human rights'[2], relevant publications don't necessarily explicate the human rights perspective in those very terms.

Looking to the healthcare user, survivor, and mad-identified movements, much of their advocacy has been about self-determination and autonomy, with respect to their own bodies as well as controlling and running their own care services. One big issue has been (and continues to be) resisting involuntary hospitalisation and coercive measures such as seclusion, restraint and (forced) pharmacological treatment (Harper & Speed, 2012; Pembroke, 1994).

It is worth pointing out that these movements were (are) not homogenous. Though survivor-led (non-medical) services was an end goal across much of the survivor movement, survivors, mad-identified people and healthcare users have also advocated for distributive justice and improved accessibility (and quality) of healthcare services (Cresswell, 2005; Pembroke, 1994; Pilgrim, 2008).

More recently, mental health has been specifically addressed as a human rights issue by the 2014-2020 Special Rapporteur on the Right to Health, Dainius Pūras, with the United Nations Office of the High Commissioner on Human Rights (OHCHR; United Nations Human Rights Council, 2017, 2020)[3]. As stated in the 2020 OHCHR report:

> Mental health systems worldwide are dominated by a *reductionist biomedical model* that uses medicalization to justify coercion as a systemic practice and qualifies the diverse human responses to harmful underlying and *social determinants* (such as inequalities, discrimination and violence) as "*disorders*" that need treatment. […] How that dominance is overcome requires transformative human rights action. […] The locus of the action must be recalibrated to strengthen communities (United Nations Human Rights Council, 2020, p. 4, emphasis added)

Put differently, the UN recognises social determinants of mental health, meaning that mental health is affected by socioeconomic factors such as inequitable access to education, job opportunities, income, quality housing, social protection, support networks, and other aspects of social power (WHO, n.d.). The 2020 OHCHR report specifically frames mental health issues as reasonable human responses to harmful social determinants like inequalities, discrimination and violence. Further, the report problematises the *biomedical model* of mental health, whereby mental health issues are understood to be caused by neurobiological deficits, chemical imbalances, and

[2] The following search terms were used: 'human rights' AND ('self-harm' OR 'self-injury' OR 'self-injur*' OR 'NSSI' OR 'suicidal behavio*' OR 'suicide attempt' OR 'parasuicide' OR OR 'para-suicide' OR 'para suicide' OR 'suicidal thoughts' OR 'suicid*').

[3] For simplicity, henceforth I will refer to these reports as 'the OHCRH report(s)'.

intraindividual dysfunctions. This understanding is imported from somatic medicine and drives pharmacological treatment of mental health issues, as well as the definition of treatment success. The 2020 OHCHR report explicitly states that the biomedical model pathologises what are really social issues, and that biomedical dominance, or hegemony, in mental health is incompatible with human rights and must be overcome.

The issues of healthcare user autonomy, as well as the right to health through fundamental access to appropriate mental health services, are repeatedly raised as key issues of human rights transformation in both the 2017 and 2020 OHCHR reports, and dignity also appears as a key term.

In this section, I will provide a brief overview of these central human rights issues in psychiatry (right to health, autonomy and freedom from coercion, and dignity) in relation to self-harm.

Right to health and the AAAQ framework

The right to health is embodied in the UDHR, the UNCRC, the UNCRPD, and the Constitution of the WHO (1946), among others. In 2000, the United Nations Committee on Economic, Social and Cultural Rights conceptualised rights-based healthcare services and realisation of the human right to health along four dimensions: availability, accessibility, acceptability, and quality. This has later come to be known as the AAAQ or the 3AQ framework (Gruskin et al., 2010; Stastny et al., 2020). *Availability* is about care providers and services existing in enough supply in relation to the needs of healthcare users, and that such services address the underlying physical[4] and social determinants of health. *Accessibility* is about services being *non-discriminatorily* accessible to everyone, especially populations that are marginalised and particularly vulnerable. Services also need to be *distributed geographically* so that users can safely reach them and be *affordable* and equitably priced in relation to the incomes of healthcare users, so that poorer users are not disproportionately economically burdened. Having access to *information* about health issues and services are also part of accessibility. *Acceptability* is about healthcare services being provided in an ethical, respectful, and culturally sensitive manner, especially being mindful of the needs of marginalised communities, as well as developmental needs throughout the life cycle. This includes healthcare providers having respectful attitudes toward service users. Finally, quality is about services being of appropriate quality in terms of e.g. skilled providers and physical equipment of good standards (United Nations Committee on Economic, Social and Cultural Rights, 2000).

[4] Physical determinants of health are factors in one's physical environment, such as having access to potable drinking water, basic hygiene, and safety (WHO, 2024).

The AAAQ framework has been taken up in subsequent UN publications, including the 2017 OHCHR report, emphasising the importance of care availability, affordability and geographic accessibility for healthcare users, as well as accessible information about healthcare services and treatments available. Quality of care was suggested to be enhanced by increased collaboration with healthcare users and their families, reframing healthcare users from passive recipients to active rights-holders. The dimension of acceptability to the healthcare user was also addressed, mostly in terms of care services respecting the individual, their choices and preferences, and committing to not doing any harm. The report especially stressed that special consideration should be given to ensure that mental healthcare services do not reproduce oppression of women through patriarchal and paternalistic influences. Other globally oppressed populations were also mentioned. All of this was explicitly related to the human right to the highest standard of health attainable, but also to the rights to non-discrimination in accessing services, and inclusion and participation in the community (United Nations Human Rights Council, 2017).

The UNCRC further stresses children's right to health and access to healthcare services, emphasising prevention, primary care, and 'abolishing traditional practices prejudicial to the health of children' (United Nations General Assembly, 1989, article 24).

Autonomy and freedom from coercion

Coercion in mental healthcare is 'a complex phenomenon that exists in a tension-filled space between therapeutic intent and the lived experience of being disrespected as a person' (Hallett et al., 2024, p. viii). Freedom from coercion is one of the biggest, if not *the* biggest, human rights issue in mental healthcare.

Coercion encompasses any practice that is inconsistent with the person's will or undertaken without their consent, usually to control their behaviour in some way. The WHO considers coercion on a par with violence and abuse as forms of maltreatment in mental health settings, as coercing someone usually requires violence to some degree, and coercion is commonly experienced as violence to the person being subjected to it (WHO, 2019). Some forms of coercion in mental health settings, like restraint and seclusion, constitute 'torture and other cruel, inhumane or degrading treatment' according to the UN (United Nations Committee on the Rights of Persons with Disabilities, 2014, 2015, 2016), and the 2010-2016 Special Rapporteur on Torture, Juan E. Méndez, has called for a complete ban on such measures (United Nations Human Rights Council, 2013).

The 2017 OHCHR report makes explicit

> … the intimate connection between the right to health, with the entitlement to underlying determinants, and the freedom to control one's own health and body. That is also linked to the right to liberty, freedom from non-consensual interference and respect for legal capacity. (United Nations Human Rights Council, 2017, p. 8)

That is, freedom from coercion is a right in itself and is intimately linked to the right to choose or refuse in the context of one's own healthcare (which I will henceforth refer to as the right to autonomy in healthcare, for simplicity), the right to bodily integrity, the right to liberty, the right to have one's legal capacity respected, and the overarching right to health.

These rights[5] are all explicitly stated in the CRPD (articles 12-17 and 25), which clarifies that 'the existence of a disability shall in no case justify a deprivation of liberty' (United Nations General Assembly, 2006, article 14). The 2014-2020 Special Rapporteur on the Rights of Persons with Disabilities, Catalina Devandas, went on to state that article 14 of the CRPD should be read as an absolute ban on involuntary psychiatric admissions based on actual or perceived impairment, which 'would be discriminatory in nature and, thus, both unlawful and arbitrary' (United Nations Human Rights Council, 2019, p. 11). The report concluded that such deprivation of liberty 'is a human rights violation on a massive scale' (p. 18), 'not a "necessary evil" but a consequence of the failure of States to ensure their human rights obligations towards persons with disabilities […] rooted in intolerance' (United Nations Human Rights Council, 2019, p. 19). This absolute ban on involuntary admissions includes people who self-harm and/or are in suicidal crisis. Instead of substitute decision-making in these situations, people have the right to supported decision-making if needed in order to exercise their legal capacity (Stastny et al., 2020; United Nations General Assembly, 2006).

In spite of this, the biomedical emphasis on deficits and inherent incapability of certain healthcare users continues to reinforce patriarchal power structures in psychiatry, whereby involuntary hospitalisation and coercive measures are justified as necessary to ensure the individual's safety (United Nations Human Rights Council, 2017, 2020), circumventing critique of human rights violations and reports of iatrogenic effects such as exacerbated self-harm, elevated suicide risk, traumatisation, and reduced help-seeking (Burrin et al., 2021; Council of Europe, 2019; Coyle et al., 2018; James et al., 2012; Large et al., 2014). Though it is frequently maintained that most hospitalisations are carried out with the individual's consent, a lack of care options would arguably impede the process of consenting

[5] Additionally, the right to participate in the community is stated in article 19 of the *Convention*, and respect for privacy in article 22.

(United Nations Human Rights Council, 2017). The presence of alternatives is thus essential for ensuring freedom from coercion and right to autonomy in healthcare.[6]

In Sweden, there are legal mandates for involuntary care as per the Compulsory Psychiatric Care Act (LPT; SFS 1991:1128) and the Forensic Mental Care Act (LRV; SFS 1991:1129). According to a report from the Swedish National Board of Health and Welfare (2023a), in 2021, about 11'000 people in total were admitted under LPT, and about 2000 people received involuntary care under LRV. There were large regional differences in frequencies of people affected, as well as the extent to which involuntary care was enforced already upon first-time presentation of certain issues. There were also regional differences in use of coercive measures such as seclusion, restriction and coercive medication during involuntary care periods. In other words, some regions were better than others at preventing coercion, favouring voluntary admissions or outpatient psychiatric care to a larger extent (Swedish National Board of Health and Welfare, 2023a).

Speaking to some of the serious social justice issues with coercion in healthcare, the report further stated that those who were subjected to some form of involuntary care were generally more socioeconomically disadvantaged at baseline, and such disadvantage was commonly aggravated after having been subjected to coercion. Strikingly, almost 40 percent lived on social benefits as their main source of income two years after discharge from involuntary care under LPT, as compared to about five percent in the general population. Further, the risk of suicide or dying from other causes within two years was substantially higher for people who had been subjected to involuntary care, as compared to the general population (Swedish National Board of Health and Welfare, 2023a).

Considering children's rights specifically, article 37 of the UNCRC makes clear that the human right to be free from cruel and inhuman treatment applies to children as well, and that *if* children are deprived of their liberty, they 'shall [still] be treated with humanity and respect for the inherent dignity of the human person' (United Nations General Assembly, 1989, article 37). The UNCRC further states that in the event that children have been subjected to inhuman and degrading treatment – such as coercion in mental healthcare, as per the previous definition – then 'States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of [the] child' (United Nations General Assembly, 1989, article 39), implying the need for special healthcare considerations to address harmful consequences of coercion.

According to another recent report by the Swedish National Board of Health and Welfare (2025), children under the age of 18 are much less commonly admitted in inpatient psychiatry in general, and less commonly subjected to involuntary care. In

[6] For examples and principles of such alternatives, see Griffiths et al. (2022) and Stastny et al. (2020).

2022, about 12'000 adults were admitted under LPT, as compared to about 550 children under 18. These numbers encompassed 25% and 16% of the total number of people admitted in inpatient psychiatry, for adults and children respectively. However, children were admitted for a total of about 24'500 days under LPT, which was almost half (46%) of the total days admitted in child and adolescent psychiatry in general. The equivalent figures for adults were about 430'000 days on LPT, 39% of the total number of days in inpatient psychiatry (Swedish National Board of Health and Welfare, 2025).

Dignity

Dignity can be described as a human right in itself. Recognition of the inherent dignity of every human being also makes up the basis of every other fundamental right. Human dignity is universal, equal to all, and inalienable; it must be respected and is meant to take precedence above other rights and laws (Official Journal of the European Union, 2007; United Nations General Assembly, 1948).

Part of human dignity is having inherent worth simply from existing, being able to lead a worthy existence, and being free to develop as a person (United Nations General Assembly, 1948). In the context of psychiatry, providing services that respect the user's dignity is foundational to secure their human rights, and can also be understood as part of the acceptability dimension of providing rights-based healthcare. In other words, the human right to dignity is interwoven with the right to health. Needless to say, measures that entail coercion, violence and humiliation are in direct violation of the right to dignity. Habitual medicalisation can also be considered to dismiss a person's dignity, for instance if medication is prescribed in lieu of proper assessment (United Nations Human Rights Council, 2017, 2020).

Restoring dignity can be conceptualised as a recovery target or part of the recovery process, and a central goal for any rights-based initiatives or mental health policies (United Nations Human Rights Council, 2017). Empowering people to make informed decisions about their healthcare and lives is integral to respecting their human dignity (United Nations Human Rights Council, 2020).

As the 2020 UN report concludes, 'there is no good mental health and well-being without embracing a human rights-based approach. […] There is an inherent and universal value to supporting dignity and well-being; furthermore, it is a human rights imperative' (United Nations Human Rights Council, 2020, p. 18).

Research on clinicians' attitudes and views on self-harm

Negative attitudes among clinicians toward people who self-harm violate the dignity of healthcare users and pose a major problem for the acceptability and quality of healthcare, in other words compromising the human right to health. Negative

attitudes have been recognised in self-harm research since at least the 1970's (Saunders et al., 2012). The experiential literature is rife with examples of healthcare users who self-harm being explicitly judged and questioned, being refused care or conversely, subjected to coercive care measures against their will, and even being refused anaesthesia (Pembroke, 1994; Rose, 2020). Negative attitudes by clinicians are still noted in more recent research (McGough et al., 2022; Rayner et al., 2019; Ribeiro Coimbra & Noakes, 2022; Wilson & Langan-Martin, 2021), though more sympathetic attitudes are sometimes reported (Friedman et al., 2006; McCarthy & Gijbels, 2010; O'Donovan & Gijbels, 2006; Patterson et al., 2007a; Rouski et al., 2017; Wilstrand et al., 2007).

In terms of dignity and the AAAQ framework (especially acceptability and quality), a large body of clinical research has reported perceptions that people who self-harm were just seeking attention and wasted clinicians' time, that their care needs were illegitimate and that they could not be helped, a sentiment often accompanied by anger, frustration, anxiety or fear, and powerlessness in clinicians (Hodgson, 2016; Karman et al., 2015; Rai et al., 2019; Saunders et al., 2012). Rather than focusing on healthcare users' needs, some studies reported that clinicians felt people who self-harm obstructed or blocked the healthcare system (Karman et al., 2015; McHale & Felton, 2010) or took up unproportional time and space (Rouski et al., 2017), which others were deemed more deserving of (McGough et al., 2022). Clinicians at an inpatient mental health unit for adolescents shared experiences of powerlessness and failure in providing care for people who self-harm (Rouski et al., 2017). One study reported beliefs among burns surgeons that people who self-harmed would sabotage their own recovery, that receiving surgery would make them more prone to self-harm, and that surgery should be limited, with some even having policies in place to refuse care; however, some surgeons recognised the role of shared decision-making and treating people who self-harmed with compassion to support physical and psychological recovery (Rai et al., 2019). Clinicians generally perceived people who self-harm to have mental health issues and felt that clinicians in somatic care were not responsible for them, that they rather needed psychiatry or other specialist care (Hodgson, 2016; Saunders et al., 2012), which sometimes resulted in people who self-harmed receiving lower-quality care (McGough et al., 2022).

In terms of autonomy and freedom from coercion, perceived risk and higher anxiety have been associated with increased support of coercive measures, though this was in a sample of clinical and non-clinical students (Cleaver, 2014). Several research reports have indicated positive relationships between media coverage on risk of violence by people with mental illness, public and political support for involuntary psychiatric admissions, and actual hospitalisation rates (Hahn et al., 2024). In a literature review (Husum et al., 2023), clinicians were reported to widely support coercion, regarding it as necessary for the sake of security, though concern about deleterious effects on healthcare users was also mentioned. Clinicians' attitudes to coercion were proposed as a prerequisite for mental healthcare staff and

management to improve the quality of services (Husum et al., 2023). Notably, clinicians tended to be desensitised to the deleterious effects of coercion with increased use, sometimes even considering coercion to be therapeutic (Hahn et al., 2024). However, one qualitative study on psychiatric nurses explicitly observed that risk management measures such as confiscating all personal belongings that could potentially be used for self-harm violated healthcare users' rights (O'Donovan, 2007). Worryingly though, one study reported that chemical sedation was routinely relied upon due to the nature of the healthcare setting itself, despite the perception that this was not what healthcare users needed and that they would have been better off if permitted to self-soothe in a more pleasant environment. In terms of accessibility, the same study explicitly noted that people who self-harmed faced discrimination and stigma within emergency care settings, which was perceived to be a product of the larger healthcare system (McGough et al., 2022).

Recognising negative attitudes to be a problem, numerous publications have considered the question how clinicians' attitudes can be understood and have looked at factors revolving around the clinician that can be associated with attitudes toward people who self-harm. Previous research frequently indicated that receiving some form of training about self-harm was positively associated with clinicians' attitudes as well as perceived ability to work with people who self-harm (Cleaver, 2014; Commons Treloar & Lewis, 2008; Gibson et al., 2019; Hodgson, 2016; Karman et al., 2015; Kilty et al., 2021; McHale & Felton, 2010; Patterson et al., 2007b; Ribeiro Coimbra & Noakes, 2022; Saunders et al., 2012). Similarly, clinicians developed more critical attitudes toward coercion in mental healthcare after having received training on the matter (Husum et al., 2023). Clinicians' attitudes toward people who self-harm have also tentatively been associated with education, more generally (Cleaver, 2014; Karman et al., 2015), as well as feeling skilled, competent, and effective at work (Ribeiro Coimbra & Noakes, 2022; Shaw & Sandy, 2016; Wheatley & Austin-Payne, 2009). A number of studies have pointed to the role of receiving support from and feeling close to colleagues, supervisors, and/or management (Hahn et al., 2024; Karman et al., 2015; McGough et al., 2022; McHale & Felton, 2010; Ribeiro Coimbra & Noakes, 2022; Rouski et al., 2017; Wilstrand et al., 2007). Conclusions have been mixed regarding gender (Cleaver, 2014; Husum et al., 2023; Perboell et al., 2015; Rayner et al., 2019), age (Carter et al., 2018; Cleaver, 2014; Husum et al., 2023; Karman et al., 2015; Perboell et al., 2015), work setting or professional area (Carter et al., 2018; Cleaver, 2014; Hodgson, 2016; Ribeiro Coimbra & Noakes, 2022; Saunders et al., 2012), and length of work experience (Cleaver, 2014; Hodgson, 2016; Husum et al., 2023; Karman et al., 2015; Rai et al., 2019; Rouski et al., 2017; Saunders et al., 2012; Wilson & Langan-Martin, 2021). A busy work environment and lack of time was consistently reported not to be conducive for clinicians' attitudes toward people who self-harm, nor for adequately helping healthcare users (Cleaver, 2014; Hodgson, 2016; Karman et al., 2015; McGough et al., 2022; McHale & Felton, 2010). Similarly, clinicians have been reported to relate lack of resources to increased use of coercion in healthcare,

while working with recovery-oriented interventions was related to more critical attitudes toward coercion (Husum et al., 2023).

Besides for clinicians' characteristics, studies have also reported healthcare user characteristics that were associated with clinicians' attitudes. For example, clinicians tended to have less negative attitudes for children and adolescents, for people perceived to have mental illness and suicidal intent, and who used more severe, lethal methods (Saunders et al., 2012), though none of this held for young people who were incarcerated (Cleaver, 2014). Attitudes were more negative for people who recurrently self-harmed (Cleaver, 2014; Hodgson, 2016; McHale & Felton, 2010; Rouski et al., 2017; Saunders et al., 2012). Conclusions regarding clinicians' attitudes and healthcare users' gender were mixed (Saunders et al., 2012).

To summarise, negative attitudes among clinicians are clearly problematic in terms of disrespecting the inherent dignity of healthcare users who self-harm and restricting accessibility, acceptability and quality of care, i.e. compromising healthcare users' right to health. Negative attitudes may also be one part of the continued condoning and use of coercion in psychiatry, compromising users' rights to freedom from coercion, liberty, bodily integrity, and autonomy in healthcare. Various factors have been associated with clinicians' attitudes toward people who self-harm, one of the main ones being training on the topic.

Self-harm and recovery

Recovery has been called a mainstreamed buzzword of mental healthcare in practice, policy, and literature (Llewellyn-Beardsley et al., 2022; McWade, 2016; Price-Robertson et al., 2017; Rose, 2014). As argued by McWade (2016), recovery is multiple and can be enacted in different ways by various stakeholders, such that 'certain enactments of recovery will marginalise or obscure others' (McWade, 2016, p. 62). To define and make sense of relational recovery, it is necessary to situate this concept among other enactments of recovery.

Biomedical (clinical) recovery

Biomedical recovery, also commonly referred to as *clinical recovery*, is defined by the clinician and centres around the aforementioned premise that mental health issues are intraindividual and caused by neurobiological deficits and dysfunctions. From a biomedical point of view, recovery entails symptom reduction or, ideally, full remission of the 'disorder'. The idea is that the healthcare user *re*-covers their baseline ('normal') level of health and functioning from before the onset of the 'disorder', a development which is externally observable to the clinician and defined

by a set of objective outcomes (Adame & Knudson, 2007; McCabe et al., 2018; Price-Robertson et al., 2017; Slade, 2009).

I put quotation marks around the notion of 'disorder' in this context to bring to attention that the very idea of (mental) disorder is a product of the biomedical model traditionally dominating psychiatry. With regard to my field of study, it is worth noting that self-harm behaviour exists in community populations as well as psychiatric populations and is not considered to be a disorder in itself at this point in time, though the diagnostic category of non-suicidal self-injury disorder (NSSID) was proposed in DSM-5 as a condition in need of further study (American Psychiatric Association, 2013; Zetterqvist, 2015).

The biomedical, deficit-based perspective of self-harm proliferates in academic and clinical settings (Crowe, 2022; Lewis & Hasking, 2023), where self-harm is commonly understood in terms of e.g. emotion regulation difficulties, emotional instability and reactivity, problems with distress tolerance, impulse control issues, reduced pain sensitivity, harm avoidance or experiential avoidance, as well as genetic factors in acquired capability to self-harm, to name a few areas (Chapman et al., 2006; Conrad et al., 2009; Iverson et al., 2012; Koenig et al., 2016; Mayo et al., 2021; Nock, 2009; Nock & Mendes, 2008; Núñez et al., 2020; Smith et al., 2012; Xie et al., 2025). Common to many approaches of treatment is addressing these proposed deficits through skills training (Bjureberg et al., 2018; Gratz, n.d.; Linehan, 2015; Rathus & Miller, 2014). Pharmacological treatment is sometimes used, despite the uncertainty of evidence (Witt et al., 2021) and recommendations that such treatment should *not* be used specifically to reduce self-harm, though may be used to treat co-occurring conditions (Apicella et al., 2025; National Institute for Health and Care Excellence, 2022).

The overarching clinical goal of any form of treatment, and the very definition of clinical 'recovery from' self-harm, is cessation of self-harm behaviour, which has become a focal point of research (Andrews et al., 2013; Aoki et al., 2024; Brausch et al., 2025; Halpin & Duffy, 2020; Kim & Hur, 2023; Meheli et al., 2021; Westad et al., 2021). Improved functioning or other expressions of a return to 'normality' may be conceptualised in terms of improvements in any of the listed areas of perceived deficit, or others (Calvo et al., 2025; Dibaj et al., 2025; Gratz et al., 2014; Griffiths et al., 2019; Teasdale et al., 2024; Yardley et al., 2019).

The biomedical model for understanding recovery and desired treatment outcomes has dominated psychiatry since its inception, long before recovery as a term was recognised.

Social justice roots of recovery

The use of *recovery* as a specific term in the context of mental health is associated with social justice activism and the early psychiatric user/survivor movement in the

1960's through 1980's (Hunt & Resnick, 2015; Llewellyn-Beardsley et al., 2022; McWade, 2016; Price-Robertson et al., 2017; Rose, 2014). This movement fought to reduce mental health stigma, spoke up about and resisted involuntary admissions and treatments, and struggled to change a healthcare system which was felt to be oppressive, paternalistic and dehumanising. The very political identity as a *survivor* in this context referred to surviving mental health struggles, mental health stigma in society, *and* surviving a mental healthcare system that perpetuated suffering. Though this movement was diverse, survivors largely advocated for de-medicalisation and for addressing the larger structural problems in society that were seen as the root of mental health issues, i.e. the social determinants of mental health (Bassman, 1997; Cohen, 2025; Cresswell, 2005; Davidson et al., 2005; Hunt & Resnick, 2015; McWade, 2016; Pilgrim, 2008).

The idea of recovery within the healthcare user/psychiatric survivor movement, then, explicitly rejected the biomedical, mechanistic idea of recovery as being rehabilitated back to baseline functioning and normality. Instead, recovery was used to describe the process by which people with mental health issues were '*recovering* a new sense of self and of purpose within and beyond the limits of the disability' (Deegan, 1988, p. 11, emphasis in original), with a firm basis in lived experience perspectives and active participation. In other words, recovery was conceptualised as a process of empowerment or liberation, entailing *living with* mental health issues while *overcoming* the social and economic challenges of being considered a patient (Adame & Knudson, 2007; Davidson et al., 2005). Hope, self-determination, rights, and collective action and care were emphasised (Deegan, 1988; Dillon, 2011; Harper & Speed, 2012; Pilgrim, 2008), and users/survivors have proposed that empowerment in itself constitutes mental well-being (Stastny et al., 2020).

Mark Cresswell (2005) provided a compelling historical overview of U.K. psychiatric survivor activism specifically in relation to self-harm, showing how, as lived experience was becoming increasingly recognised as a source of knowledge, people with lived experience of self-harm took up self-advocacy as a form of activism. This self-advocacy became a political practice to garner public support as well as contend the 'hegemonic truth' (p. 1673) of psychiatry and biomedicine. One important focus for this performative and educative effort was to dispel myths that self-harm *per se* was a suicidal act or indicative of psychopathology. Survivor activists (mostly women) also exposed the gendered social conditions of self-harm survivors: having survived suicidality, societal devaluation of self-harm, an oppressive healthcare system, *and* additionally also gender-based violence as well as the '"normal" socialisation process' of growing up and living in a patriarchal society, summatively described as 'gendered trauma' (Cresswell, 2005, p. 1675).

One of the sources that Cresswell leaned heavily on is *Self-Harm: Perspectives from Personal Experience*, a collection of lived experience perspectives published by the U.K. organisation Survivors Speak Out (Pembroke, 1994). In her own contribution to this publication, Louise Pembroke described the roles of global systems of

oppression as well as oppression and maltreatment by healthcare professionals and psychiatrisation in aggravating distress and catalysing self-harm. She also described the imposition of clinical and societal recovery ideas over her own definitions of what she needed:

> Care with make-up and hairstyle was seen to be clear indications of 'getting better'. Likewise wanting marriage and children were viewed by some as part of recovery. Individuals have been told that their problems would get better if they simply acquired a boyfriend. Gender issues were never discussed in a political context. (Pembroke, 1994, p. 30)

This is not to say that survivors did not relate to self-harm as a problem or a source of suffering. *Self-Harm: Perspectives from Personal Experience* is rife with descriptions of self-harm as having 'tortured myself' (p. 8), as being 'in intolerable pain, desperately trying to preserve my life' (p. 24), or that it was a way to avoid hurting others. Andy Smith described that he was driven to self-harm as 'I was sure that being human was not compatible with the degree of difference between you and me' (p. 18). Others expressed that self-harm was a form of controllable pain, helping them cope as 'it took away the horrible feelings I had inside for a short while. I could even begin to love my wounds.' (p. 9). Famously, Maggy Ross described self-harm as 'a silent scream. It's about trying to create a sense of order out of chaos. It's a visual manifestation of extreme distress. Those of us who self-injure carry our emotional scars on our bodies.' (Pembroke, 1994, p. 15). She concluded by stating that she was still currently self-harming at the time of writing, expressing nuances of pride and self-worth while struggling with difficult experiences:

> I am still going through the battle. The battle is predominantly with myself, my past, and of course professional ignorance. You rarely come through a battle without scars. I, like many, am battle scarred. But I'm proud. Proud because I am going to win this battle. My scars are my proof. (Pembroke, 1994, p. 15)

Louise Pembroke, on her part, concluded her contribution by stressing the need for 'access to survivor-led/run non-medical services. […] Too many people need them. We must make it a reality.' (Pembroke, 1994, p. 35), finishing with a collective call to action for distributive justice.

Using the social justice definition of recovery as a *process of social change* addressing the social determinants of mental health, strengthening the rights of people who self-harm and consequently their sense of self and purpose, I propose that the testimonies of Pembroke and other contributors along with their demands for social change could be seen as recovery acts in themselves. Crucially, with the framing of self-harm as a means of survival in an oppressive social context (Cresswell, 2005; Pembroke, 1994), self-harm could also be understood as *part of* survivors' recovery processes, rather than the problem they should recover *from*.

This last point has been further explored in an analysis (Spandler, 2020) of the work of psychiatric survivor Tamsin Walker, who used cartoons as satirical activism to illuminate key contentions with the way psychiatry dealt/deals with self-harm. In one such cartoon, one person (presumably representing the psychiatric system) asks another (with lived experience of self-harm), 'So how is your self-harm going?', to which the reply is a smiling, 'Good thanks!' This illustrates the frequent misinterpretation of the function and value of self-harm and the imposition of the biomedical recovery model by the healthcare system, while also pointing to self-harm as a reasonable and valued coping strategy in survivors'/healthcare users' (re)claiming of their own recovery processes (Spandler, 2020).

These were merely a few selected examples of social justice commentary on recovery in relation to self-harm. However, recovery started to be framed differently by other stakeholders from the 1990s and onwards, giving rise to understandings of personal recovery that prevail today.

Personal recovery

With global political, economic, and mental healthcare reforms and with increasing attention devoted to the idea of recovery in research as well as policy, came Anthony's (1993) well-known definition of recovery, as:

> … a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony, 1993, p. 17)

Anthony's (1993) definition has subsequently become the 'classic' understanding of recovery in research and policy. This definition centralises the individual and has later come to be referred to as *personal* recovery (Harper & Speed, 2012; McWade, 2016; Price-Robertson et al., 2017; Slade, 2009).

As critics have pointed out, however, the recovery concept has been mainstreamed, stripped of its social justice origins, neutralised and co-opted by clinicians and policy-makers, reaffirming the hold that the biomedical model has in psychiatry and mental healthcare (Cohen, 2025; Harper & Speed, 2012; Howell & Voronka, 2012; Hunt & Resnick, 2015; McWade, 2016). Emphasising individual rather than social issues and introducing the idea that recovery could be understood from different, not necessarily opposing angles, has been considered a crucial step in this neutralisation process (McWade, 2016).

The vast field of research on self-harm today, like mental health research at large, is largely dominated by biomedical ideas of recovery, occasionally supplemented by perspectives of personal recovery (Faulkner, 2017). Personal recovery is often

approached and justified from the logic that we must consider this *also*. Rarely is there any mention of how the recovery perspective itself initially starkly challenged the very foundation of psychiatry and biomedicine.

Even when used within a seemingly progressive 'person-centred' framework (Lewis & Hasking, 2023), notions of recovery and a focus on strengths are often operationalised in this individualised personal recovery manner. Rather than truly challenging the biomedical model, such counter-framings still require the deficit-based perspective to make sense. For instance, Lewis and Hasking (2021) appear to want to challenge the biomedical focus on cessation of self-harm, though they remain within an understanding of their personal recovery approach as *different but complementary* to the biomedical model:

> Consideration of *all aspects* of recovery, *not just* cessation of the behavior, can help minimize focus on the behavior itself and offer opportunities to recognize growth and resilience (3, 10). *Together with* behavior change, recovery encompasses a growing belief in the ability to *resist ongoing urges* to self-injure and to *engage alternative coping strategies*. Addressing underlying mental health concerns may also lead to a *reduction in urges* to self-injure. (Lewis & Hasking, 2021, p. 722, emphasis added)

In taking such a reframing approach, though still implicitly relying on deficits and biomedical understandings of recovery, it has been argued that even well-meaning efforts to value the individual's voice and preferences risk to limit people's societal participation and inadvertently perpetuate social stigmatisation (Harper & Speed, 2012).

Neorecovery

Key critique against the evolution of the recovery concept comes from present-day healthcare users, survivors, or mad-identified people. One important example is Recovery in the Bin (n.d.), an initiative formed in 2014 by a group of mental health survivors in the U.K. to critique the co-option of recovery from the perspective of critical theory, advocating for human rights and social justice. In 2017, they coined the term *neorecovery* to signify the erosion of recovery in contemporary (Western) healthcare systems (Recovery in the Bin et al., 2019).

The word neorecovery refers to the central role of neoliberalism in reshaping recovery (Braslow, 2013; Cohen, 2025; Harper & Speed, 2012; Howell & Voronka, 2012; McWade, 2016; Recovery in the Bin et al., 2019). Neoliberal politics deregulates and privatises the economy, cutting back on welfare, social care and public healthcare. Neoliberal values of freedom, choice, rationality, and individual responsibility for self-reliance and risk-management, are emphasised (Cohen, 2025; Recovery in the Bin et al., 2019; Rose, 1996). The term *responsibilisation* has been used to describe the neoliberal process by which responsibilities, such as managing

health and risks, are relocated from the state or other authoritative agencies onto individuals for self-management (Peters, 2017; Rose, 1996, 1999).

It follows that neorecovery vastly differs from the original notion of recovery propagated by the early survivor movement. Mental health and disability are framed as individual rather than social issues, meaning that interventions aim to educate individuals and change their attitudes and behaviours rather than address their social conditions. Instead of healthcare users owning and leading their recovery processes, clinicians and other authority stakeholders hierarchically define and take the lead on recovery work. Further, the recovery vision of the early survivor movement was specific to people with enduring, severe mental health conditions, who advocated for mental healthcare services to be provided flexibly for the duration needed by the user. Contemporary enactments of neorecovery, instead, are present everywhere within a care system that rather promotes a one-size-fits-all approach of low-intensity, time-limited services provided in a mechanistic, progression-oriented manner (Recovery in the Bin et al., 2019).

Specifically in relation to self-harm, I would like to again raise Tamsin Walker's cartoon activism (as referenced by Spandler, 2020). In another single-panel piece, a person is depicted with visible cuts on their arm, holding a protest sign reading 'Stop the cuts'. This alludes to the self-harm cessation demand that healthcare services are commonly conditioned on (as per biomedical understandings of recovery), though Tamsin recontextualises it as a protest against budget and service cuts coming down on the healthcare system due to neoliberal politics (Spandler, 2020).

In sum, neorecovery can be described as a 'new' way of packaging old biomedical ideals, discursively aligning them with choice and individual autonomy in a way that *appears* to promote healthcare users' rights, though users are really made disproportionately responsible for their own health while biomedicine firmly retains its hegemonic grip on psychiatry.

Spreading awareness of the issue with neorecovery is part of a renewed call for increased acknowledgement of political and societal structures that disadvantage people with severe mental health conditions in their everyday lives. Mental health interventions need to address these issues to effect change and make real, valuable impact (Cohen, 2025; Recovery in the Bin et al., 2019).

Relational recovery

In critiquing overly individualistic understandings of recovery, numerous efforts have been made to re-emphasise the centrality of social issues and social relationships (Harper & Speed, 2012; Hunt & Resnick, 2015; Jacobson & Farah, 2012; Karlsson & Borg, 2022; Rosa-Rosa et al., 2025; Schön & Topor, 2009; Tew et al., 2012). The concept of *relational recovery* was propelled by Price-Robertson et al. (2017) to emphasise the interdependency of human nature, departing from the

basic assumption that 'people's lives and experiences cannot be separated from the social contexts in which they are embedded' (p. 109). That is, we aren't isolated islands or single entities separate from one another.

The authors' critique of individualistic understandings of recovery does not stop on the cultural level – i.e. that they aren't meaningful in collectivist populations or more collectivist countries beyond the Western world. Rather, they argue that human relationships are central to each and every aspect of experiencing recovery, using the well-known framework of connectedness, hope, identity, meaningfulness and empowerment (CHIME; Leamy et al., 2011) as an example. The CHIME framework originated in an individualist context and all aspects but connectedness tend to be viewed as intraindividual qualities or processes, though Price-Robertson et al. (2017) make the case that they can all be understood in relational, interactional terms.

Granted, relational recovery as construed by the aforementioned authors does not specifically engage with interdependence in the sense of collective political identities and shared, structural experiences of injustice (Price-Robertson et al., 2017). However, I still find the relational emphasis fruitful in a psychiatric setting, offering one way to challenge highly individualised, biomedically ruled, deficit-based understandings of self-harm and recovery, without implicitly depending on them.

The application of relational understandings of recovery in research on self-harm appears to be in its infancy. Using PubMed, a database for medical literature, a search for 'self-harm' and related concepts[7] in combination with the term 'relational recovery' resulted in only one hit: an article produced by members of the research team I am part of, on relatives' experiences of BA for adult loved ones (Lindkvist, Eckerström, et al., 2024). I replicated this search strategy in EBSCOhost, an information service gathering 45 different research databases including e.g. MEDLINE for life sciences, SocINDEX and other databases for sociology literature, and PsycInfo and other APA databases for psychology literature. This search produced no additional hits. I will save discussion of the BA article for the next chapter.

[7] The following search terms were used: 'self-harm' OR 'self-injury' OR 'self-injur*' OR 'NSSI' OR 'suicidal behavio*' OR 'suicide attempt' OR 'parasuicide' OR OR 'para-suicide' OR 'para suicide' OR 'suicidal thoughts' OR 'suicid*'.

Chapter 4. Self-harm, user-controlled admissions, and Brief Admission by self-referral (BA): history and outcomes

> I think, in moments of complete distress and hopelessness, our survival may still try to search the grounds for even a pinch of salt of hope. Because deep down we know, life is beautiful even though living is hard. (Quote by Ishita Mehra, appearing in Figure 4 of the Lancet commission on self-harm; Moran et al., 2024, p. 1460)

Brief Admission by self-referral (BA) is a relatively novel intervention in Swedish psychiatric care. From its origins in the Netherlands, many interventions involving user-managed admissions in mental healthcare settings have appeared internationally, going by different names such as Brief Admission, Brief Admission by self-referral (BA), Patient-Initiated Brief Admission (PIBA), Patient-controlled admission (PCA), Self-referral to inpatient treatment (SRIT), and self-admission.

In this dissertation, I will use the term *BA* to refer specifically to Brief Admission by self-referral, as it has been developed and standardised in Sweden as a crisis management and prevention method targeting people who self-harm. I will use *Brief User-Controlled Admission* (BUCA; Westling et al., 2025) as a broader umbrella term encompassing various methods involving user-managed admission, for the same or different target groups.

In this chapter, I will briefly contextualise the development of BUCA interventions historically and internationally. Next, I will describe the structure, procedures, and conditions specific to the BA method in adult as well as child and adolescent psychiatry. I will then summarise what research on BA and other BUCA can tell us about human rights and recovery.

Historical context of BUCA in mental healthcare

The earliest initiatives toward BUCA can be traced back to the Netherlands (Helleman, 2017). In the 1970s, there was a movement away from institutionalised psychiatry toward community care, and with this came new crisis management interventions aiming to reduce hospitalisation. Hospitalisations still increased during the 1980s, however. The negative effects of lengthy hospitalisations, particularly for people with BPD, came into awareness. From this, Brief Admission was developed as a complement to day treatment, to give healthcare users the possibility of admitting for short periods to de-escalate or prevent crisis. It was widely implemented across the country though not in a standardised manner, giving rise to substantial geographical differences in the conditions and quality of care. Systematic studies on the method, its outcomes, and experiences among users and clinicians only appeared about a decade ago (Helleman, 2017).

In the 1990s, BUCA were launched in the UK as secondary prevention initiatives to promptly address early instances of hospitalisation due to self-harm in adults (Morgan et al., 1993) and adolescents (Cotgrove et al., 1995). The terms deliberate self-harm and attempted suicide were used synonymously in both reports of the randomised controlled trials. In both cases, participants in the control group received treatment as usual while the experimental group received treatment as usual and a token which allowed them one opportunity to re-admit on demand if feeling suicidal (Cotgrove et al., 1995; Morgan et al., 1993). In the paper involving adults, the token also granted them phone contact with a doctor at any time (Morgan et al., 1993). Both articles have been cited over 100 times in Scopus, including in recent review articles, but BUCA does not appear to have taken hold in the UK.

Most of the research on BUCA was published in the last two decades. One example worth mentioning is an older report from the USA on various forms of brief admission plans, for two to five days, intended for people with BPD. The report summarises five cases of individuals getting admitted as per such plans where the intention was for the individual to be allowed to self-admit, though in most cases decisions on admission were also based on professional assessments or made in consultation with a case manager. Conditions also varied for participants, where current self-harm could be required for admission or an exclusion criterion, and self-harm during admission could result in premature discharge or losing one's admission contract altogether (Nehls, 1994). This is the only report I have identified on (supposed) BUCA in the USA.

Another, more recent example is the Open Borders programme in Australia, described as a recovery-oriented intervention for people with BPD, whereby they were offered the opportunity to self-admit for brief periods of up to a week to a residential facility staffed by nurses only. While admitted, healthcare users received DBT-influenced skills training (Mortimer-Jones et al., 2016). The perspectives of

individual users and staff were reported about six years ago (Mortimer-Jones et al., 2019), though to my knowledge, no further research has appeared on this intervention since.

At the time of writing, BUCA has mostly been researched in the Scandinavian countries. Some variants specifically target people who self-harm and/or have symptoms or a diagnosis of BPD (Eckerström et al., 2022; Eckerström et al., 2020; Enoksson et al., 2022; Helleman et al., 2014b; Hultsjö et al., 2025; Mortimer-Jones et al., 2019), yet it may also be offered to people with e.g., eating disorder (Strand et al., 2020; Strand et al., 2017), schizophrenia spectrum diagnoses (Skott et al., 2021), or trans-diagnostically to people deemed to have 'severe' or 'complex' mental healthcare needs (Ellegaard et al., 2017; Ellegaard et al., 2020; Moberg, 2025; Moberg & Schön, 2022; Moljord et al., 2017; Moljord et al., 2016; Nyttingnes & Ruud, 2020; Nyttingnes et al., 2021; Olsø et al., 2016; Rise et al., 2014; Sigrunarson et al., 2017; Thomsen et al., 2018). Current self-harm may be an exclusion criterion in some cases (Moljord et al., 2017; Moljord et al., 2016; Sigrunarson et al., 2017; Strand et al., 2020; Strand et al., 2017).

Aside from the target population, differences in delivery may pertain to practicalities, such as what professions are involved (e.g. psychiatrists or registered nurses and psychiatric aides), routines for intake and discharge meetings, assessment of suicide risk, routines for when beds are occupied (e.g. a waitlist system or phone support and encouragement to try again the next day), how many consecutive days healthcare users may be admitted (e.g. three or up to four, five, or seven days), or how many times per month (limited or unlimited).

The implementation of BA in Sweden began in the Skåne region, around the same time as in our neighbouring countries: in 2015 in adult psychiatry and 2018 in child and adolescent psychiatry. Some form of BUCA is currently available within public healthcare in almost all regions in Sweden, with some offering such services specifically for people who self-harm, and others including people who self-harm and a range of other psychiatric healthcare users (Swedish National Board of Health and Welfare, 2021, 2023b).

In the following section, I will describe the distinctive features of the standardised BA method in the regional psychiatric settings of this dissertation.

Structure, content and procedures of BA

BA was brought to Sweden in a clinical research collaboration between Sweden and the Netherlands. The standardisation and implementation of BA in Sweden, through the Brief Admission Skåne Randomized Controlled Trial (BASRCT; Liljedahl et al., 2017; Westling et al., 2019), was directly based on the accumulating evidence from

the Netherlands (Helleman, 2017; Helleman et al., 2014a, 2014b), which could then be expanded in a Swedish context (Daukantaitė et al., 2025; Helleman et al., 2018; Lindkvist et al., 2019; Lindkvist, Steen Carlsson, et al., 2024; Westling et al., 2019).

BA is offered as an add-on to treatment as usual in psychiatric settings in Sweden. The delivery of BA is slightly different in CAP, so I will summarise the core features of BA in adult and CAP settings separately.

BA in adult psychiatry

BA (Liljedahl et al., 2017; Liljedahl, Lindkvist, et al., 2023) is a form of psychiatric admission intended for people who repeatedly self-harm and have a history of contact with emergency psychiatric inpatient care, with the purpose of preventing self-harm and enhancing the healthcare user's autonomy and control over their own health and care. In contrast to conventional forms of psychiatric admission, which are managed by physicians, the user is empowered to decide for themselves and can to self-admit when they feel the need to, within certain time frames.

In line with promoting their autonomy and competence in caring for themselves, the healthcare user remains in charge of bringing and administrating their prescribed medication during their stay at the unit. They are also expected to maintain their regular healthcare commitments during BA, such as attending appointments in outpatient care or calling in to reschedule if needed. The healthcare user will not see a psychiatrist or any other treating clinician for adjustment of medications, therapy sessions or treatment planning at the inpatient clinic, but they are free to contact and visit outpatient care for this while they are admitted with BA.

Admissions with BA are brief, one to three nights and maximum three times per month. Aligned with enhancing autonomy, the healthcare user is free to come and go as they wish during BA, e.g., to go for walks, visit a friend, or go to school/work during the day. This further enables them to remain in touch with health-promoting aspects of their everyday life.

BA is managed solely by registered nurses and psychiatric aides, not psychiatrists. Professionals working with BA are trained to interact with healthcare users in a warm, welcoming, engaged, respectful, collaborative, and validating manner. The importance of non-judgmental listening is emphasised.

The healthcare user may be considered for BA at the initiative of psychiatric inpatient or outpatient care contacts, though different clinics have somewhat varying routines regarding which healthcare professionals are able to make this request, or submit a formal referral. The head psychiatrist at the inpatient unit assesses the suitability of BA for each individual based on the referral information and/or medical records, often in dialogue with colleagues. If BA is believed to be helpful for the individual, an inpatient clinician initiates a contract negotiation involving the

healthcare user and representatives from inpatient and outpatient care, held at a time when the healthcare user is not in distress.

During negotiation, the general purposes and procedures of BA is introduced, and the healthcare user and professionals collaboratively discuss how BA might be used. The healthcare user writes down personalised items on the contract, including their specific goals with BA (e.g. ask for help more often, signal to myself that I deserve to feel better), personal early signs that they might need to self-admit (e.g. withdrawing from friends, sleeping poorly), strategies for self-care during admissions (e.g. sketching, playing games, talking to a friend), preferred approaches from professionals during BA (e.g. invite me/remind me to join activities, leave me be by myself when I'm in my room), personal arrangements that may need tending to prior to admission (e.g. who will take care of my dog when I'm admitted, who will let my school/work know that I will be absent for a few days), or other matters of importance for the healthcare user. The contract also includes the standardised framework of BA, such as maximum duration and frequency, procedures for intake and discharge, what the healthcare user is offered during BA (e.g. brief talks about their day with psychiatric aides twice daily, activities taking place at the unit), and the responsibilities and commitments of the healthcare user during admission with BA (e.g. not self-harming during BA, not bringing dangerous items or being intoxicated at the unit).

The healthcare user receives a copy of the BA contract, and one copy is kept at the inpatient unit for reference. Having access to BA means that the healthcare user may call in and request self-admission whenever they feel the need to. The healthcare user is not assessed in any way upon making this request; their own judgement that they need a BA is valid and enough. The professional will check the current capacity of the unit and propose a time during the same day when the healthcare user is welcome for intake. If no beds are currently available, the professional will encourage the healthcare user to try again the next day and talk to them about how they might cope in the meantime. As a few beds are usually earmarked for BA, they are likely to become available shortly.

At intake, a contact person working at that time greets the healthcare user and reviews their contract together, discussing the person's goals and preferences for the current BA. They agree on how many nights the individual will stay admitted, three being the maximum. The date and time of discharge is decided.

The healthcare user is free to discharge themselves earlier than planned but cannot prolong a BA. At the end of the BA, a discharge conversation takes place where the healthcare user fills out an evaluation form and discusses their experience of this admission in terms of their goals and changes needed for future BAs. If, at the end of the BA, the healthcare user wishes to stay admitted, they can either go home to sleep one night and call in the next day for a new BA request, or, if they feel a more acute need of care, they are free to seek emergency psychiatric services as usual.

The healthcare user may be discharged prematurely from BA if e.g., they self-harm, are intoxicated, are exposing others to danger or otherwise do not comply with the rules at the unit. The rationale for premature discharge is that BA is supposed to be a safe context for everyone at the unit. Importantly, during a premature discharge conversation, the professional clearly reiterates the terms of the BA contract while validating the person's experience. The healthcare user is not judged or blamed; rather, the professional emphasises that the healthcare user has not failed and that there is a learning-curve to using BA. The professional takes care to remind the healthcare user that they are welcome back for a BA at another time and that they are also welcome to seek emergency services if needed.

BA in child and adolescent psychiatry

BA in CAP (Johansson et al., 2023; Johansson et al., 2024) works in much the same way as in adult settings, with the same purposes and core components in the intervention. A few key issues are worth highlighting, centred around the balancing act of promoting adolescent autonomy while providing adequate support, not requiring the same level of self-management as with adults.

The basic tenet is to provide the same degree of support as the adolescent would reasonably have at home in their everyday life. For instance, they will not be expected to manage their own prescription medications; these will be managed and administered by registered nurses.

Contract negotiation also involves a parent, legal guardian, carer or other key adult, meaning that the adolescent and adult is informed about the purposes, procedures, and conditions of BA simultaneously. The adolescent is encouraged to be the one to seek BA when they wish, while the key adult is welcome to offer encouragement and reminders that BA is available.

The adolescent is free to decide whether they want their key adult present with them during admission with BA. If they prefer to be admitted alone, adults are expected to respect this. The key adult is usually present at intake and discharge meetings; if not, the general rule is to inform them over the phone. This is a marked difference from conventional psychiatric admissions at CAP, where a parent or other key adult is required to stay with the child throughout admission.

Outcomes of BUCA for people who self-harm

The varying terms, target populations and conditions for BUCA in mental healthcare makes it difficult to summarise research findings and their implications succinctly and accurately.

In the following section, I will attempt to summarise the results of research on BUCA when offered to people who self-harm. I will apply the theoretical concepts of the previous chapter to summarise the results of research into BA as well as other forms of BUCA.

BUCA and human rights

Right to health and the AAAQ framework

As noted previously, promoting equitably available, accessible, accepted, and high-quality care services is interlinked with protecting healthcare users' right to health. Virtually all research on BUCA points out that this form of service delivery improves access to care, though they rarely explain what exactly they mean by that.

The most obvious changed condition for care is the reorganisation and adaptation of psychiatric services so that BUCA are user-controlled rather than clinician-controlled. This can be considered a means of enhancing *non-discriminatory accessibility*, as users are presumed to be capable of recognising their own needs and managing their own admissions, rather than assumed to be incapable from a deficit-based perspective. The latter discriminatory assumption has previously warranted substitute decision-making and coercion for people in crisis, including people who self-harm (Stastny et al., 2020; United Nations Human Rights Council, 2017, 2020). With BUCA, healthcare users can access psychiatric services more freely and in a timelier manner; they are usually able to self-admit the same day or within a few days from the first request. This is a major strength of this form of healthcare service, which also taps into the *acceptability* dimension of rights-based services.

Both users and their families frequently described relief in knowing that BUCA users were able to access care more freely, reliably and immediately without much stress or drama. This was often contrasted with experiences seeking psychiatric emergency care, waiting for hours in crisis, only to be sent home (Eckerström et al., 2020; Enoksson et al., 2022; Hultsjö, Appelfeldt, et al., 2023; Hultsjö, Rosenlund, et al., 2023; Hultsjö et al., 2025; Lindkvist, Eckerström, et al., 2024; Lindkvist et al., 2021; Lindkvist et al., 2022; Moberg, 2025; Värnå et al., 2025). Improved access in this way was also noted by clinicians working with BA (Lindkvist et al., 2025; Lindkvist et al., 2019). For adolescents with BA in particular, getting to self-admit without parents uniquely helped them focus on themselves and not feel guilty about how their parents might be feeling (Lindkvist et al., 2022). Interestingly, in one study, family also felt they were more involved in their loved one's care during BA, in contrast to conventional admissions where family weren't offered any insight into care processes and would sometimes be criticised by clinicians for being overly involved (Hultsjö, Appelfeldt, et al., 2023). In sum, accommodating psychiatric admissions to facilitate non-discriminatory accessibility and strengthen user and

family participation clearly aligns with a rights-based approach to psychiatry, supporting healthcare users' human right to health.[8]

However, some issues highlighted by users and family were restrictions on BA utilisation, such as the number of consecutive nights allowed (Daukantaitė et al., 2025; Lindkvist et al., 2022) or that it wasn't possible to request self-admission at night, though this was when some felt they most needed it (Hultsjö, Rosenlund, et al., 2023; Lindkvist, Eckerström, et al., 2024; Lindkvist et al., 2022). Importantly, seeking BUCA but being denied due to bed occupancy was a difficult and discouraging experience, which could result in fear of seeking and being rejected again (Eckerström et al., 2020; Helleman et al., 2018; Hultsjö, Appelfeldt, et al., 2023; Hultsjö, Rosenlund, et al., 2023; Hultsjö et al., 2025; Lindkvist, Eckerström, et al., 2024; Lindkvist et al., 2021) as well as a sense of betrayal for relatives who lost faith in psychiatry (Hultsjö, Appelfeldt, et al., 2023). Users, family, and even clinicians have also pointed out that it might be better to offer BA in its own clinic or care unit, as users may be triggered when admitted in an emergency environment where they had had previous negative, potentially traumatising experiences, and/or when admitted together with people who were there on emergency admissions (Daukantaitė et al., 2025; Eckerström et al., 2020; Helleman et al., 2018; Hultsjö, Rosenlund, et al., 2023; Lindkvist, Eckerström, et al., 2024; Lindkvist et al., 2025; Lindkvist et al., 2019; Lindkvist et al., 2021; Lindkvist et al., 2022). Of note, BA is indeed offered in its own unit in Lund, the site where the method was first implemented in Sweden, as well as a few other sites for adults.

Another issue according to clinicians was that BUCA wasn't considered to be well-adapted to CAP, specifically in relation to handling parental involvement while seeking to support the autonomy of adolescents (Lindkvist et al., 2025; Moberg & Schön, 2022). Further, while some studies suggested improved collaboration between inpatient and outpatient care with BA (Lindkvist et al., 2025; Lindkvist et al., 2019), a study on BUCA for a wider target group suggested such collaboration was not sufficient and that lack of communication between management, clinicians and healthcare users hampered implementation (Moberg & Schön, 2022). The aforementioned issues can restrict access to and quality of care with BUCA, limiting gains in terms of the human right to health.

Another dimension to consider is that of *availability*, that enough care services are offered in relation to healthcare users' needs. I understand this in terms of what sort of services are available for what sort of mental health issues. Considering BA, part of the reason why it came about was to cater to a need that was previously not fulfilled in psychiatry: managing suicidality without aggravating self-harm or causing other iatrogenic harms for people with BPD (Burrin et al., 2021; Coyle et al., 2018; James et al., 2012; Large et al., 2014). One could argue that another

[8] I will elaborate more on the right to autonomy in healthcare under the next headline.

distinctly important aspect of rights-based BUCA, apart from accommodating the conditions for admissions, was about providing a model of care that was *preventively oriented*: one where users were explicitly encouraged to seek care *before* rather than during crisis, and clinicians on the floor were trained to welcome, encourage, and collaborate with them warmly, so as to support users' sense of self-worth and competence rather than aggravate self-blame and impulses to self-harm. This model of care did not exist previously in Sweden. Its introduction catered to the needs of healthcare users to get support early on, which helped them take care of themselves, take control of their health and feel better (Eckerström et al., 2020; Enoksson et al., 2022; Hultsjö, Appelfeldt, et al., 2023; Hultsjö, Rosenlund, et al., 2023; Hultsjö et al., 2025; Lindkvist, Eckerström, et al., 2024; Lindkvist et al., 2022; Moberg, 2025), aligned with their right to health.

In terms of the *affordability* aspect of accessible care, public healthcare in Sweden is heavily subsidised so as to be more affordable to everyone. The individual healthcare user pays 130 SEK, which is the equivalent of about 10 GBP, 12 EUR, or 14 USD, per night of admission in both somatic and psychiatric inpatient care, and the same goes for BUCA. Does this mean that BUCA have no special bearing on affordability? Not necessarily. Healthcare users have reported that BA enabled them to get back on track with everyday life more quickly, including getting back to work or even being able to work while admitted, so that they didn't lose as much income as they otherwise might have (Enoksson et al., 2022; Helleman et al., 2018; Hultsjö, Rosenlund, et al., 2023).

As for *geographic* accessibility, BA as well as other BUCA models have been spreading across Sweden and other Scandinavian countries, mostly over the last decade (Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2021), meaning that more and more healthcare users are able to reach these services. Such improvements in health equity would also entail improvements in assuring everyone's equal right to health. Interestingly, family members seemed to consider BA as a potential bridge into conventional psychiatric admissions, in effect making the latter more accessible as well (Hultsjö, Appelfeldt, et al., 2023), though another study has suggested the contrary (Daukantaitė et al., 2025).

Finally, considering (additional) *acceptability* outcomes, healthcare users as well as their families and clinicians have generally reported satisfaction with BUCA models of care. The trust-based approach in BUCA appeared to lay the foundation for an open, relaxed, friendly atmosphere and a feeling of safety during such admissions (Eckerström et al., 2020; Enoksson et al., 2022; Helleman et al., 2018; Hultsjö et al., 2025; Lindkvist, Eckerström, et al., 2024; Lindkvist et al., 2025; Lindkvist et al., 2021; Lindkvist et al., 2022; Moberg, 2025; Mortimer-Jones et al., 2019; Värnå et al., 2025). Overall, contact with clinicians during BUCA helped people overcome difficulties, find helpful strategies to cope, and feel seen, accepted, and calm (Daukantaitė et al., 2025; Eckerström et al., 2020; Enoksson et al., 2022; Helleman

et al., 2014b; Helleman et al., 2016; Lindkvist et al., 2021; Lindkvist et al., 2022; Mortimer-Jones et al., 2019). Clinicians felt they gained more time with self-admitted BUCA users and more adaptability, flexibility, and independence in their work situation (Lindkvist et al., 2019; Mortimer-Jones et al., 2019), though others have argued that BA delivery can be hampered by an inflexible overarching healthcare setting (Lindkvist et al., 2025).

The clear framework, collaboratively established BA contract and routine intake conversation were considered to bring predictability for healthcare users (Eckerström et al., 2020; Helleman et al., 2014b; Helleman et al., 2018; Lindkvist et al., 2021; Lindkvist et al., 2022) as well as the family (Hultsjö, Appelfeldt, et al., 2023; Hultsjö, Rosenlund, et al., 2023) and clinicians working with BA (Lindkvist et al., 2019). As previously mentioned, clinicians are trained to be welcoming, warm, non-judgmental, respectful, engaged, validating and collaborative in interacting with healthcare users, as part of the BA method. Clinicians experienced inspiration, joy and hope in working with BA, related to it as a reformed way of working in psychiatry, and especially appreciated being able to break with destructive power struggles in favour of constructive collaboration with healthcare users (Lindkvist et al., 2025; Lindkvist et al., 2019). This all suggests that BA is an acceptable model of care, and is acceptably delivered, in a psychiatric context. Good quality of care and high acceptability aligns with healthcare users' right to health both directly and indirectly, as it would arguably make users more prone to seek such care.

However, healthcare users have also shared experiences of clinicians not being available or not prioritising self-admitted users, making them feel forgotten or neglected, which could aggravate emotional distress and impulses to self-harm (Helleman et al., 2014b; Helleman et al., 2018; Lindkvist et al., 2021; Lindkvist et al., 2022). For the surrounding family, BA could seem pointless when their loved one did not seem to receive proper support (Hultsjö, Rosenlund, et al., 2023). Further, clinicians have been reported to lack sufficient knowledge about the conditions of BA and behave dismissively, questioningly, or otherwise inappropriately in interactions with BA users (Eckerström et al., 2020; Helleman et al., 2018; Lindkvist et al., 2021; Lindkvist et al., 2022; Värnå et al., 2025). Some of these issues echoed in studies on clinicians' experiences with BUCA (Lindkvist et al., 2025; Lindkvist et al., 2019; Moberg & Schön, 2022). There were also testimonies of clinicians rigidly refusing to help with medication, a toothbrush, or dressing a wound, as well as denying emergency services in times of crisis by reference to the fact that they have access to BA (Daukantaitė et al., 2025; Lindkvist, Eckerström, et al., 2024; Lindkvist et al., 2021). Such clinical approaches are highly problematic and have, in fact, led some individuals to terminate their BA contracts (Daukantaitė et al., 2025).

Taken together, research on BA and other BUCA generally suggests that these models improve the availability, accessibility, acceptability, and quality of care in a

number of ways, directly supporting healthcare users' human right to health. However, this is not to say that these improvements are inherent to the method or occur automatically with implementation. Some important challenges still need to be addressed, specifically to further improve accessibility and acceptability.

Autonomy and freedom from coercion

BUCA, by their very nature, are a user-controlled model of care that can be considered diametrically opposed to coercion. In the case of BA, specifically, the freedom to choose if and when to get oneself admitted for a few days exists alongside the freedom to opt out, as the healthcare user is free to self-discharge at any point during admission. The user is also free to come and go from the unit during the day (Liljedahl, Lindkvist, et al., 2023). This evidently aligns with healthcare users' rights to liberty, freedom from coercion, and autonomy in healthcare. The brevity of admissions and the freedom to come and go from the unit while admitted also supports users' right to participate in the community.

Apart from inherently aligning with healthcare users' rights to autonomy and freedom, a few studies on BA have included involuntary admissions and coercive measures among the assessed outcomes. An RCT including 125 adult participants reported a significant within-group reduction of days on involuntary admission for those with access to BA, though no significant between-group effect was demonstrated. No significant effect was found for coercive measures (Westling et al., 2019). An observational study using pre-post design on 63 adolescents who self-harmed did not demonstrate any statistically significant changes in terms of compulsory admissions, with eight such instances in total prior to gaining access to BA, and five subsequently (Johansson et al., 2023).

Qualitative studies have highlighted aspects of trusting, empowering and engaging users to decide about their own healthcare as particularly helpful (Eckerström et al., 2020; Enoksson et al., 2022; Helleman et al., 2018; Hultsjö, Rosenlund, et al., 2023; Lindkvist et al., 2025; Lindkvist et al., 2019; Lindkvist et al., 2021; Lindkvist et al., 2022; Moberg & Schön, 2022; Mortimer-Jones et al., 2019), although completely restoring power to the user was not done easily or instantly (Moberg & Schön, 2022). The elements of deservingness and trust arguably also tap into the matter of dignity, reviewed below. Additionally, enhanced autonomy has been suggested to facilitate and increase help-seeking (Lindkvist et al., 2022), whereas experiences of being kept against one's will would do the opposite (Hultsjö, Rosenlund, et al., 2023). In this way, BA and other BUCA align with healthcare users' rights to liberty, freedom from coercion, and autonomy in healthcare, as well as indirectly with their right to health.

Dignity

Qualitative research on BUCA have reported experiences of improved self-esteem, sense of self-worth and dignity among healthcare users, as well as increased

confidence in one's ability to cope, which may bring about a sense of independence and/or pride (Eckerström et al., 2020; Enoksson et al., 2022; Helleman et al., 2014b; Hultsjö et al., 2025; Lindkvist et al., 2019; Lindkvist et al., 2021; Lindkvist et al., 2022; Moberg, 2025; Värnå et al., 2025). Relatedly, having access to BUCA as well as self-admitting with them may give healthcare users a sense of agency and personal control of one's health and care, and in life more generally (Eckerström et al., 2020; Enoksson et al., 2022; Helleman et al., 2018; Lindkvist et al., 2025; Lindkvist et al., 2022).

Both users and clinicians experienced that healthcare users were increasingly met as human beings, supported and encouraged (Eckerström et al., 2020; Helleman et al., 2018; Lindkvist et al., 2019; Mortimer-Jones et al., 2019), rather than being considered sick patients as per the traditional, deficit-based and disease-focused biomedical model (Lindkvist et al., 2019; Mortimer-Jones et al., 2019). A few studies stressed the importance of being believed and taken seriously when requesting help (Lindkvist et al., 2021; Moberg, 2025; Moberg & Schön, 2022). Clinicians found it uplifting to get to meet healthcare users' needs and give back their rights and dignity (Lindkvist et al., 2019).

Notably, obstacles have been described for users wanting to self-admit, such as difficulty making the phone call or finding the words to request help. Healthcare users may question their own needs for a BA, feel ashamed and unworthy of care, or feel guilty about seeking BA and taking up a spot that someone else might need more (Eckerström et al., 2020; Helleman et al., 2016; Helleman et al., 2018; Hultsjö et al., 2025; Lindkvist et al., 2021; Lindkvist et al., 2022; Värnå et al., 2025). Such experiences highlight the potentially detrimental consequences of *not* being treated with dignity, providing all the more reason why dignity needs to be prioritised in psychiatry. Failure to treat people who self-harm with dignity violates one of their most basic human rights, as well as threatening their right to health.

BUCA and recovery

Outcomes aligned with biomedical recovery

The quantitative research on BUCA has tended to focus on recovery in terms of symptoms, care utilisation, and level of functioning. I am considering such outcomes as aligned with a biomedical understanding of recovery, since symptom reduction and improved functioning are widely defined as clinical goals of interventions delivered in psychiatry. To be clear, this in no way excludes the possibility that such goals can be personally important to healthcare users, as well.

The UK studies on token access to BUCA reported statistically non-significant tendencies toward reductions in repeated self-harm/suicide attempts for the experimental groups at one-year follow-up (Cotgrove et al., 1995; Morgan et al.,

1993). More recently, a Danish study on PCA not specifically focused on people who self-harm, but which did include self-harm as an outcome measure, found no statistically significant effect on self-harm neither between nor within groups (Thomsen et al., 2018). A Swedish RCT on BA for adults who self-harm found no evidence of significant between-group differences in self-harm, though the authors noted a statistically significant within-group decrease for the group who had access to BA (Westling et al., 2019). An important consideration in this context is that the clinical definition of self-harm as the main intervention target had consequences for healthcare users; specifically, adolescents self-admitting with BA found it tough and unfair to be discharged if they self-harmed, feeling that this was when they needed help the most (Lindkvist et al., 2022). Apart from self-harm, symptom reduction has been demonstrated for anxiety and depression in a repeated measures study (Eckerström et al., 2022).

Paradoxically, another commonly studied outcome is healthcare utilisation. Some evidence has been reported of pre-post reductions in visits to psychiatric emergency services and days admitted in inpatient care for both adults (Westling et al., 2019) and adolescents with access to BA (Johansson et al., 2023), though no significant between-group effects were observed (Westling et al., 2019). A register study (Eckerström et al., 2024) comparing BUCA users to psychiatric healthcare users without access to BUCA found evidence of reduced days in inpatient admissions for both groups over a three-year period, with a statistically significant reduction in length of admissions for BUCA users. BUCA users also showed a statistically significant increase in utilisation of outpatient services, as compared to the control group (Eckerström et al., 2024). Curiously, despite BUCA entailing short care periods, some clinicians have still been reported to worry that healthcare users risked being dependent on healthcare (Moberg & Schön, 2022; Mortimer-Jones et al., 2019). Of note, defining healthcare utilisation as a recovery outcome clearly stems from a biomedical point of view, as it is not said that such reductions would have inherent value to healthcare users or be indicative of feeling better in life at large – especially as healthcare users are actively encouraged to use BUCA, and there may be other experienced value in taking control of one's health and care, as will be discussed below.

Relatedly, a large body of qualitative research has suggested that knowing one has the opportunity to self-admit may be perceived as helpful for the individual not to act on self-harming impulses, being able to cope at home rather than self-admitting, or spending fewer days being admitted (Daukantaitė et al., 2025; Eckerström et al., 2020; Enoksson et al., 2022; Helleman et al., 2014b; Helleman et al., 2016; Helleman et al., 2018; Lindkvist et al., 2021; Lindkvist et al., 2022; Mortimer-Jones et al., 2019; Värnå et al., 2025), experiences which were also reported by family members and clinicians (Hultsjö, Appelfeldt, et al., 2023; Hultsjö, Rosenlund, et al., 2023; Lindkvist et al., 2025; Lindkvist et al., 2019; Moberg & Schön, 2022).

In terms of daily functioning, qualitative studies have reported that BUCA could help people pursue or stay connected to work or education (Enoksson et al., 2022; Helleman et al., 2014b; Helleman et al., 2018; Hultsjö, Rosenlund, et al., 2023; Lindkvist et al., 2021; Lindkvist et al., 2022; Mortimer-Jones et al., 2019). Further, an RCT assessed daily life functioning with the *World Health Organization Disability Assessment Schedule II (WHODAS-II)* and reported a significant between-group improvement in mobility (moving and getting around), as well as within-group improvements in cognition (understanding and communicating), domestic responsibilities, and participation (joining in community activities) not observed in the control group (Westling et al., 2019). Another study considered self-reported functioning and quality of health according to a five-item scale, the *EuroQol Five-Dimensions Questionnaire (EQ-5D)*, with questions on anxiety and depression, pain and discomfort, self-care, mobility, and activities in daily life. The study noted statistically significant pre-post improvements with medium-large effects (Eckerström et al., 2022). Moreover, a health-economic evaluation (Lindkvist, Steen Carlsson, et al., 2024) based on WHODAS-II data from an RCT on BA (Westling et al., 2019) suggested that BA was associated with a gain in quality-adjusted life years equivalent to almost one month of perfect health (Lindkvist, Steen Carlsson, et al., 2024).

Softer values of personal recovery

Other values that went beyond – but didn't challenge – the biomedical take on recovery have also been emphasised in qualitative studies. These could be considered part of the personal recovery discourse, focused on various aspects of individual wellbeing and quality of life.

Part of this was getting some rest and peace of mind, as BUCA could offer a precious time-out from the stresses and demands of everyday life. BUCA could also ensure people's basic needs were met, in terms of food, sleep, hygiene, etc., which could help them get back into daily routines in their everyday lives (Eckerström et al., 2020; Enoksson et al., 2022; Helleman et al., 2014b; Helleman et al., 2018; Lindkvist et al., 2021; Lindkvist et al., 2022; Värnå et al., 2025).

Some people with access to BUCA experienced an increased commitment to their own health and self-care (Enoksson et al., 2022; Lindkvist et al., 2019; Lindkvist et al., 2021), paying more attention to their own internal states and needs, feeling that they understood themselves better (Eckerström et al., 2020; Enoksson et al., 2022; Lindkvist et al., 2022; Mortimer-Jones et al., 2019; Värnå et al., 2025). There were also reports of a sense of inner stability after gaining access to BUCA (Eckerström et al., 2020; Mortimer-Jones et al., 2019), as well as increased self-compassion, self-love and acceptance of one's emotions (Lindkvist et al., 2021; Lindkvist et al., 2022; Mortimer-Jones et al., 2019; Värnå et al., 2025).

A slippery slope toward neorecovery

The flip side of increased personal autonomy is that having more influence and responsibility of one's care can be difficult. As noted in qualitative research, BUCA may entail a challenging learning process in terms of e.g., being able to define one's own goals, identify early signs of needing to self-admit, recognise such signs on time, and manage one's own medication while self-admitted (Eckerström et al., 2020; Helleman et al., 2014, 2016, 2018b; Lindkvist et al., 2021, 2022; Moberg & Schön, 2022). Having more freedom, as in not being monitored by clinicians and being free to go outside, could feel unsafe sometimes, as healthcare users could face situations where they had impulses to self-harm (Lindkvist et al., 2021, 2022). Additionally, the experience of ending up on conventional admissions when having tried to use BA was described as exhausting and disheartening (Lindkvist et al., 2022).

Such experiences highlight the risk of overemphasising autonomy and personal responsibility, overshadowing the healthcare user's care needs. As noted in the previous chapter, this would signify a pull in a more neoliberal direction, where the focus is on individual choice and responsibility, rather than a truly rights-based grounding of care (Cohen, 2025; Recovery in the Bin et al., 2019). Arguably, the previous mentions of clinicians refusing to help with medication, dressing a wound, or other needs expressed by healthcare users during BA (Daukantaitė et al., 2025; Lindkvist, Eckerström, et al., 2024; Lindkvist et al., 2021) suggest rigid reference to user autonomy to the *detriment* of healthcare users' recovery and rights to health and dignity. This illustrates the pitfall of thinking that BA *per se* ensures users' rights, and the importance of a firm grounding of BA and other BUCA in a human rights approach and a wider perspective on recovery.

Support for relational recovery

Finally, relational recovery has explicitly been discussed in a recent focus group study (Lindkvist, Eckerström, et al., 2024) on family experiences with BA for adult users. Family members described that BA provided 'virtuous cycles of rest and recovery' (p. 9) not just for the user, but for the family as well. Knowing that their loved ones were safe and okay on BA meant that family members could relax, and family members and their loved ones on BA were all perceived to experience less relational guilt and shame. Access to BA facilitated relational boundary work which was perceived to improve the relationship between the BA user and family members, as well as allowing family members to focus more on caring for children in the family. Family members also shared perceptions that their loved ones could self-admit with BA as an act of care for their family (Lindkvist, Eckerström, et al., 2024). This illustrates the interdependency of human nature generally, and of recovery specifically.

Additional qualitative studies further supported valued social and relational gains with BUCA (Helleman et al., 2014b; Hultsjö, Appelfeldt, et al., 2023; Hultsjö,

Rosenlund, et al., 2023; Lindkvist et al., 2021; Moberg, 2025; Mortimer-Jones et al., 2019), reporting how family members were relieved of responsibility and the need to be in control, along with relief from difficult feelings of helplessness, sadness, anger, guilt, shame, and fear (Hultsjö, Appelfeldt, et al., 2023; Hultsjö, Rosenlund, et al., 2023). For the user, being admitted with BUCA could offer opportunities to connect with others (Helleman et al., 2014b; Lindkvist et al., 2021; Mortimer-Jones et al., 2019) as well as decreased conflicts with partners and increased chances to maintain contact with family and friends. Some users also reported having an easier time caring for and reassuring their children when they would go away for just a few days to self-admit (Enoksson et al., 2022; Hultsjö, Appelfeldt, et al., 2023; Hultsjö, Rosenlund, et al., 2023; Lindkvist et al., 2021). A final noteworthy result is that BUCA users reported experiencing a feeling of safety during these admissions, attributed in part to the relational, trust-based approach of BUCA (Eckerström et al., 2020; Enoksson et al., 2022; Helleman et al., 2014b; Helleman et al., 2018; Hultsjö et al., 2025; Lindkvist et al., 2021; Lindkvist et al., 2022; Moberg, 2025; Mortimer-Jones et al., 2019; Värnå et al., 2025).

Chapter 5. Methods

> I am really happy with having had my voice heard a bit and that we, uh, you have gotten some answers, good answers to your questions I was about to say, but I do hope so. […] This has been rewarding for me as well, actually. Um, it's beyond expectations, I would say. (Jonas, biological father interviewed for papers III and IV)

In this chapter, I will summarise the methods choices for the four papers making up the body of this dissertation. The quantitative papers (I and II) are summarised together, as are the qualitative papers (III and IV). Ethical considerations have been part of the entire research process across all studies, though for the sake of readability, these are presented at the end of this chapter.

Papers I and II

Papers I and II were quantitative. Paper I was a validation study that aimed to revise, adapt, and evaluate the psychometric properties of the Swedish version of the Self-Harm Antipathy Scale (SHAS-SR) among psychiatric workers. Paper II built upon this, using cross-sectional data to examine response patterns and explore what factors might predict clinicians' attitudes toward people who self-harm.

Setting

For both studies, the setting was Psychiatry Skåne, all public psychiatric services in the region, including both adult and child and adolescent psychiatry. At the time of data collection (2018), Psychiatry Skåne catered to about 1.3 million inhabitants. Outpatient services were available in a number of locations throughout the region: CAP existed in ten different cities, and adult psychiatry in thirteen, with multiple locations and branches within the bigger cities. Inpatient clinics existed in Malmö for children and adolescents, and in Malmö, Lund, Helsingborg, and Kristianstad for adults. Each of the adult inpatient clinics had 1-2 beds earmarked for BA, though implementation was quite new; Lund was the first clinic in Sweden to implement BA, in 2015. BA was not yet implemented in CAP at the time of data collection.

Recruitment and participants

Both studies were based on the same sample and data. The full population, i.e. everyone employed at Psychiatry Skåne at the time according to the staff register, comprised of 4676 unique individuals. However, accounting for vacation, sick leave, leave of absence, etc., only 3507 people technically had the opportunity to participate during the recruitment period. The population consisted of healthcare counsellors, psychologists, physicians, nurses, psychiatric aides, physiotherapists, occupational therapists, and a small number of non-clinical staff (administrative staff and researchers).

Data collection took place in the period of February-July 2018. Recruitment was primarily digital; all employees at Psychiatry Skåne received an email with information about the study, participant rights, and a link to the questionnaires used. We complemented this strategy by offering in-person visits to each unit, where employees would have a chance to receive verbal information, ask questions, and complete paper versions of the questionnaires. Only two units accepted, and a colleague or I visited them in May-July. This generated 14 additional responses.

A total of 596 people participated in the project (17% of the population). Due to ethical concerns, we didn't collect data on participants' professions, but less than 5% of the sample indicated they had no clinical role *or* did not work in outpatient or inpatient care to any extent. Our sample was representative of the population in terms of legal gender and working in emergency versus non-emergency settings. People with post-secondary education were overrepresented, while young people (30 years old or younger) were underrepresented in our sample.

Materials

The questions we sent out included demographical questions of gender, age, level of education, work experience, area of work, whether participants had received any specific training about self-harm, and whether they had training and experience working with BA. We also sent out a number of questionnaires:

The Self-Harm Antipathy Scale (SHAS)

This was our primary outcome scale in both papers. It was originally designed and used to assess attitudes toward people who self-harm among nurses in the U.K. (Patterson et al., 2007a) and we received co-author Whittington's approval to use it in our research. The original scale contained 30 items rated on a 7-point Likert scale with the endpoints of 'strongly disagree' and 'strongly agree', where higher overall scores reflected higher antipathy, i.e. more negative attitudes. As per the original scale validation study, the SHAS had six subscales: *Competence Appraisal*, *Client Intent Manipulation*, *Care Futility*, *Rights and Responsibilities*, *Acceptance and Understanding*, and *Needs Function*. The version we provided to participants

included all 30 items in Swedish, after having been translated, back-translated, then refined and discussed by various members of the research team.

The Lund Tolerance Toward Self-Harm scale (LUTOSH)

This was a briefer attitude scale (Nilsson et al., 2019), consisting of only five items scored on a ten-point scale from 'completely disagree' to 'completely agree'. Higher scores on this scale overall reflected more positive attitudes. We included this scale to be able to cross-examine results from the Swedish SHAS in paper II.

The New Community Attitudes towards the Mentally Ill, Swedish version (New CAMI-S)

This scale was a 29-item questionnaire on broader attitudes toward people with mental illness (Högberg et al., 2012). Items were scored on a six-point scale with the endpoints of 'totally disagree' and 'totally agree'. Higher scores overall suggested more positive attitudes. We included this questionnaire in paper I to assess convergent validity with the SHAS, as self-harm was commonly associated with mental illness. We believed ratings on these two scales would be positively correlated.

The Work-related Basic Need Satisfaction scale (W-BNS)

This questionnaire assessed fulfilment of employees' psychological basic needs at work (Van den Broeck et al., 2010), and aligned with the elements of autonomy, relatedness, and competence as recognised in self-determination theory. The questionnaire contained 18 items scored on a 5-point scale from 'totally disagree' to 'totally agree'. Higher overall scores indicated higher degree of need satisfaction. We used this scale in paper II to assess factors we believed could be related to attitudes toward people who self-harm among psychiatric workers. We analysed the three subscales separately.

Support for autonomy

This scale assessed degree of perceived support for employee autonomy from managers as well as coworkers (Jungert et al., 2013). The original questionnaire had six items, scored on a seven-point scale from 'not at all true' to 'very true'. Higher scores reflected higher perceived degree of autonomy support. For paper II, we only used the three items assessing managerial autonomy support, as we believed this might be related to our primary outcome.

Analysis

Both studies relied on the latest version of SPSS Statistics (IBM Corp, 2017, 2023) for certain analyses. In paper I, SPSS was complemented by the EQS 6 Structural Equations Program (Multivariate Software Inc, 2006) to run the confirmatory factor

analysis, and the MBESS package in R Statistical Software, version 3.5.1 (Kelley, 2018; R Core Team, 2018) to compute McDonald's omega. In paper II, Mplus version 8.10, Base Program and Mixture Add-On (Muthén & Muthén, 2023) was used for the latent profile analysis and its associated logistic regressions.

Missing values

We analysed missing values with Missing Value Analysis in SPSS. For SHAS, all items had some degree of missing values, with 3.1% missing data in total (1.3-5.0% across items). For LUTOSH, 1.5-3.2% were missing across items. Managerial support for autonomy had 3.5-4.9% missing cases, the autonomy subscale of W-BNS had 1.5-4.9%, and the competence and relatedness subscales had 3.9-6.9% and 3.7-4.7%, respectively. These figures may sound slim, though missing data affected 29.7% of participants in total.

The spread of missing data appeared to be random in the pattern matrix, though a statistically significant result on Little's MCAR test suggested that the data was Missing At Random (MAR) rather than Missing Completely At Random (MCAR). Thus, for the continuous variables, we decided to impute data using the Expectation-Maximization technique (Olinsky et al., 2003; Roth et al., 1999; Soley-Bori, 2013).

As for the categorical variables, missingness ranged from 0.5-3.0%. We deemed these cases negligible and excluded them from analysis.

Analyses in paper I

We performed an item analysis to consider the means and standard deviations of each SHAS item, as well as its (corrected) correlation to the whole scale, providing a first indication of the items that did not seem to perform well in terms of assessing attitudes and distinguishing between different participants' overall attitude ratings. We didn't use this item analysis as a basis for exclusion of items, though; rather, we carried on with all items into the next stage of analysis.

We evaluated construct validity of the Swedish SHAS through factor analyses. Exploratory factor analysis (EFA) is as open as it sounds, used for generating theory about how certain observed variables (the scale items) relate to each other and how groups of items may all assess a few latent (unobserved) underlying factors (here, subscales). Confirmatory factor analysis (CFA) is theory-driven, predefining how we think the items group together to form the underlying structure (Thompson, 2004). As there was already some existing theory (subscales of the original SHAS), it made sense to try to confirm that theory on our translated version of the scale.

However, given that we used the scale in a culturally and even historically different setting – in Sweden instead of the U.K., on psychiatric workers rather than exclusively on nurses, and about fifteen years later in time, where we had reason to believe that norms, values, and understandings of self-harm were different – and we wanted to adapt rather than merely adopt the scale for use in our current setting, we

also deemed an exploratory approach appropriate (see e.g. (Balqis-Ali et al., 2021). The two approaches are commonly used together when adapting questionnaires for new settings (Borsa et al., 2012; Li et al., 2024; Pedruzzi & de Andrade, 2025; Yan et al., 2020).

To avoid biasing the CFA toward the model suggested from the EFA rather than the original SHAS model, we split the sample into random halves (Hurley et al., 1997), so that the EFA and consecutive CFA based on it were run on separate subsamples, each of $n = 298$. We ran the Kaiser-Meyer-Olkin test (which should be ≥ 0.60) to make sure that the sample size was adequate. We also ran Bartlett's test (which should be significant) to make sure item correlations were adequate for us to be extracting factors (Kaiser, 1974; Tabachnick & Fidell, 2014).

For the EFA, like in the original development of the SHAS (Patterson et al., 2007a), we used principal components analysis to extract factors and orthogonal rotation to maximise high correlations and minimise low ditto. This type of rotation method assumes the subscales would be uncorrelated to each other, which seemed reasonable given the very different items included in the scale. Specifically, the Varimax rotation method enhances high factor loadings by maximising their squared variance, making each item primarily load on only one subscale, which facilitates interpretation. We retained factors with an Eigenvalue ≥ 1.0 that explained 5% or more of the variance. As for the items, those with factor loadings < 0.40 were suppressed (Tabachnick & Fidell, 2014; Thompson, 2004).

After the EFA, we ran CFA using the maximum likelihood estimation method, in two separate iterations: one based on the subscale structure from our EFA, though using the other half of the sample, and one based on the subscales of the original SHAS, using the full sample of $n = 596$. We adjusted and re-ran both models after the first analysis round, based on the results of the fit indices, factor loadings (again removing loadings < 0.40), and the Lagrange multiplier test. We used the following fit indices: chi squared (χ^2) and the Satorra-Bentler scaled chi squared (SB χ^2), both of which should be non-significant, the comparative fit index (CFI) and the normed fit index (NFI), both of which should be ≥ 0.90, as well as the root mean square error of approximation (RMSEA), which should be ≤ 0.08 (Browne & Cudeck, 1992; Marsh & Hau, 1996). We also evaluated internal consistency from Cronbach's alpha (α) and McDonald's omega (ω), the latter not assuming tau-equivalence, i.e. that all items are related to the same latent construct and all factor loadings are equal (Dunn et al., 2014). We used the traditionally suggested cutoff of 0.7 for acceptability.

Lastly, we evaluated the correlation between the Swedish SHAS and the New CAMI-S with two-tailed correlation coefficients, considering both the standard Pearson's r and Spearman's rho (ρ), the latter being a non-parametric equivalent used on ordinal data, which the attitude scale technically is (Healey, 2015;

Kowalski, 1972). We ran these analyses for both of the proposed subscale structure models and compared the results.

Analyses in paper II

All analyses in paper II were *post hoc* explorations, i.e. not prespecified but decided about once we had already collected the data. To address the multiple comparisons problem – that when running a large number of statistical comparisons, one is more likely to obtain some statistically significant results – we applied the Bonferroni correction to all our analyses, meaning that we divided our alpha value by the number of comparisons to obtain a stricter cutoff for statistical significance (Armstrong, 2014).

We produced a correlation matrix with all our variables of interest: gender, age, education level, work experience as well as work area in psychiatry, training as well as experience working with the BA method, specific training on self-harm, the three subscales of experienced autonomy, relatedness, and competence at work, as well as managerial autonomy support, and the two outcome variables of SHAS-SR and LUTOSH. Indicator variables that didn't correlate statistically significantly with the outcome variables were omitted from further analysis.

We used standard multiple regression to see if our selected variables could predict wholescale attitude scores on the SHAS-SR. As mentioned, SHAS-SR was our primary outcome, though we re-ran all analyses with LUTOSH as the outcome as well, for cross-validation purposes.

As we identified theoretical as well as statistical correlation between some of our indicators (specifically, managerial autonomy support and the psychological well-being variables), we separated out three multiple regression models: one including general demographic variables, one on the non-intervention workplace variables, and one on those workplace variables that could be considered to involve some sort of active intervention from management.

Further, we ran latent profile analysis (LPA) to explore subscale response patterns on the SHAS-SR and see if our predictor variables could indeed predict such patterns. The variables used as indicators in LPA should be carefully chosen with a theoretical rationale; they should have acceptable internal consistency, i.e. correlate with one another, but they should also be theoretically distinct (Spurk et al., 2020; Weller et al., 2020). We had previously demonstrated these properties of the SHAS-SR subscales in article I.

To facilitate interpretation, we reversed the subscales that reflected more 'positive' regard, so that higher scores on them would indicate more positive attitudes, while higher scores on the 'negative' subscale still suggested more negative attitudes. Since LPA is sensitive to outliers, we removed the 15 cases of multivariate outliers

that we identified, leaving a sample of $n = 581$ deemed sufficient for the LPA (Spurk et al., 2020).

We specified 500 initial stage random starts, 50 final stage optimisations, and 50 initial stage iterations (Li et al., 2014; Spurk et al., 2020). LPA tests different model solutions for the data, starting from the most basic model where all of the observed data is related to the same single latent construct, and then running more models by consecutively adding one more construct. Usually, a two-profile solution tends not to be very meaningful either, as in our case participants could simply be grouped in more 'negative attitudes' versus more 'positive attitudes', providing little additional information. Usually, one hopes for a more informative model, but not an overfitted one which would hold only for the current dataset.

To compare the relative fitness of the proposed models, we looked for statistically significant results on the Lo-Mendell-Rubin test (LMR) and the bootstrapped likelihood ratio test (BLRT), as well as lower figures on the Bayesian information criterion (BIC), the sample-adjusted Bayesian information criterion (SABIC), and the Akaike information criterion (AIC). We looked at the sizes of the proposed profiles in different models, with the general heuristic of the smallest profiles encompassing ≥ 5% for them to be meaningful. Further, we considered entropy, not as a fitness indicator but an indication of the uncertainty of the model. Most importantly, though, our model retention decision was guided by the softer values of interpretability, theoretical usefulness and alignment of the model with existing literature (Ferguson et al., 2020; Weller et al., 2020).

Finally, once we had selected a model solution, we ran multinomial logistic regression to explore whether our independent variables of interest (the same ones as before) could predict profile membership. That is, rather than predicting wholescale attitude scores, we now tested whether our predictors could tell us which attitude profiles our participants had been assigned to. We opted for the three-step Bolck, Croon and Hagenaars approach for this purpose (Ferguson et al., 2020).

Papers III and IV

Papers III and IV were qualitative studies. Paper III was a phenomenological psychological study that explored the lived experience of parents as their adolescents self-admitted using BA. Paper IV was a social constructionist, discursively oriented study that explored how parents and other family members spoke of involvement and responsibilities regarding children's access to BA.

Setting

Both paper III and IV were based in a child and adolescent psychiatric setting, at the only inpatient CAP clinic in the region, in Malmö. At the time of recruitment, this clinic catered to the approximately 300 000 children residing in the region, who may have received outpatient services in any of the multiple clinics located in ten cities throughout the region.

There was a total of eleven beds at the clinic, out of which two were earmarked for BA. The clinic was divided into two units. Children or adolescents who self-harmed were most often admitted together with those with acute eating disorders. BA admissions were mixed with voluntary and involuntary emergency admissions.

BA was only offered to adolescents who self-harmed if they had been in frequent contact with inpatient CAP services, with the general rule that they should have experienced emergency admissions (voluntary or involuntary) at least once before. In practice, this meant that the adolescents who were offered BA tended to be struggling with suicidal thoughts and behaviours as well as self-harm.

Recruitment and participants

Eligible for participation were parents, legal guardians, or other significant adults who had some degree of awareness of the child's access to BA. We recruited participants by going through all the BA contracts that were in place as of December 2021, as BA contracts were signed by at least one parent, legal guardian, or other adult responsible for the everyday care of the child.

In cases where only one adult was listed, I asked this person if there were other parents or important adult figures in the child's life with some awareness of BA, who should perhaps be invited to participate as well. When I was unable to retrieve relevant contact information from the BA contracts alone, e.g. if the adult(s) listed had common first- and surnames, or if only staff from residential treatment facilities or service housing were listed and I also wanted to offer participation to parents and legal guardians, the BA coordinator assisted me by retrieving relevant phone numbers from the child's medical records.

This put the identified eligible population at a total of 70 individuals. I attempted to contact all of them via phone to inform about the study and invite them to participate, though a few never answered my calls. Three individuals spoke neither Swedish nor English and I was unable to offer them participation, something I will discuss further in chapter 7.

Those I was able to invite included biological parents, their partners, adoptive parents, foster parents, second-degree relatives, and staff from special housing arrangements who were closely familiar with the child and cared for them on a daily basis. I obtained the email addresses of everyone who expressed interest in

participating and sent them written information about the study, encouraging them to read this information and get back to me if they were still interested in arranging an appointment. I sent one reminder via email and attempted to call them again after three weeks, then again after about five weeks. Those I was still unable to reach after this were considered to have opted out of participating.

A total of 26 people consented to participate and were enrolled in the study. These 26 adults were connected to 23 adolescents, whose access to BA spanned between two months and several years. Twenty-three were biological parents (seventeen mothers, six fathers), one was an adoptive father, one was a foster father, and one was the grandmother of an adolescent. Participants ages ranged between 37-75 (median 48 years old). Fifteen participants were at least part-time responsible for the care of other children in the household. In nine cases, either the child had never self-admitted with BA, or the participant in question had no insight into such admissions. This was the only demographic information I enquired about in interviews, though many participants volunteered additional information throughout the interviews, including job status, work leaves, contact with social services, and lived or personal experience with mental illness.

The socioeconomic status of participants varied considerably, with a broad range of job areas represented: hourly jobs, homecare, seasonal jobs, construction, education, healthcare, office jobs, and being retired. Some participants had lengthy commutes and/or jobs involving frequent travel, and the possibility to work remotely varied. It was common for participants to have experienced periods of lengthy sick leave, and/or the Swedish juridical term of 'leave to tend to a child with severe illness'[9]. A few had been away from work for several years and some were currently away from work at the time of the interview.

Nine participants spontaneously reported that they had been, or were currently, in contact with social services. Six volunteered information that they had their own lived experience with mental illness, including self-harm, psychiatric admissions, depression, substance abuse, trauma-related conditions, and neuropsychiatric conditions. A few participants also mentioned having personal experience with such issues from significant others apart from the child with BA, including partners, their own siblings, and their other children who required extensive care.

Of note, all 26 participants were included in paper IV. Paper III focused specifically on the lived experience of parents during the period when the child was admitted on

[9] In Swedish *Vård av barn (Vab) som är allvarligt sjukt*. Under certain circumstances, supported by a medical statement issued from a physician, parents or legal guardians may receive reimbursement for an unlimited number of days if they need to be away from work to tend to a child who has not yet turned 18 years old. In child and adolescent psychiatry, such medical statements are often issued when the child is at risk of dying from suicide.

BA, meaning that a subset of 17 participants who had such lived experiences were included in paper III.

Materials and data collection

We collected data from semi-structured, in-depth individual interviews, supported by an interview guide as well as a mind map. The mind map was presented as a visual aid to participants throughout interviews. It was made up of circles summarising some areas of interest in the interview, including e.g. 'Your experiences with BA as [a parent or significant adult]', 'Everyday life? Family relations?', 'The admission period', and 'What feels most important to you'.

We developed the interview guide together with a representative of the Swedish Partnership for Mental Health (NSPH), a non-governmental, not-for-profit organisation working to increase healthcare user and family participation in mental healthcare. We designed the guide specifically to facilitate a free-flowing narrative of lived experiences, asking questions on a quite concrete level with varying specificity, such as 'Tell me about your experiences being a [parent or significant adult] of a child who self-harms', 'How would you describe your experiences with BA? What has BA meant for you?', 'Have you ever been present [at the psychiatric unit] during a BA? What was that like?', and 'How do you spend your days when [your child] is admitted with Brief Admissions?' The only question that invited more abstract reflection was 'Can you relate BA to other forms of psychiatric care that the child [has] received?'

The interview guide was reviewed and revised a few times and then we tested it in two pilot interviews. My co-supervisor Kajsa Landgren listened to these interviews and concluded that we did not need to adjust the interview guide any further. The pilots were subsequently included as part of the interview data to be analysed.

Throughout the interviews, I would largely listen and follow participants' own spontaneous narratives, sometimes probing for specific examples of concrete everyday experiences. Importantly, I never inquired about participants' involvement in care, their perspectives on person-centred care or participatory care, nor how they viewed responsibility in regard to BA or CAP; however, if spontaneously expressed, I followed these narratives for a bit, as I would with any other topic, before gently redirecting attention back to more concretely lived experiences with BA.

I conducted interviews between December 2021 and May 2022. Interviews were initially offered in person, via video, or via phone. Participants were encouraged to choose a private location of their convenience, and three interviews took place in participants' homes. Due to covid-19 restrictions, all other interviews took place via Zoom, save for one that started out via Zoom but then had to be converted to a phone interview due to technical difficulties. Audio was recorded via dictaphone (in person or on speakerphone), or directly in Zoom.

Before initiating interviews, I went over the written information about the study with participants, answered their questions, and obtained their consent in writing or verbal recording.

Interviews lasted between 38-93 minutes (median duration 55 minutes), except for one that needed to be interrupted after 22 minutes on the initiative of the parent, as their adolescent reached out to them in crisis. We were never able to resume this interview, though as the parent had expressed a continued interest in participating, the data collected so far was still included in analysis.

Analysis

Analysis in paper III

As we were interested in explicating rich descriptions of adolescent BA utilisation from the perspective of the parent, who was not the main target of the intervention, we decided to use Englander and Morley's (2023) take on phenomenological psychology as our analysis method for paper III. This is a Giorgian, descriptive approach to elucidating psychological phenomena (Giorgi, 2009; Giorgi, 1985), a whole-part-whole form of analysis, where we started out getting a sense of the whole, then going through analysis of details to obtain a new sense of a more general and structured whole. Four co-authors were involved in the analytical process.

I started getting familiar with the data by conducting interviews, listening to the recordings, and transcribing some of them.[10] Once all interviews were transcribed, we read through them in a phenomenological psychological attitude, obtained by practicing epoché and psychological reduction. Adopting such an attitude was a complex, iterative process, but essentially it was about setting aside our pre-acquired ideas that the phenomenon existed as an independent entity in the world (i.e. abandoning realism/positivism and explanatory ambitions), instead narrowing in on the psychological meaning of the parental lived experience.

Becoming more detail-oriented, we identified all parts of the interviews that were related to the adolescent's utilisation of BA and divided them up into meaning units in a table in Microsoft Word. In the column next to the verbatim expressions, we rewrote them in a way that summarised the psychologically relevant meanings.

Approaching a new whole, I wrote up rich idiographic (i.e. contextualised in each parent's subjectivity) explications of the psychological meaning structure of the adolescent's self-admission with BA, i.e. describing what it was like as a whole and the components that made up this whole. We discussed these texts together, focusing

[10] We hired a medical secretary external to the research team to help transcribe about half of the interview data. I read through and corrected these transcripts while listening to the audio recordings.

on the existentials of lived experience (lived body, lived time, lived space, lived relations, lived reality, and lived sense of self). We practiced free imaginative variation, i.e. we imagined what would happen to the phenomenon if one aspect of the description was removed and realising in this way what was essential and what wasn't.

It was not until the last phase of analysis that we started comparing between participants. The goal at this point was to move from the contextualised descriptions to a nomothetic (general) meaning structure that would elucidate the essence of adolescents' self-admissions with BA in the experience of the (any) parent. Again, we used imaginative variation to peel away everything that did not appear as part of the essence. Because of this move away from contextualised experiences, we refrained from using direct quotes from parents when writing up the results section (Englander & Morley, 2023).

Analysis in paper IV

As we took a discursive interest in family perspectives for paper IV, considering the experience of healthcare involvement and ditto responsibilities to be socially constructed, our method of choice was reflexive thematic analysis, which explicitly utilises researcher subjectivity and reflexivity as the foundation for analysing patterns of meaning in qualitative data (Braun & Clarke, 2019, 2021, 2022). Three co-authors were involved in the analytical process. Reflexive thematic analysis can be understood in terms of six phases, though we progressed through them in a recursive rather than linear, stepwise fashion.

As previously mentioned, I had already begun to familiarise myself with the data by conducting, listening to, transcribing, and re-reading the interviews. Specifically for paper IV, I re-read all interview transcripts again, took reflective notes on what participants had expressed, and kept a living reflexive journal document where I noted down my own reactions to and interpretations of my interactions with participants in the interview situation.

Most of the analysis was carried out in Microsoft Word, with NVivo 14 (Lumivero, 2023) used as complementary software for easy overview of codes and interview excerpts. From our social constructionist and discursive grounding, we worked with manifest as well as latent content in the analysis. I coded in a more inclusive manner at first, gradually narrowing in on the study aim. I produced coding maps in Word, like visual mind maps where the levels and relations between various codes were represented in text boxes of various sizes and positions: one such map illustrated how participants spoke about BA more generally, one illustrated their narratives about responsibility, and one was about inclusion and non-inclusion. This visual aid helped us remain grounded in detailed aspects of participants' narratives, while also getting an overview of the whole. From here, we revised the codes, making sure that they captured full, comprehensible meanings. We also discussed the coding maps

in terms of relevance to our aims, what the codes said about the nuances and complexities of participants' perspectives, what they may implicate clinically and how they could contribute understandings relevant to our study population.

I then generated initial themes by asking self-reflective questions about the overarching discourses of care involvement and the responsibilities attributed to various stakeholders. Colour-coding the visual maps facilitated this process, giving an overview of how every single theme crossed over all three coding maps, making up their distinct patterns of shared meaning around a unifying core.

Naming, refining, and renaming themes required several reiterations, where we focused on the distinctiveness of our themes and whether they were substantiated in a sense that made them meaningful. I want to stress that these considerations had nothing to do with the number of participants 'behind' each theme, or the number of times each participant discursively positioned themselves (Davies & Harré, 1990) according to a certain theme. Importantly, the same participant could position themselves in multiple ways throughout the interview; distinctiveness was about making sure that the themes themselves expressed different core concepts, rather than sorting participants exclusively into one theme or another. In our process of refinement, we used the metaphorical figment of a theatre performance to compare various discursive positions.

Extended analysis

I also want to mention that I conducted extended analyses on the interview data when writing this dissertation. That is, I re-read the interview transcripts again with a deductive lens, specifically to explore additional accounts of human rights and (relational) recovery beyond those examples that made it into the published versions of papers III and IV. When participants' accounts illuminated additional perspectives not already seen in the published papers, I chose to incorporate them into the results of the next chapter. I have noted clearly when this is the case.

Ethical considerations

A lot of research publications tend to describe ethical considerations in terms of measures taken to ensure that research participants are protected from harm, that their anonymity is protected as well as their free will – the latter in terms of taking care to inform people about what exactly it is that they are considering to partake in, so that they are indeed in a position to provide informed consent, which they can also freely withdraw again. These can be referred to as *microethical* considerations, i.e. they are concerned with ethics on the level of individuals and interactions within the research process. *Macroethics*, in contrast, is concerned with the wider impact of research on a societal level, i.e. how the research produced may be interpreted

and used and what kind of effects this may have on people and populations, not only the individuals participating in research (Brinkmann & Kvale, 2005).

To do ethical transformative research, it is integral that the researcher is culturally respectful and mindful of one's privilege and power to define reality, to make evaluations and judgements that can impact others in helpful or harmful ways. The researcher must be critically self-reflective and attempt to see how participants view them. Crucially, ethical transformative research needs to address social inequities and give back to the communities it wants to say something about (Mertens, 2017). I have tried to enact these considerations on both micro- and macroethical levels.

Microethical considerations

All studies included in this dissertation were approved by the regional ethical review board at Lund University (Reg. No. 2017/774, revised 2018/332), and the Swedish Ethical Review Authority (Reg. No. 2020 − 01840). For papers I and II, we informed potential participants about their rights and issues such as data collection, data storage and management, and protection of confidentiality. We obtained written informed consent from those who filled out paper forms, while in the electronic cases participants provided consent by following the link and completing the questionnaires. One specific issue regarding confidentiality arose: as we collected data for these studies so early on in the implementation of BA, there were single individuals in certain professional roles working with BA at the time. In effect, this meant that even as questionnaire responses were connected to codes rather than personal data, the combination of responses to questions about profession and experience working with BA could be enough to identify certain individuals. For this reason, we decided not to collect data about professional roles.

Microethical considerations for papers III and IV included the same general principles. Verbal consent was recorded and stored separately from the interview data in LUSEC, Lund University's high-security digital environment for storing and managing sensitive data, compliant with GDPR and other legislation. Interview transcripts were de-identified in the sense that any names, dates, specific locations, or other potentially identifying data was replaced with more generic descriptions. Even so, as we collected more in-depth, personal information from each participant, aggregated pieces of transcribed data could still risk identifying participants. For this reason, we did not include data sharing in our application for ethical review, we did not ask participants to consent to this, and we did not agree to make any form of data available publicly or upon request. When writing up the report for paper IV, we chose to use pseudonyms to protect participant confidentiality while favouring readability and resonance. These pseudonyms will also appear in this dissertation.

Concerning informed consent and protecting participants' autonomy, as mentioned, before the interviews I went over the information about the study and answered any questions that came up. I stated that the interview could potentially stir up distress

and oriented participants to external support if needed. I also emphasised that they could choose to withdraw their consent and data even after the interview, that they could interrupt the interview without needing to provide a reason for doing so, that they could choose not to respond to interview questions, and encouraged them to talk about whatever felt most relevant to them. I made effort to continuously recognise the power position I had in the interviewer-interviewee dynamic and attempted to be humble and open in my way of asking questions, largely following participants' narratives and repeatedly asking about *their* experiences, occasionally asking to verify if I had understood them in the way they intended, encouraging them to express themselves in their own ways.

Furthermore, when participants expressed strong emotions during interviews, I became particularly mindful of my role as a researcher in this scenario. Rather than trying to suppress the clinical psychologist part of me, I considered that *personal* transformation was also part of the transformative research agenda (Mertens, 2017). I tried to harness my conversational, relational, and emotional skills and use them in such a way that participants felt validated and supported during interviews, while still empowered in their roles as research informants. I obviously can't speak for participants' experiences during the interviews; what I can say is that participants had a lot to say and weren't deterred by feeling emotional or crying during interviews. All interviews generated rich material. Whenever I felt that participants may have been surprised by their own emotions during interviews or found them difficult to handle, and/or when it transpired that participants lacked informal and formal support networks, I reminded them again of where they could obtain support if needed. Importantly, I took care to normalise such needs, which seemed like a crucial step as some parents expressed that they constantly needed to suppress their own feelings and needs. I felt that the interview situation helpfully centred each participant, as an enacted reminder that they did indeed have needs, that they were human, and that it was encouraged to take up space. I received unsolicited feedback at the end that the interview itself had been helpful for some participants, including Jonas who was quoted at the start of this chapter.

Another issue which felt like a role conflict at the time, was when I involuntarily started thinking in diagnostic terms upon hearing participants' descriptions of children and adolescents. To me, this was an ethical dilemma on several dimensions. I picked up on participants' descriptions of suffering and how they often hadn't received proper help. Part of me felt that the most ethical thing to do would be to overstep my researcher role and suggest specific care interventions that the families may want to seek. Another part of me was aware that I had in no way gotten the whole picture of the child and their context from this interview. Beyond that, I didn't want to impose psychiatry as a solution when these families felt let down by the psychiatric system, and I didn't want to make a pretence of having the power to change things in that moment. Me disclosing my perspectives could be futile or even make matters worse for these families, as parents might feel that their experiences

were reduced and their children were pathologised, and still they received no help. I discussed these matters with my main supervisor, though it was still up to me how to handle these situations. In the end, I opted not to provide unsolicited advice but kept listening to participants' experiences, recognising and supporting their authority to define their own needs, rather than trying to 'fit them into' the healthcare system once more. I made these calls with transformative considerations in mind, though I can't know if my choices *supported* personal transformation for participants, or if I *failed* to realise transformative potential.

Additionally, I encountered unexpected ethical dilemmas in one interview. Before interviewing Claes, I noticed that his child had a chosen name written on the BA contract which did not conform to their legal name or gender. It occurred to me that this child may be trans-identified or have some other identity beyond gender norms. Then as I was interviewing Claes, he quickly shared that his child didn't want to be in touch, so their contact was limited. He expressed that he wasn't sure why but mentioned 'differences of opinion'. His tone of voice and other non-verbal cues further suggested that he did not seem to recognise he could have a role in their lack of contact. He also consequently referred to his child by their legal name and gender. I had no way of knowing if my assumption regarding the child's gender identity was correct, but I was still uncomfortable with Claes' way of relating to his child during the interview, in terms of gender and generally dismissive comments. In his way of talking, this parent reproduced stigma with respect to self-harm, and *perhaps* he was also perpetuating transphobia. In this situation, I felt that my phenomenological directive to follow the participant's narrative clashed with my axiological assumptions and commitment to social justice. This child was a 'third party' in the interview, but part of the target population for my overarching research agenda. I decided to address my concerns without making assumptions, by explicitly asking if Claes was referring to the child with access to BA when he said 'my boy', and by using the child's preferred name myself, which resulted in Claes recognising that the child did have a preferred name (though he continued to use the legal name). Further along, I paused mid-sentence to ask 'Is it- should we be saying "she"?' Claes laughed and replied 'Uh, I…I'm saying "she". But I don't know what she thinks herself, or, like…' At this point, I tried to verify whether the child had asked to be referred to in any other manner, to which the parent replied 'No, not to me in any case'. I decided to go along with the parent's narrative for the rest of the interview, not only to maintain collaboration and a phenomenological orientation; mostly, I reasoned that even if the child *did* identify beyond gender norms, they may have deliberately chosen not to bring this up with their parent. I did not want to risk outing[11] the child or leaving Claes bewildered, potentially putting the child in a position of having to defend their identity in subsequent, unwanted interactions with

[11] Outing is a way of describing when people have their (often marginalised) identities or practices openly disclosed by someone else, without their consent.

their parent. From that point on, despite experiencing persistent discomfort and feeling unsure about the most right (or least wrong) thing to do, I chose to mimic Claes' language regarding the child in question.

Macroethical considerations

These wider considerations ought to be read in concert with the next chapter, as they largely consider results and possible consequences post publication.

I realise that the quantitative papers I and II are likely to be read as making realist truth claims: e.g. that the SHAS-SR objectively measures clinicians' attitudes, that the majority of Swedish psychiatric clinicians have unproblematic attitudes toward people who self-harm, that the attitude profiles of paper IV are real and distinct entities, and that clinicians who score in alignment with an antipathic pattern simply *are* antipathic (and beyond rescue). To be clear, none of these statements correctly represent our results or implications. When writing up the research reports, my coauthors and I made effort to clarify the limitations of our research and explicitly stated that we did not wish to reify the proposed attitude profiles as if they existed independently 'out there'. Granted, we also proposed that the SHAS-SR may be used to evaluate interventions aimed at improving clinicians' attitudes, which to some degree implies objective pre- and post-measures.

My intention in this dissertation has been to use the SHAS-SR not to say 'how it is' regarding clinicians' attitudes, but rather to shed light on one aspect of a complex social process from clinicians' perspectives, that can speak to the realities that healthcare users/survivors and their families face in psychiatry. My hope is that if they would read paper II, they could feel validated in their experiences. Beyond that, we recognised negative attitudes as a health equity issue, which we believed would make it more likely to capture the attention of management and policymakers. One of the co-authors for papers I and II is in a managerial position within adult psychiatry and has continued working to address these issues in research as well as clinical practice. Regrettably, the realisation of such hopes and efforts are not demonstrated in the research output itself. Of note, I recognise a risk that the SHAS-SR may be used to reinforce biomedical hegemony in psychiatry, which can be indirectly harmful for people who self-harm. Much of my writing in this dissertation constitutes my effort to ameliorate this risk.

For paper III, part of the reason why we chose phenomenological methodology was to be able to describe the parent's experience in a way that rang true to parents as well as resonated deeply with clinicians. Importantly, we did not shy away from the strong voice of critique expressed in some interviews. In explicating ways of experiencing BA, we tried to clarify on an emotional as well as intellectual level that CAP risked failing to realise the full potential with BA if parental needs, beliefs, and experiences remained unaddressed. We hoped that the evocative way of writing would make a lasting impression on clinicians and management, being more likely

to effect necessary change. We chose to submit this paper to a child psychiatric journal, rather than e.g. a mental health nursing journal or methodologically oriented journal, as we thought that would have the biggest clinical impact. I have presented this paper in psychiatric settings, most importantly discussing it with clinicians in managerial positions at the local CAP clinic where BA was provided.

For paper IV, we took a discursive and social constructionist approach to issues of care involvement and responsibilities, rather than adopting the traditional (clinical) conceptualisations of person-centred care. This allowed us to recognise the centrality of power structures in enactments of responsibilities and involvement. This was one way to illuminate mental healthcare inequities as described by family members, while explicating rights-based approaches to psychiatry. With three coauthors being psychiatrists connected to the CAP inpatient clinic where BA is delivered, one in a local and another in a regional managerial position, work has already commenced to translate clinical implications of this study and secure the rights of families.

Chapter 6. Results

> In the beginning […] she could be a bit, like, if we got mad at her […] then she wanted to [self-admit with BA]. […] I remember [my husband] and I talked about, well, 'is she going to go there every time things get, like, tough between us at home?' But we let her do it, and it wasn't long before she distinguished when she was feeling poorly, herself. (Mira, biological mother interviewed for papers III and IV)

In this chapter, I will present the results of my body of research first as brief summaries in terms of each specific study aim, then in a more elaborate analysis in terms of the overarching theoretical frameworks.

Paper I

As a reminder, paper I was about obtaining a valid and reliable Swedish version of the SHAS. From the exploratory factor analysis, 27 items loaded onto three subscales of the Swedish SHAS. These subscales explained 25.7%, 7.4%, and 6.7% of the variance, and contained nine, eleven, and seven items, respectively. The CFA that was conducted based on this structure initially had poor results. After removing ten items, results were more acceptable: $\chi^2(136) = 1781.87$, SB $\chi^2(116) = 214.22$, $p < 0.001$, CFI = 0.94, NFI = 0.88, RMSEA = 0.04.

The CFA conducted on the subscale structure of the original SHAS, with 23 items loading on six factors, also had initially poor results but improved after removal of four items (and consequentially also one subscale): $\chi^2(171) = 2164.24$, SB $\chi^2(142) = 306$, $p < 0.001$, CFI = 0.92, NFI = 0.86, RMSEA = 0.04.

In this latter solution, however, two subscales contained only two items each and their differentiation appeared theoretically redundant. This was supported by indication of unacceptable internal consistency values (with α between 0.57-0.66 and ω between 0.59-0.66) for three out of five subscales. As for the three-factor version, Cronbach's α and McDonald's ω were acceptable for all subscales (with α ranging between 0.73-0.79 and ω between 0.78-0.79).

The wholescale internal consistency was good for the three- and five-factor versions, α = 0.86 for both, and ω = 0.85 and 0.88, respectively. Pearson's and

Spearman's correlation coefficients were all statistically significant to 0.1% and similar for both versions (with r = -0.57 and -0.55, and ρ = -0.48 and -0.47, respectively), indicating a moderate-strong negative correlation with the New CAMI-S.

In sum, theoretical understanding and interpretability as well as statistical results favoured the three-factor, 17-item version of the scale. This version showed acceptable validity and reliability, and we adopted it as the official Swedish, revised version of the SHAS, the SHAS-SR. The items and associated subscales of the SHAS-SR are shown in Table 1.

Table 1. SHAS-SR items and subscale groupings

ITEM	SUBSCALE
1. People who self-harm are usually trying to get sympathy from others	Judgement
5. When individuals self-harm, it is often to manipulate carers	
6. People who self-harm are typically trying to get even with someone	
7. A self-harming client is a complete waste of time	
9. Self-harm is a serious moral wrongdoing	
15. A self-harming client is a person who is only trying to get attention	
16. Self-harming clients have only themselves to blame for their situation	
12. Self-harm may be a form of reassurance for the individual that they are really alive	Acceptance and understanding
13. Self-harming individuals can learn new ways of coping	
14. Acts of self-harm are a form of communication to their situation	
17. For some individuals self-harm can be a way of relieving tension	
18. Self-harming clients have a great need for acceptance and understanding	
20. I listen fully to self-harming clients' problems and experiences	Sympathy and dedication
21. I feel concern for the self-harming client	
23. I demonstrate warmth and understanding to self-harming clients in my care	
26. I acknowledge self-harming clients' qualities	
27. I find it rewarding to care for self-harming clients	

Paper II

Paper II was about exploring potential predictors of wholescale SHAS-SR scores, as well as predictors of potential subscale response patterns (latent profiles). There were no statistically significant correlations between SHAS-SR and participants' ages, BA training, nor BA experience, and so these variables were omitted from further analysis.

All multiple regression models turned out to be statistically significant. The first model, with gender and education as predictors explained 7.5% of the variance, $F(2, 577) = 24.42$, $p < 0.001$. Model 2, including work experience, area of work, and relatedness, explained 10.8% of the variance, $F(3, 569) = 24.14$, $p < 0.001$. Model 3, with training on self-harm and managerial autonomy support, explained 5.6% of the variance, $F(2, 585) = 18.32$, $p < 0.001$. All of the included predictors contributed significantly to the variance in attitudes, to some extent. To summarise, more positive attitudes toward people who self-harm were predicted by having attained post-secondary education, being a woman, working in non-emergency psychiatric settings, experiencing a higher degree of relatedness at work, having worked in psychiatry for 10 years or less, having had some training about self-harm, and experiencing a higher degree of managerial autonomy support at work. Overall, results were similar with LUTOSH as the outcome, though a few predictors (gender and work experience) didn't contribute significantly.

As for the latent profile analysis, a four-profile solution was suggested to have significantly better model fitness as compared to the three-profile model, indicated by an LMR test that was significant to 1%. Though the other fit indices kept decreasing even for more advanced models, none other than the four-profile solution was significantly better than its more parsimonious neighbour as per the LMR test. The four-profile model was also interpretable and more theoretically informative than any of the other models, and even the smallest profiles encompassed more than 5% of participants, as opposed to the more advanced models. Model fitness statistics are summarised in Table 2. Standardised average scores for the four profiles are illustrated in Figure 1.

Mean subscale scores (and standard deviations) for the whole sample were 29.03 (4.89) for Sympathy and dedication, 12.28 (5.20) for Judgement, and 29.50 (4.58) for Acceptance and understanding. That gave a mean item score of 5.81 and 5.90 on the two reversed subscales, where 7 reflected the most positive attitudes. For the Judgement subscale, the mean item score was 1.75, where 1 was the minimum score reflecting the most positive attitudes.

Table 2. Model fitness statistics for the latent profile analysis

MODEL	LL	AIC	BIC	SABIC	LMR *p*	BLRT *p*	PROBABILITIES
1	−5237	10486	10512	10493	-	-	1
2	−5020	10060	10104	10072	0.00	< 0.001	0.79, 0.21
3	−4970	9968	10030	9985	0.27	< 0.001	0.24, 0.07, 0.69
4	**−4932**	**9900**	**9979**	**9922**	**0.01**	**< 0.001**	**0.08, 0.08, 0.19, 0.66**
5	−4916	9875	9971	9901	0.42	< 0.001	0.03, 0.13, 0.67, 0.03, 0.14
6	−4902	9856	9969	9887	0.53	< 0.001	0.04, 0.03, 0.63, 0.18, 0.05, 0.07

Note. LL: log likelihood; AIC: Akaike's information criterion; BIC: Bayesian information criterion; SABIC: sample-adjusted Bayesian information criterion; LMR *p*: the significance level of the Lo–Mendell–Rubin adjusted likelihood ratio test; BLRT = bootstrapped likelihood ratio test. *n* = 581. Retained model in bold. Values rounded to nearest integer for LL, AIC, BIC, and SABIC. Values rounded to two decimal points for LMR *p* and probabilities.

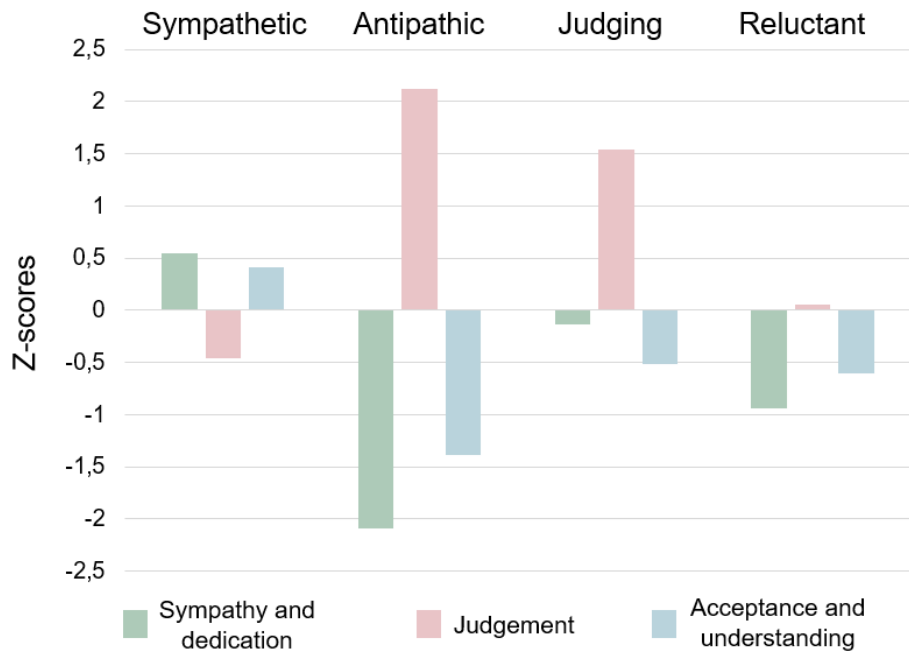

Figure 1. Standardised mean subscale scores for the four attitude profiles
The standardised means were as follows for Sympathy and dedication, Judgement, and Acceptance and understanding, respectively: *Sympathetic*: 0.54, -0.45, 0.41. *Antipathic*: -2.09, 2.12, -1.38. *Judging*: -0.13, 1.53, -0.51. *Reluctant*: -0.93, 0.05, -0.60. Note that, for ease of interpretation, the Sympathy and dedication and Acceptance and understanding subscales have been reversed so that higher scores indicate more positive attitudes, while higher Judgement scores indicate more negative attitudes.

The biggest profile represented two thirds of the sample (65.7%). We named it 'Sympathetic' as it had scores slightly above the mean for Sympathy and dedication as well as Acceptance and understanding, and slightly below the mean for Judgement. One of the smallest profiles (7.6%) had the reverse scoring pattern, though with much more extreme values, so we called it 'Antipathic'. The other, equally small profile (7.6%) had a high mean score on Judgement, but scores close to the mean on the other subscales; we named it 'Judging'. Lastly, one profile encompassed a fifth of all participants (19.1%). We found it a bit more challenging to understand and name, as profile members didn't appear to judge people who self-harmed, though also didn't quite understand or accept them and didn't sympathise or feel particularly committed to their care, either. We eventually decided to call it the 'Reluctant' profile.

Finally, with α set at 0.007, the multinomial logistic regression showed that emergency psychiatric workers were significantly more likely to have an Antipathic scoring pattern rather than Sympathetic (odds ratio [OR] = 8.82, $p < 0.001$) or Reluctant (OR = 5.56, $p = 0.006$), as compared to non-emergency workers. Men were significantly more likely to score according to the Reluctant rather than Sympathetic profile as compared to women (OR = 2.68, $p = 0.003$).

Other factors were not significant to 0.7% but to 1% or 5%, though with relatively high odds ratios they may be of potential relevance. For instance, those who had worked in psychiatry for over 10 years seemed to be more likely to score according to the Antipathic profile, with about three times higher odds when compared to the Sympathetic profile (OR = 3.21, $p = 0.020$), and almost six times higher odds when compared to the Judging profile (OR = 5.85, $p = 0.011$). Curiously, having received training about self-harm didn't appear to be particularly relevant for scores on the SHAS-SR, though approaching significance for the Sympathetic vs. Reluctant comparison, favouring the Sympathetic profile (OR = 2.11, $p = 0.028$).

Paper III

Paper III was about explicating rich, lived descriptions of what it was like for a parent when their adolescent self-admitted using BA. This resulted in two different meaning structures of the BA self-admission experience: one in which it felt like a gift of hope and relief for the parent, and one where the parent conversely felt robbed of their beliefs and hopes.

For the purposes of this initial, brief summary, I will not go into depth about the interrelatedness of the various existential constituents that structured these distinct experiences (lived body, lived time, lived space, relations, and so on). Rather, I present the full gestalts, i.e. a summary of the whole for both of them.

In the first meaning structure, the parent experienced the adolescent's self-admission with BA as a blessing. The parent's lived world was generally one where they constantly spotted dangers for the adolescent, at home, out in the city, and at the psychiatric clinic on regular admissions. But being in on BA was experienced as uniquely safe, giving the parent a bodily felt wave of relief, making them feel safely held just like the adolescent. The parent's lived space and time was liberated as they no longer needed to live from moment to moment, constantly ready to respond to crises. The parent felt that both they and the adolescent experienced more autonomy during BA. Life began to feel normal again, for the parent, the adolescent and the rest of the family, where other sibling could go back to being children and the parent could go back to work and having a social life of their own. The parent felt that they all shared a collective feeling of hope. The adolescent was perceived to grow more independent in tandem with the parent increasingly trusting them to take care of themselves and their own healthcare. The parent stepped down into a new role where being a supportive parent had an altogether different meaning, of providing encouragement from behind the scenes. This shift in relationship dynamics could feel difficult, yet also healthy, nourishing the adolescent's growth and allowing the parent to be their own person.

Conversely, the essence of the parent feeling robbed was experiencing how the adolescent was deprived of their rights with BA, not having their needs met. The parent's lived world, again, had been a war against dangers threatening the adolescent's life. Now that the adolescent had gotten access to BA, the parent had hoped and believed that the war would be over, that these admissions would be different – but they weren't in a good way. Instead, the parent felt robbed of their own control, no longer being allowed inside the unit during BA if the adolescent didn't want them there, losing insight. The parent didn't trust the adolescent nor the clinicians, meaning they entered into a tug of war against everyone, where 'winning' made little difference in the adolescent's nor parent's life. The lived space at the unit was like a wasteland deprived of hope, with an air of indignity and despair hovering everywhere. The parent felt like the clinicians during BA didn't care for the adolescent, abandoned them like an object in storage, giving the parent no sense of purpose with BA. Though in desperate need of something to believe in, the parent was trapped in the present and felt disillusioned, experiencing BA as yet another pointless, misplaced psychiatric intervention failing the parent's expectations.

Paper IV

Paper IV was about exploring how parents and other adult family members talked about the adolescents' access to BA, specifically in terms of their own involvement and responsibilities. In summary, parents and other family members discursively positioned themselves in four distinct ways with respect to all of this: stating that

there was no need for them to be involved with the BA process, that their role was to selflessly support the adolescent's process, that the family was insufficiently involved with BA, and finally expressing that family members were left to shoulder full responsibility as psychiatry checked out on them altogether. These different positions are illustrated in Figure 2.

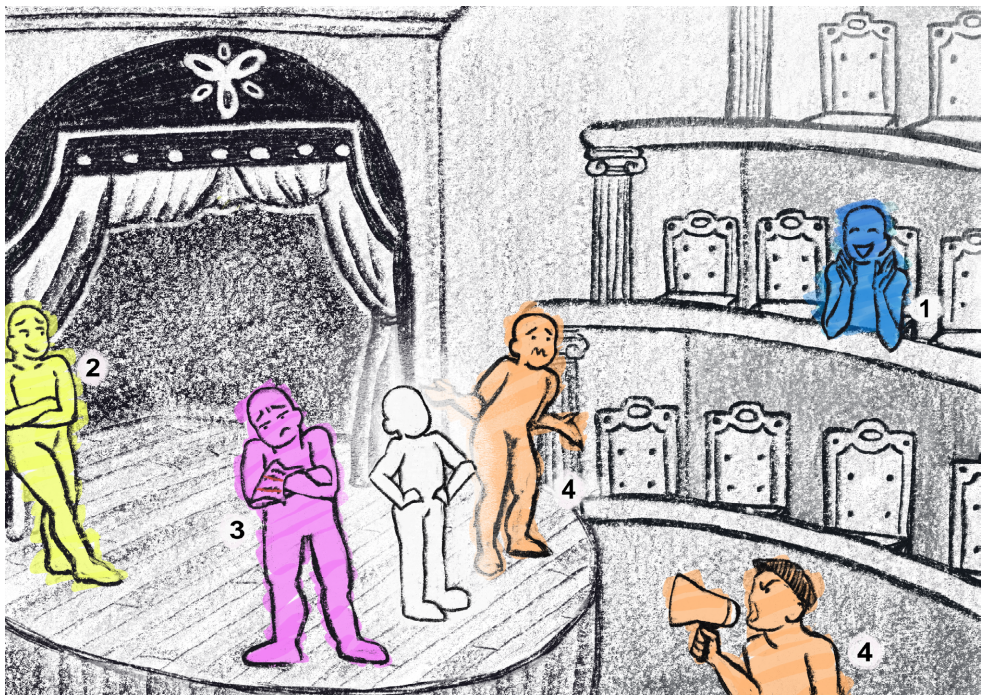

Figure 2. Family members' discourses on involvement and responsibility
Discourses among family members could be described through the metaphor of a theatre performance. In the first theme (blue), family members assumed little responsibility and were satisfied with their low degree of involvement, cheering the child on from the audience. In the second theme (yellow), family members described having been informed about BA, expressed that they shared responsibility with CAP, and assumed the role of a supportive background character, fully focused on the child. In the third theme (purple), family members described being unsatisfied with receiving little information or consideration of their own needs, feeling that they took on more responsibility than they should and were under-involved, like important characters having their lines cut out of the script. In the fourth theme (orange), family members felt forced to assume complete responsibility as CAP abandoned them, describing that they were alone and lost in caring for the adolescent, like main characters performing prior to rehearsal or a director exclaiming 'this is all wrong'. Illustration © Embla Hallberg.

In the first theme, family members expressed no recognition of any personal responsibility with respect to BA. They talked about BA as essentially a matter between CAP and the adolescent, expressing a high degree of confidence in the adolescent's capabilities and self-insight, and that CAP was there to provide this

safe environment that the adolescent was in charge of. Family members voluntarily assumed background roles in this context, like spectators watching a performance at the theatre, occasionally cheering to support the adolescent who played the lead.

In the second theme, family members described themselves as sharing the responsibility with CAP to support the adolescent's wellbeing, independence, and growth. This responsibility was selfless, meaning that family members downplayed any needs that they themselves had in favour of being a vessel for the adolescent, automatically patching them up when they were injured, accepting that there was no space for their own feelings or wishes. Family members commonly described their own experiences of BA from the perspective of the adolescent and framed any possible benefits to themselves (being unburdened, getting to rest up) as fortunate, coincidental side-benefits, stressing that BA was intended for the adolescent. In sum, the adolescent was the main character and family members only had supportive roles.

Family members accounts in the third theme essentially expressed that they weren't as involved with BA as they expected to be, while taking on more responsibility than they should have to, doing some things that really were supposed to be up to CAP. For example, family expected to be properly informed about BA, as with other matters in CAP, and expected to have their own needs considered in the context of BA, though described that this didn't happen. Crucially, family members didn't sit around waiting to be involved; rather, they made agentic moves to involve themselves in various ways, for instance by informing themselves about BA from informal routes, explicitly objecting to certain conditions of BA when they felt dangerous and nonsensical, and seeking out supportive counselling outside of CAP. Parents resisted the idea that there was an inherent conflict between adolescent autonomy and family involvement, suggesting that parents needed to be properly involved in order to do their job as parents. It was as if they were important characters that had their lines removed from the playscript.

Finally, in the fourth theme, family members described being forced to assume full responsibility for the adolescent's life, safety, and wellbeing, even though they lacked professional training to manage suicidal adolescents who self-harmed. They felt that the clinicians at CAP were the experts, but that they walked out on the adolescent and the whole family, refusing to fulfil their healthcare responsibilities, as if these weren't psychiatric issues but general human experiences where everyone was responsible for themselves (and parents were responsible for their children). Family members didn't believe this, though, and resisted perceived attempts from CAP to relocate responsibility, arguing that this wasn't right and questioning decisions that seemed unreasonable to them. Family members were in the position of actors expected to deliver a performance without having had a chance to rehearse their roles, or possibly that of a director or theatre critic who pointed out that the entire stage setting was wrong.

Interpretations of human rights

Clinicians' attitudes: implications from papers I and II

As both of the clinician-oriented, quantitative studies are based on the SHAS-SR, it seems appropriate to scrutinise the underlying implications about human rights that the scale itself carries. For a summary of these interpretations, see Table 3a.

Table 3a. SHAS-SR items, subscale groupings and implications for human rights

ITEM	SUBSCALE	IMPLICATIONS FOR HUMAN RIGHTS
1. People who self-harm are usually trying to get sympathy from others 5. When individuals self-harm, it is often to manipulate carers 6. People who self-harm are typically trying to get even with someone 7. A self-harming client is a complete waste of time 9. Self-harm is a serious moral wrongdoing 15. A self-harming client is a person who is only trying to get attention 16. Self-harming clients have only themselves to blame for their situation	Judgement	Negatively affecting acceptability and quality of care, i.e. failing to respect right to health, as well as dignity
12. Self-harm may be a form of reassurance for the individual that they are really alive 13. Self-harming individuals can learn new ways of coping 14. Acts of self-harm are a form of communication to their situation 17. For some individuals self-harm can be a way of relieving tension 18. Self-harming clients have a great need for acceptance and understanding	Acceptance and understanding	Positively affecting acceptability of care, i.e. supporting right to health
20. I listen fully to self-harming clients' problems and experiences 21. I feel concern for the self-harming client 23. I demonstrate warmth and understanding to self-harming clients in my care 26. I acknowledge self-harming clients' qualities 27. I find it rewarding to care for self-harming clients	Sympathy and dedication	Positively affecting acceptability of care, i.e. supporting right to health, as well as dignity

The Judgement items conveyed negative attitudes toward people who self-harm, and such attitudes per definition violated user acceptability of healthcare services, one aspect of the AAAQ framework defined as essential to ensure users' right to health. Given that such negative attitudes are likely to come across to the user in healthcare interactions, these items also compromised the dignity of healthcare users who self-harm. Conversely, the items in the Acceptance and understanding subscale conveyed neutral to more positive attitudes, with the potential for positive impact on acceptability and the right to health. Of note, as these items reflected general, privately held beliefs that wouldn't necessarily shine through or make tangible impact for the healthcare user, I don't believe agreement with these items would necessarily convey respect for the healthcare user's dignity. Lastly, Sympathy and dedication items conveyed helpful clinical behaviours and approaches which were likely to impact positively on dignity as well as the right to health for healthcare users who self-harm. It should be noted that these interpretations are subjective and general, and that there is much more to securing healthcare users' rights than clinician's attitudes toward people who self-harm.

Also of relevance, there were a few items in the original SHAS that directly explicated the rights of people who self-harm, though these ended up not being included in the SHAS-SR. These were items 2 ('People should be allowed to self-harm in a safe environment'), 8 ('An individual has the right to self-harm'), and 19 ('A self-harming client deserves the highest standards of care on every occasion'). Item 2 suggested a harm reduction approach, implying that clinicians might offer a safe setting where people may self-harm, aligned directly with the right to bodily integrity and indirectly with the right to health. Item 8 aligned straightforwardly with the right to bodily integrity. Item 19 aligned directly with the right to health for people who self-harm. Theoretical interpretations of excluded items are summarised in Table 4 on page 104.

As we saw in paper II, the ratings of most clinicians (about two-thirds of the sample) aligned with the Sympathetic profile, generally endorsing Sympathy and dedication as well as Acceptance and understanding items while rejecting Judgement items, which appears to favour human rights to dignity and health. However, about a quarter of the clinical sample (the Antipathic and Reluctant profiles, together) self-rated less dedication with respect to the care they provided to people who self-harm. Further, about one-seventh of the sample (the Antipathic and Judging profiles) self-rated higher degrees of judgement about self-harm and endorsed stereotypical ideas of people who self-harm as 'attention-seeking' and 'manipulative'. This suggests that, arguably far too commonly, still, healthcare users who self-harm risk having their rights to dignity and health violated in the context of psychiatric care.

Family perspectives: implications from papers III and IV

BA as supportive of human rights

In general terms, the result of paper III that BA enabled the parent to go back to work and the whole family to go out, attend social events and live what felt like 'normal' lives, could be considered to support the right to health as well as participation in the community for the whole family.

In paper IV, curiously, some family members didn't expect to have their needs considered in relation to BA and didn't speak in terms of their *own* right to health. Rather, they suggested that by strengthening *their* wellbeing, BA helped them to care for and support the adolescent's health, in turn. This implied a form of mutual collaboration between adult family members and CAP, which ultimately came to ensure the adolescent's right to health.

In terms of the AAAQ framework, some parents and other adult family members spoke highly of this new, brief, preventive, predictable, safe method becoming *available* to adolescents, and were especially happy that adolescents were able to *access* BA by choice. As noted in paper III, 'the parent relates to the BAs as […] *uniquely* safe, in contrast to the controlled environment during conventional admissions, which is accompanied by […] unpredictability, incomprehensibility, and imprisonment' (p. 5, emphasis in the original). This protected the adolescent's right to health, as well as their dignity, autonomy, liberty, freedom from coercion, and freedom from discrimination on the grounds of self-harm.

In paper IV, participants echoed that it was a good thing that BA was available and accessible for the adolescent, stating that this meant that the family didn't need to surveil the adolescent, protecting the integrity of the adolescent and the dignity of the whole family. Some family members emphasised the adolescent's competency to make sound decisions for themselves and collaborate with CAP. As described by grandmother Agatha:

> Since it is so important [to her] to have that sense of safety that she feels [with BA], it simply is important to me, too. […] In reality, it's the child who knows how they're feeling. And the doctors are good at it, of course, but they really can't go, like, inside of the child. (Paper IV, p. 5)

From these examples, access to BA could be understood as aligned with the adolescent's right to health. Accommodating the conditions for care so that the adolescent controlled their own admissions, rather than being controlled, obviously also supported their right to autonomy in healthcare and freedom from coercion, as well as respect for legal capacity.

Paper III also touched on the affordability dimension of accessibility, income being an important social determinant of health (Mills, 2015; United Nations Committee

on Economic, Social and Cultural Rights, 2000; WHO, n.d.). The parent's return to work was described as 'a huge positive leap […] in terms of escaping the stress of leave-of-absence and stabilizing the family's economy' (p. 6). In this way, even though the cost of an inpatient stay remained the same for the family (about 12 EUR per night regardless of whether it was BA or an emergency admission), the family's reduced loss of income indirectly aligned the BA intervention further with the right to health of the entire family.

Furthermore, paper III described that before the adolescent gained access to BA, the parent was forced to stay at home, constantly '[watching] over the teenager, surveilling their every move as their warden'. Fulfilling this duty meant that the parent wasn't able to go outside to see other people or even take care of their own bodily needs. Heartbreakingly, during this period, 'younger siblings may witness frightening episodes during crisis, [and] older siblings may tackle the teenager in crisis like security guards to protect them'. Emergency admissions were also described in heavy terms, with the parent being 'detained in the psychiatric unit, forced to breathe down their teenager's neck against both of their wishes' (p. 5). When the adolescent was able to self-admit with BA instead, the whole family was freed from these situations. From this, not only did BA support the adolescent's right to autonomy; it restored dignity to the whole family in multiple ways and supported their right to health. There was also a sense that clinicians treated the adolescents with dignity in caring for the adolescents' basic needs during BA and '[looking] out for them' (paper III, p. 5) – rather than, say, keeping an eye on them.

Additionally, dignity can be related to being met as a human being, experiencing self-worth in interactions with others, and being supported to develop a more positive self-image. Though the following material was not included in the papers, a few participants who had their own lived or personal experiences with self-harm and being institutionalised, spontaneously framed it as a good thing that self-admitting with BA didn't require a physician's assessment. In their view, this saved the adolescent from adopting a self-image as someone who was acutely sick, helping them feel that they were worthy of the opportunity to self-admit with BA:

> The first time she was admitted, I thought 'Oh no! She will, like, go into this- maybe feel even more strongly that she is a person who feels poorly.' Um, so that she would identify with, uh, the situation. Because- And I mean, I'm making that assumption from my own egocentric experience of a form of institutionalisation, sort of. […] But, well, that feeling passed rather quickly and I also think that it partially had to do with BA, because, well, since there isn't any- hm, how to say this? Well, not quite such a heavy assessment behind how much she is 'worth' having that spot, or how to put it… How 'sick' she is, kind of […] And maybe not quite the same label on herself, either. That, um, yes. 'I have to get admitted for people to understand how badly I'm feeling', sort of. But instead, yeah, 'I'm feeling poorly, but I have this opportunity', sort of. And just having that opportunity is a recognition. (Mira, biological mother interviewed for papers III and IV)

> One could imagine, if something very dramatic has happened and you've been admitted for such a long time, and then having to come back [to the same clinic on BA], that that would stir up a lot of difficult feelings, sort of […] But I haven't perceived that at all, on the contrary I think it seems like she […] has felt safe there […] I think that has been a positive surprise, like […] that she doesn't seem to have perceived it as a defeat to get [herself] admitted, but rather it seems like she's found it quite uncomplicated […] Because, well, my sister was also [*stutters*] admitted when we were teens. [*sniffles*] Um, so I spent a lot of time in there at [inpatient] CAP with her […] and she just felt, like, um, humiliated sort of … [*inaudible*] and thought that everything was terrible. So I probably had that expectation, that it would be more like that, sort of… Uh, that [my daughter] would feel, like, institutionalised against her will and that it was a prison, sort of […] It's really great [that didn't happen]. (Mikaela, biological mother interviewed for papers III and IV)

Another mother described that she had a sort of advantage from her own lived experience with self-harm, that she understood better what BA was about and how it differed from emergency admissions. She suggested that there was a lot of stigma and fear attached to the public view of psychiatric admissions, but that BA was divorced from that, which helped her in reassuring others:

> I know, now when I have said 'oh yeah, now [my daughter] is admitted' and then I forget to say that it's on BA, then people are terrified. And then, 'no, it's on BA', 'what the hell is that?' kind of. And then you need to explain, I needed to explain to my mother too, that 'there's nothing to worry about when she's on BA, it's a good thing when she's on BA.' […] That you get admitted but of your own free will and that you're there for three days and […] there's a meaning to it. (Agnes, biological mother interviewed for papers III and IV)

Other participants also echoed the perception that there was no stigma attached to BA. One further elaborated that it was a relief to be able to frame BA as something the adolescent did for self-care purposes:

> Sometimes I avoided calling my mum because I didn't want her to ask how [my daughter] was doing. Because if I told her that [my daughter] was in on a psychiatric emergency [admission], then my mum would be hysterical. Um, because also, if someone would ask my mum where [my daughter] was, my mum would have never been able to say that '[she] is admitted at the psychiatric emergency clinic'. Like, it is so, uh, negatively charged. While Brief admission- If I call and my mum asks, 'where is [your daughter]?' 'She's on BA.' 'Yeah, okay.' Then it is something [my daughter] needs to feel good. And she is still doing well, she's feeling a bit worse but [pauses for two seconds] but it's not chaos, or crisis. […] BA, Brief admission, is not at all as charged and negative as emergency psychiatric [admissions]. BA is rather something positive. (Lisbeth, biological mother interviewed for papers III and IV)

These examples suggested that the uncomplicated, undramatic, brief nature of BA and its orientation toward preventive self-care, helped spare the adolescent from

internalising stigma and helped them feel a sense of self-worth, that they deserved to feel better. All of this, it can be argued, safeguarded their human dignity.

BA falling short in securing human rights

Both papers III and IV also addressed issues where BA was not aligned with human rights. A central part of experiencing BA as being robbed was that the parent felt that 'in using BAs their teenager is being *deprived* of their fundamental needs' (paper III, p. 6, emphasis added). This could be seen as a direct critique that BA deprived adolescents of their human right to health.

Further, the parent related to the room at the unit as 'a prison cell or broom closet – a tight, barren, inhospitable and unpleasant space devoid of hope', from which 'the sense of unworthiness oozes' (paper III, p. 7), i.e. that the physical space was counterproductive to human dignity. In general, lack of dignity was intertwined with a perceived failure to secure the adolescent's right to health, as seen in repeated descriptions on page 7 of paper III: the perception that 'staff consider BA patients less worthy of care, like second-class patients, deprived of their rights', implied that the adolescent wasn't treated with dignity and didn't receive sufficient help. The experience that 'their teenager is in a no-man's-land, a trench where no one will claim them, contained like an object', could be described as upsetting both in terms of the adolescent being deprived of care (i.e. having their right to health denied), and because they were perceived to be dehumanised and objectified (i.e. deprived of dignity). Further, the description that 'the parent is left feeling that they expected more from the BAs and psychiatry. They have been to war for ages to get their child the healthcare they need' (p. 7), suggested that the parent assumed a rights-based approach and experienced a strong sense of betrayal and failed expectations after having fought for so long to ensure the adolescent's right to health would be upheld.

Paper IV addressed additional dimensions of rights that weren't perceived to be upheld. For instance, some family members had expected to be more involved in BA and positioned themselves as rights-holders along with the adolescents. They felt that they had a right to be supported in their own health as well, but CAP didn't meet this expectation. Indeed, CAP didn't even seem to consider that the family was affected by BA, as they were the last to know. 'Rather than receiving an invitation into collaborative care, participants described needing to fight for involvement, for their child and themselves' (paper IV, p. 6).

One more concrete issue raised was that CAP wasn't perceived do their part in securing mental health literacy for families and ensuring that information systematically went out about BA. This meant that fulfilment of adolescents' and families' right to health was left to chance.

The mother Petra further suggested that in the status quo of CAP, the adolescent's right to integrity and autonomy in healthcare was pitted against, and ended up trumping, parental involvement:

> Sometimes the healthcare system forgets that, parents have an important role […] We're talking about minors so we, like- They should really get to feel heard, but us parents, we must also be heard and be, like, involved in, in, the care plan more closely. […] We would need to hear part of what [our child] says in there to be able to do our job as parents. (Paper IV, p. 7)

Furthermore, as previously mentioned, some family members 'related to the child's access to BA as missing the target' and felt that CAP 'checked out on them altogether, leaving parents solely responsible for the survival of their children' (paper IV, p. 7). When family members felt they lacked proper training and skills to be able to manage the adolescents' suicidality, CAP refusing to step in could be perceived to obstruct and deny the adolescent's right to health.

Lastly, one important issue raised concerning accessibility wasn't mentioned in the published papers but was spontaneously raised by interviewees who lived far away from the CAP inpatient clinic. These participants perceived less of a difference between BA and emergency admissions in that BA still disrupted everyday life; it was still a hassle as the family needed to travel long distances to get there:

> I don't know, if we would have lived closer, if she would have used [BA] more if it would have been easier. Because maybe you get the feeling, 'well, let's wait it out for a bit', because it will still be a project to get [on the road] and all of that. (Lina, biological mother interviewed for papers III and IV)

> For us to drive from [the other end of the region] to [the clinic where BA is offered] for one day, and then it was two days, and then it was three days. I mean, that's just- and having three children at home, on top of that. That- No, I can't feel that [access to BA] has been very positive, really. I think it is lousy that there is no [psychiatric] emergency care [closer to where we live]. There absolutely should be. […] It affects the whole family. You're standing there trying to cook and then it was, 'no, now we need to go there', and siblings and everything. […] It's not very good that you can't- well, going down to [the city where BA is offered] and then going home over night and then going down again… It's just not reasonable. (Clara, biological mother interviewed for papers III and IV)

Participants who lived far away explained that they couldn't let the adolescent travel that far alone, it wasn't really feasible for adult family members to come and go from the clinic so they felt forced to stay there during the whole BA period, but at the same time they also couldn't always be away from younger children overnight. This was especially a problem for single-parent households, or in situations where family members felt that both the adolescent on BA and younger siblings needed the presence of the same adult family member. This all resulted in very different experiences between families, where those who lived close to the CAP clinic experienced a more radical shift with BA toward a fuller life with a more independent adolescent, while those living far away remained in the experience that

BA disrupted everyday life for the whole family in much the same way as emergency admissions. This issue of inequitable accessibility meant that there were structural barriers to realising the right to health for some adolescents.

Interpretations of recovery

Clinicians' attitudes and understandings of recovery

Papers I and II: what the SHAS-SR implies about recovery

Similarly to the human rights section, I interpreted the SHAS-SR items in terms of recovery, as well. Again, these interpretations are clearly subjective, and I am sure readers may make different associations with respect to these items. Rather than 'correctness', my aim with presenting my interpretations is to begin engaging with multiple understandings of recovery in research on clinicians' attitudes and stimulate readers to do the same. For a summary of my recovery interpretations, see Table 3b.

First, I propose that the items in the Judgement subscale draw on a biomedical understanding of self-harm recovery. All items are formulated as prejudiced beliefs and stereotypes about people who self-harm and their motives, echoed in testimonies about healthcare encounters by people who self-harm (Pembroke, 1994). In these generalised statements, people who self-harm are *othered* (de Beauvoir, 2015; Corfee et al., 2020; Spivak, 1985); they are labelled as different from and devalued with respect to the dominant social group which clinicians are presumed to belong to, with no presumed overlap between these groupings. In rating these questionnaire items, the freedom of clinicians to assess and evaluate people who self-harm could be said to mimic the epistemic authority and power position of clinicians relative to healthcare users who self-harm in a psychiatric setting. Hence, self-harm, and recovery, become issues for the clinician to define and understand. The Judgement items all view self-harm as problematic, with cessation of self-harm as an implied desired objective, though some statements suggest that it is impossible for 'these people' to recover (*from* self-harm). In understanding self-harm as manipulative or attention-seeking, the implication is that clinicians wishing to aid recovery should distance themselves from people who self-harm, to avoid reinforcing the behaviour (i.e. to make it less likely to reoccur). In sum, whether or not one considers recovery at all possible, self-harm and recovery are defined strictly by the clinician, which is why I consider these items to be discursively aligned with the biomedical model.

Table 3b. SHAS-SR items, subscale groupings and implications for recovery

ITEM	SUBSCALE	IMPLICATION FOR RECOVERY
1. People who self-harm are usually trying to get sympathy from others 5. When individuals self-harm, it is often to manipulate carers 6. People who self-harm are typically trying to get even with someone 7. A self-harming client is a complete waste of time 9. Self-harm is a serious moral wrongdoing 15. A self-harming client is a person who is only trying to get attention 16. Self-harming clients have only themselves to blame for their situation	Judgement	Biomedical recovery (or none at all)
12. Self-harm may be a form of reassurance for the individual that they are really alive 13. Self-harming individuals can learn new ways of coping 14. Acts of self-harm are a form of communication to their situation 17. For some individuals self-harm can be a way of relieving tension 18. Self-harming clients have a great need for acceptance and understanding	Acceptance and understanding	Personal recovery or neorecovery
20. I listen fully to self-harming clients' problems and experiences 21. I feel concern for the self-harming client 23. I demonstrate warmth and understanding to self-harming clients in my care 26. I acknowledge self-harming clients' qualities 27. I find it rewarding to care for self-harming clients	Sympathy and dedication	Personal recovery or relational recovery

Next, the Acceptance and understanding as well as Sympathy and dedication subscales both make frequent use of individualising language, referring to people who self-harm interchangeably as 'individuals' or 'clients'. They both also appear to place value on seeing the individual's unique inner experience, in a way that I believe aligns with popularised understandings of personal recovery.

However, looking more closely at the Acceptance and understanding items, people who self-harm are never suggested to have agency or power. The lens of acceptance remains paternalistic, where the seemingly benign statement that people who self-harm have a 'great need' for acceptance and understanding (item 18) is coupled with the statement that people 'can learn' to replace self-harm with socially accepted

behaviours (item 13). Self-harm may be non-judgementally framed as an understandable response when lacking other coping strategies, but self-harm cessation or reduction is still implied to be a goal, and proper support and skills-training from the healthcare system is implied to be the way forward. This behavioural target of teaching better coping strategies to the masses discursively aligns with the contemporary definition of neorecovery. Notably, the clinician's position of power to define what skills are lacking and what coping strategies would be more appropriate lingers unspoken in this subscale as well; their epistemic authority remains a given, illustrating how the personal recovery framework doesn't challenge, but rather reaffirms, biomedical hegemony.

The items in the Sympathy and dedication subscale by no means level the power imbalance between the clinician/rater and the person who self-harms (not least by the very fact that the clinician freely gets to self-assess, rather than being assessed by people who self-harm). However, this subscale opens up for understandings and values beyond the biomedical model. Items about feeling concern and finding care interactions rewarding denote inner experiences in the clinician, implying that people who self-harm affect them as well as the other way around, discreetly hinting at human interdependency. Additionally, listening fully, demonstrating warmth and understanding, and acknowledging the person's qualities are all behavioural items that imply deservingness and humanity of people who self-harm, as well as provide direct guidance for clinicians on how they might support people's recovery processes by relational means. For this reason, I interpret the items of this subscale to fit within the personal recovery discourse, while also leaving room to consider a relational understanding of recovery.

Next, I would like to also say something about the items that were *not* included in the final SHAS-SR. As a reminder, three items (2, 10, and 25, see Table 4) were omitted due to low factor loadings in the exploratory factor analysis, meaning they didn't correlate well with their associated subscale (Acceptance and understanding, Judgement, and Sympathy and dedication, respectively). Ten additional items were removed when running confirmatory factor analysis on the other half of the sample. My understanding of these results is the items removed didn't contribute well toward the overarching construct of clinicians' attitudes. This could be for a number of reasons, e.g. ambiguous item formulations, participants interpreting the items differently, or that these items tended to be rejected (or endorsed) regardless of whether participants responded more positively or more negatively to the rest of the questionnaire items (e.g. both 'highly accepting' and 'highly non-accepting' participants disagreeing with statements such as item 2, 'people should be allowed to self-harm in a safe environment').

Table 4 provides a summary of what I understand the excluded items to imply in terms of recovery (as well as a rights-based approach in psychiatry). I won't go into a lot of detail about my reasoning behind considering some of these items to imply biomedical, personal, or relational understandings of recovery. The important thing

here is really not exactly how one might theoretically understand every single item. Rather, what I want to bring attention to is the fact that a few additional perspectives appeared to be implicated here, as compared to the included items in the SHAS-SR.

Table 4. Theoretical implications of items not included in SHAS-SR

ITEM	THEORETICAL IMPLICATIONS
2. People should be allowed to self-harm in a safe environment 8. An individual has the right to self-harm 19. A self-harming client deserves the highest standards of care on every occasion	Rights-based approach
4. Self-harming clients do not respond to care 10. There is no way of reducing self-harm behaviours	Biomedical recovery (or none)
3. A rational person can self-harm	Social justice
22. I feel critical towards self-harming clients 25. I feel to blame when my clients self-harm	Social justice or relational recovery
11. People who self-harm lack solid religious convictions 24. I help self-harming clients feel positive about themselves 28. I can really help self-harming clients 29. I would feel ashamed if a member of my family engaged in self-harm 30. I am highly supportive to clients who self-harm	Personal or relational recovery

Interestingly, there were a few items that were relevant to the social justice origins of the concept of recovery. Most prominently, item 3, 'a rational person can self-harm', forced the rater to consider the possibility that a person who self-harms could be 'just like you' and that self-harm could be a reasonable behaviour in response to an unreasonable situation (much like it was portrayed in Maggy Ross' notion of the 'silent scream'; Pembroke, 1994, p. 15), rather than a problem to be treated.

Other statements that could have some bearing on ideas from the social justice movement (though less apparently so) were items 22 and 25, 'I feel critical towards self-harming clients' and 'I feel to blame when my clients self-harm'. These formulations focused attention more deliberately on the rater/clinician, and one could argue that they implicitly suggested that clinicians may be part of the problem, locating (some degree of) responsibility and accountability onto clinicians rather than (solely) people who self-harm. As mentioned, I believe this way of reasoning also tied into understandings of recovery as inherently relational, implicitly begging the clinician to consider, 'if *you* feel this way – how do you think the person who self-harms would feel, if met with that?'

However, as noted, none of these ideas ended up included in the SHAS-SR. Very generally speaking, their exclusion may reflect that they did not clearly align with any one latent factor (subscale) or the overall construct of attitudes toward people who self-harm; in other words, no consistent response pattern could be statistically inferred for these items.

Results from paper II: understandings of recovery implicated in clinical attitude profiles

Now, what can paper II additionally tell us about understandings of recovery in terms of subscale-level response patterns among our sample of psychiatric clinicians?

The short version is that the results provide limited support for distinct profiles. The response patterns identified by no means support the existence of four clearly separate groups of people with vastly different attitudes and clinical responses to people who self-harm. On an individual level, the rating differences between e.g. person A, assigned to the Sympathetic profile, and person B, assigned to the Reluctant profile, may have been slim. In applying my theoretical interpretations on top of this, I want to stress that I am painting in very broad strokes on top of already general study results.

As previously mentioned, the majority of clinicians' ratings aligned with the Sympathetic profile, generally rejecting Judgement items while endorsing the other two subscales. I tentatively suggest that this might imply that the general majority of psychiatric clinicians to some degree subscribe to ideas of personal recovery (or, at least, they seem aware that this is a strong discourse at this point in time in Sweden). It is not possible to infer anything about participants' awareness of neoliberal versus relational leanings in these personal recovery discourses. It is also not reasonable to suggest that the majority reject the biomedical model. (As a reminder, with the popularisation of personal recovery, the recovery concept ceased to challenge biomedicine). What we seem to be able to suggest, however, is that most clinicians no longer appear to subscribe to stereotypic ideas of people who self-harm as 'manipulative' or 'attention-seeking' and appear to believe that recovery (as per the biomedical and/or personal recovery definition) *is* possible.

Further, about a fifth of the sample's ratings aligned with the Reluctant profile, scoring similarly to the Sympathetic profile on Judgement, but generally less favourably on Acceptance and understanding as well as Sympathy and dedication. My tentative interpretation here is that these clinicians also believe that recovery is possible, though they don't seem to be quite as swayed by the personal recovery discourse. Most distinctively, they don't appear to be dedicated to supporting other possible recovery values, beside from the biomedical ones (as suggested by the low agreement with the Sympathy and dedication subscale, in particular).

It seems less meaningful to interpret understandings of recovery as per the other two profiles, as they each made up less than one-twelfth of the sample. Very generally speaking, clinicians who scored in alignment with the Antipathic profile appear to favour biomedical understandings of recovery, while those in the Judging profile may also, partially, subscribe to the personal recovery discourse.

Family perspectives on recovery

In this subsection, I will focus on what the two family-oriented articles can contribute in terms of relational recovery, though I will also demonstrate how ideas of neorecovery come through in both works.

The interdependent nature of humanity – and recovery

The whole of article III seems to read as an ode to relational recovery. Relational recovery is present everywhere throughout the phenomenological descriptions of the parent's lived experience when their teenager utilises BA.

When self-admissions with BA were experienced as receiving a gift, it's clear that this gift was for the parent, the teenager, and the whole family. The interdependency within the family echoed through descriptions of life while the teenager was self-admitted. Knowing that the teenager was safe on BA, the parent felt safe as well. The teenager's relief became the parent's relief. The parent related to the teenager as being contained, safely held, by the BA framework, and described the same experience for themselves as well.

Prior to BAs, the parent used to be trapped at home while waiting to hear from the psychiatric clinic, and whenever the parent would leave to go there, the other children in the family became the ones trapped at home. When the teenager was able to self-admit with BA, they weren't the only one liberated and strengthened in their autonomy; the sense of empowerment and liberation reverberated through the parent and the rest of the family, also. From sharing collective feelings of despair and anxiety, the parent felt that the whole family started to feel calm and safe, instead.

One key aspect mentioned is that 'the parent willfully surrenders control and responsibility. The more the parent can let go, the more they get to experience their teenager growing and maturing, gaining self-understanding and self-regulation skills' (paper III, p. 6). Wilfully surrendering in this way is inherently relational; it can only be done with trust that someone else will be there to take over. In this case, the parent puts their trust in the teenager as well as clinicians working with BA. This trust becomes key to the teenager's growth. From this, it does not make sense to talk about the parent's and teenager's recovery in plural, as if they were two separate phenomena occurring in parallel; rather, their recovery process is one and the same.

Similarly, when the BAs were experienced as being robbed, no one experienced recovery. The parent's *lack of* trust in the clinicians during BA – and, by extension, the BA method – could be described as a relational process with relational consequences. When clinicians were perceived as passive, e.g. not providing adequate care, unaware of the child's whereabouts, or when they otherwise failed to frame BA in a manner that inspired trust, the parent engaged 'in a tug of war for control' (paper III, p. 6) against both clinicians and the adolescent on BA, meaning that the adolescent's development was hampered.

While at the unit during BA, the parent sensed a collective air of suffering which made them uneasy and vigilant. Other children were perceived as threats and competition rather than promising new connections for their child. We don't know how the adolescents themselves responded to the other children at the unit, but the essential point here is that due to the interdependency of human nature, *the parent* was negatively affected by relating to the other children in this way.

Further, though the description of the material room at the unit might seem as far as one could get from a relational orientation, the previously mentioned sense of unworthiness that the parent experienced is inherently relational. Being worthy as a person, or not, is something we experience in relation to other people, an internalised collective of 'others', even if they weren't manifest in this room; they might not even exist as individual persons outside of the parent's mind. Regardless, the parent went through a relational process of evaluation, concluding that the space reflected a sense of unworthiness upon their teenager, which made *the parent* feel hopeless.

Human interdependency was also clearly illustrated in paper IV. For instance, family members (mostly biological parents) frequently responded to questions about their own experiences and views on BA by describing how they perceived *the adolescent's* experiences and opinions.

In terms of relational recovery, adult family members also recognised that they needed to hold space so that the adolescent wouldn't be negatively affected by the adult's feelings. This translated into them having to 'mechanically [patch] the wounded child up "like a machine" (Lina), feeling "almost heartless" (Jonas) when doing so' (paper IV, p. 6).

The mother Petra reflected on how her recovery was intertwined with her child's:

> When I'm not getting unburdened, I'm not good for [my child]. So [BA] does fulfil like a positive function beyond me resting up, which is that when [my child] comes back home, I […] can sort of be better for her. (Paper IV, p. 6)

One additional example of human interdependency and relational recovery (though not included among the selected examples published in paper IV) was that some parents mentioned that adolescents had said how they preferred to be self-admitted

alone on BA, so that they wouldn't be negatively affected by their parents' moods and feel the need to 'hold themselves together' to make their parents feel better.

That is, family members recognised that the adolescents were affected by them just as they were affected by the adolescents, and that being apart from each other during BA could support the family's mutual relational recovery process.

BA and a relational interpretation of the CHIME framework

As mentioned in chapter 3, in a call for increased relational understandings in recovery research, Price-Robertson et al. (2017) used the well-known CHIME framework to demonstrate that aspects of recovery which are often considered to be intraindividual, could be construed as relational as well. I will continue in this vein, applying the same framework to paper III and emphasising relational foundations.

Connectedness is obviously a relational aspect of recovery, but from paper III, I would argue that it was also foundational for the experience of all the other facets of CHIME in terms of BA. Aligned with traditional conceptualisations of connectedness, in the experience of receiving a gift, the parent described that BAs enabled reconnection with valued social relationships, making the parent feel supported and like they belonged with others. Forming a new relationship dynamic with their teenager, where the parent was able to be encouraging and permissive rather than controlling, appeared to bring them closer as well:

> The parent attunes to where the teenager needs them to be. They acknowledge the teenager's capabilities, validate their need for space, mirror their disappointment in the face of setbacks, and encourage them. In place of the previously hierarchical parent-child relationship, a more symmetrical relationship is forming. (Paper III, p. 6)

Perhaps most importantly, however, important connections don't just happen outside of healthcare. The aforementioned, crucial element of trust simultaneously requires and enhances connectedness with clinicians, as human beings and as representatives of the healthcare system. High turnover was referenced to create a sense of chaos, hampering the formation of connections and a sense of continuity in care. When the teenager contacted the parent during BA to say that they felt lonely, it '[tugged] at the parent's heartstrings' and they related to them as an abandoned 'street child' (paper III, p. 7), feeling instinctively and deeply that the teenager's lack of connectedness was detrimental. Lack of connection, the perception that 'no one was there' for the teenager, nor for the parent, made all the other facets of CHIME fall like dominos.

As for *hope*, it has already been mentioned that the family shared collective feelings of despair as well as hopefulness. The family jointly experienced hope due to the radical shift of family dynamics, when life suddenly became more liveable for all of them. This clarifies that hope is not an intraindividual matter of 'thinking better', but an interdependent experience where the sum is greater than the parts. I would

argue that hope (or hopelessness) is implied in such a relational sense throughout much of the results descriptions, from feeling that the teenager is kept safe by clinicians working with BA, to feeling that said clinicians fail to interact with the parent and fail to frame BA in a way that makes sense to them, making them unable to envision a hopeful future for the teenager and family.

As mentioned, the parent's impression of the physical space at the unit intermingled with the air of despair from children's collective suffering and hopelessness. This made the whole setting come across as 'devoid of hope', which 'in its silence and givenness, has a demonstrative property to it, declaring *this is the world you live in now; this is all there is for your child*', (paper III, p. 7) causing the parent's heart to sink. Again, other people were represented in the parent's mind as those who had 'given' them this silently demonstrative room. That is, the room was animated as a symbol of a relationally felt hopelessness.

Strikingly, even as the parent could lose hope and feel disillusioned with BA, they kept up a façade because they were 'certain that *their teenager* would not survive losing hope' (paper III, p. 7, emphasis added). That is, the parent understood the experience of hope as relational and realised that the teenager may still feel hopeful, as long as the parent remained able to inspire it.

The dimensions of identity, meaning, and empowerment frequently overlapped. For example, the parent's trust in the teenager arguably brought *meaning* to the BA intervention, in a sense of helping the parent navigate the world. Trust was also foundational for the teenager to truly be *empowered* with BA, and to grow into an *identity* of someone able to take care of themselves. The shift in family dynamics also made the parent renegotiate what it meant to be a parent and how they could be supportive of their teenager at that point in time. The parent was empowered in learning to distinguish 'the teenager's needs from wants and preferences' and could thereby 'begin to consider their own as well, taking shape as person-beyond-parent even in relation to the teenager' (paper III, p. 6). That is, the parent was empowered and grew in their identity through the shift in relational dynamics with the teenager, engendered by the teenager's use of BAs.

Further, getting to return to work and get back in touch with the roles of colleague and professional brought 'gratitude and meaningfulness' as well as 'a sense of wholeness to their selfhood' (paper III, p. 6), a fuller identity in connection with others. Also, as mentioned, the parent even perceived the other children in the family as empowered in the sense of being liberated to live their regular lives again, filling them with more meaningful activities and connections as an effect of the teenager being able to self-admit with BA.

Conversely, the parent related to the perceived passivity of clinicians as a betrayal, losing trust and a sense of meaning with the BAs. This also made the parent start relating to clinicians differently, no longer viewing them as authority figures or

professionals at all. This relational process locked the parent back into a rigid identity as the constant, sole protector of their child.

Further, the parent could struggle with being shut out and losing insight into admissions, being 'distinctly *not-there*, so painfully on the *outside* physically that they must always remain *inside* mentally. They frequently call the unit and text their teenager, they worry incessantly, and may even try reaching the teenager's friends for updates' (paper III, p. 7). This impacted negatively on the parent's experience of meaning in life, in the sense of being so preoccupied that they lacked space or time to be with their other children or fill life with other meaningful experiences. In essence, this preoccupation and lack of meaning was an effect of the lack of connection with the adolescent during BA.

Contesting neorecovery

Worth mentioning in this context, some parents in papers III and IV also implicitly related to neorecovery, which was critically described as the *antithesis* of recovery, from their perspective. As mentioned briefly in paper III, 'In the parent's lived world, the BAs are bookkept along with other disappointments, as a budget alternative to *real* care for a healthcare system on its knees' (p. 7, emphasis in the original). The parent here appeared to understand BA as part of a larger political and financial scheme, cutting back on healthcare expenditure and offering low-intensity, brief interventions to the masses, while failing to meet the needs of those with severe conditions and higher needs of care.

This was further explored in paper IV, where some participants discursively related to BA by reference to the larger psychiatric and general healthcare system. These participants described a sense of refusal of CAP to provide care, as if 'the system' washed its hands and stated that managing children's suicidal behaviours and ensuring their survival was an individual problem (i.e. each parent's problem). As described in paper IV:

> Some stated that the general healthcare system lacked resources and faced cutbacks, understanding BA as a budget option compromising care quality. Parents stated that their children needed treatment, which was out of the parents' hands, yet they needed to step into such roles in the absence of a functional CAP. (p. 7)

Here again, BA was related to cutbacks on healthcare expenditure. There were even accounts of participants feeling pressured to act as stand-in professionals during BA due to this lack of resources within CAP. In one way or another, family members related healthcare cutbacks to responsibilisation of individuals to manage their own health and risks, a core critique of neorecovery.

Some participants actively resisted such responsibilisation, as seen in this comment by Holger in relation to his daughter's suicidal behaviour:

> The healthcare system and psychiatrists and doctors, they are the ones who are supposed to be the experts. I'm not supposed to, be that. […] I have always, like, pushed back and told them, 'But this can't possibly be right. We can't take her home now. She is trying to kill herself. All the time!' 'Oh but surely you can handle it.' (Paper IV, p. 7)

In such instances, family members implicitly described neorecovery as the antithesis or *absence* of recovery, and the perceived push to responsibilise individuals for their own (and their children's) health was described as undesirable for these participants. Arguably, given this hyper-individualisation of recovery, neorecovery could also be constructed as the *antithesis of relational recovery*.

Chapter 7. Discussion

Is this how it is?
Is this how it's always been?
To exist in the face of suffering and death
And somehow still keep singing
(Florence Welch in her song *Free*)

In this dissertation, I endeavoured to contribute to the field of self-harm research by illuminating human rights and relational recovery in research on clinicians' attitudes toward people who self-harm (papers I and II) and family perspectives on BA for adolescents who self-harm (papers III and IV). In this chapter, I will discuss the contribution of these four papers in relation to previous literature in the field. I will highlight the clinical implications of the four papers in terms of rights-based and relational perspectives. Then, I will discuss methodological considerations and the limitations of said papers. I will finish with some concluding remarks and suggestions for future research.

Clinicians' attitudes toward people who self-harm

Our revised version of the SHAS, the SHAS-SR, ended up containing a few items that could be interpreted to at least open up for relational understandings of recovery. Further, while it could be argued that most items indirectly aligned with the right to health, and some indirectly supported respect for dignity, none of the included SHAS-SR items explicitly framed healthcare users who self-harm as rights-holders. This does not necessarily mean that no-one valued relational and rights-based perspectives. However, it does suggest that these matters – especially that of healthcare users' rights – were somewhat controversial at the time of data collection, as participants' positions on excluded items did not align with their endorsement of other items contributing to the overall picture of attitudes among our sample of Swedish psychiatric clinicians.

This can be compared to other existing questionnaires about attitudes toward people who self-harm. For instance, the *Attitudes To Deliberate Self-Harm Questionnaire*

(ADSHQ; McAllister et al., 2002) includes items such as clinicians' self-perceptions of their degree of control, effectiveness, the extent to which they feel sorry for people who self-harm, or feel used, helpless, or useful, their perception of whether they could do anything to help, and whether they themselves or the general healthcare system actively tries to discourage repeat help-seeking. Additionally, there are items about clinicians' positions on the value of receiving ongoing training, the importance of risk assessment, knowledge about where to refer healthcare users, judgements that people who self-harm seek attention, waste time, that they become a hindrance for the healthcare system, or that they cope ineffectively. A lot of these items implicate biomedical understandings of self-harm and recovery. However, a few items could be interpreted to implicate relational recovery, such as the value of directing people who self-harm toward community support, and that one's cultural beliefs may condone self-harm. Additionally, some items could be considered to recognise social justice issues for people who self-harm, such as the perception that they are victims of social issues, the extent to which the healthcare or legal system is perceived to impede effective care provision, and the perception that people who self-harm are not being treated as seriously as other healthcare users. A few of these latter ones imply that people who self-harm have rights, though similarly to the SHAS-SR, human rights could be said to be supported *indirectly* rather than explicitly by the more sympathetic items.

Another questionnaire worth mentioning is *Attitudes to children who self-harm* (Crawford et al., 2003). This is a brief questionnaire, including items about the clinician's self-perception as useful, helpful, or empathic, that their effort makes a difference, whether their intervention will be impactful, whether a mistake by the clinician can cause suicide and how much the clinician worries about being blamed, as well as the existence of collegial support for the clinician. More negative items ask about the extent to which the clinician is angered by children who self-harm or their parents, the perception that self-harm in children stems from neglect, and posit that children who self-harm waste resources and time. These few items aren't as easily discussed in terms of various understandings of recovery, but what is evident is the limited relational perspective and the complete lack of recognition of children's rights.

To summarise, then, rights-based and relational perspectives tend to be limited across questionnaires about clinicians' attitudes toward people who self-harm, and the SHAS-SR is no exception. This is regrettable, especially considering the *normative* potential of questionnaires to formulate and nudge clinicians toward more desirable behaviours. Considering this potential use, it could have been relevant to include more items explicitly recognising and protecting the rights of people who self-harm and prompting clinicians to deliberately mentalise with the experience of people who self-harm, rather than basing decisions on item retention mainly on statistics.

In terms of scores on the SHAS-SR, our participating clinicians on average showed high agreement with the items in the Sympathy and dedication and Acceptance and understanding subscales, and low agreement with items in the Judgement subscale. When considering the four attitude profiles, about two thirds of participants aligned with the Sympathetic profile, showing near full agreement with the two more 'positive' subscales and near complete disagreement with Judgement. About a fifth aligned with the Reluctant profile, scoring a little bit lower on Acceptance and understanding and somewhat lower on Sympathy and dedication, though these scores were still high on average. Less than one-twelfth of participants aligned with the Judging profile, showing higher agreement with the Judgement subscale, though it should be noted that they still disagreed more than agreed with these items, on average. A subgroup of equally small size aligned with the Antipathic profile, showing even higher agreement with the Judgement subscale, and lower agreement with the two other subscales. However, to nuance the essentialist ring to these profile labels, even this last group on average responded between the point of neither disagreeing nor agreeing, and disagreeing slightly with the Judgement items, leaning toward the latter. They responded similarly to the Sympathy and dedication items, though leaning toward neither disagreeing nor agreeing. Finally, on average they responded between neither disagreeing nor agreeing, and agreeing slightly with the Acceptance and understanding items, leaning toward the latter. Taken together, all of this suggests that our sample self-rated as having quite positive attitudes, on a group level. This is in line with some research reporting a degree of relative sympathy toward people who self-harm among clinicians (Friedman et al., 2006; McCarthy & Gijbels, 2010; O'Donovan & Gijbels, 2006; Patterson et al., 2007a; Rouski et al., 2017; Wilstrand et al., 2007) and suggests that our sample of Swedish clinicians in psychiatry largely self-rate attitudes and behaviours that support the dignity of healthcare users who self-harm as well as favour acceptability of care, indirectly supporting healthcare users' right to health (United Nations Committee on Economic, Social and Cultural Rights, 2000; United Nations Human Rights Council, 2017, 2020). Then again, it could be argued that anything but a resounding complete disagreement with ideas of people who self-harm as attention-seeking or manipulative would likely be felt as negative by healthcare users and would be unhelpful in healthcare encounters.

There remains cause for concern regarding clinicians whose responses aligned with the Antipathic and Reluctant profiles: the latter chiefly because it was not uncommon in our sample, and healthcare users who self-harm are likely to pick up on behavioural signs of even slightly lower dedication to care. The main cause for concern is with the former group, which comprised a minority of the sample but self-rated reduced sympathy and increased judgement, likely to show in healthcare encounters. Those in our sample who scored in this way were much more likely to work in emergency psychiatric care, i.e. in inpatient care or the emergency reception, where people who self-harm will often present when feeling at their most vulnerable. This is of major concern as it threatens the human rights of people in

times of crisis. The SHAS-SR attitude questionnaire could mostly be interpreted in terms of the rights to dignity and health; however, these rights aren't the only ones threatened in the psychiatric emergency setting. As mentioned, Swedish legal mandates for involuntary admission (SFS 1991:1128) are commonly justified as necessary for the person's safety, with substitute decision-making in place by clinicians defining the best interest of the person in crisis, violating the person's rights to legal capacity, liberty, freedom from discrimination, and freedom from coercion, explicitly violating the Convention on the Rights of Persons with Disabilities (United Nations General Assembly, 2006; United Nations Human Rights Council, 2019). Use of coercive measures during admission further violates the person's rights to freedom from coercion and inhumane or degrading treatment (United Nations Committee on the Rights of Persons with Disabilities, 2014, 2015, 2016; United Nations Human Rights Council, 2013). All this also violates the person's fundamental human rights to dignity and health (United Nations General Assembly, 1948, 2006). As such, the attitudes of clinicians working in emergency psychiatric settings dovetail with legal and structural issues to create an environment in which the human rights of people who self-harm are violated or at risk of being violated. The present research on the SHAS-SR cannot say anything about causation or what came first in the relationship between more antipathic attitudes and working in emergency psychiatric settings, though research suggests that working in an environment where coercion occurs negatively affects clinicians' wellbeing as well as desensitises them to the harmful consequences of coercion (Hahn et al., 2024), which could be one explanation for generally more antipathic attitudes among clinicians in these settings. This desensitisation process could be understood to be emotional, moral and cognitive, like in research on cognitive dissonance and moral disengagement when being party to some form of cruelty (Huggins et al., 2002; Kim et al., 2025; Manzano-Bort et al., 2022; Radkiewicz & Korzeniowski, 2017; Soares et al., 2018). I would also suggest that the foundation for these moral and cognitive aspects is relational in nature (Price-Robertson et al., 2017), as emotions are social, circulating through and binding communities together (Ahmed, 2014). These social, affective processes of desensitisation could mutually reinforce the continued use of coercion in psychiatry, counteracting relational recovery as well as human rights.

Considering the results of the regression analyses, having attained a higher level of education, being a woman, working in non-emergency areas, feeling more relatedness at work, having worked for a shorter period in psychiatry, having received training about self-harm, and experiencing a higher sense of autonomy support from management, were all statistically significant factors predicting more *positive* attitudes toward people who self-harm. Most of these factors are supported in previous research (Cleaver, 2014; Hodgson, 2016; Karman et al., 2015; McHale & Felton, 2010; Perboell et al., 2015; Rayner et al., 2019; Ribeiro Coimbra & Noakes, 2022; Rouski et al., 2017; Saunders et al., 2012; Wilstrand et al., 2007), though our results contradicted some previous studies in terms of directedness of the relationship with work experience (Hodgson, 2016; Rai et al., 2019). To my

awareness, our study is still the only one to incorporate managerial autonomy support as an indicator variable in quantitative research on clinicians' attitudes. However, beyond statistical significance, the unique effects of all included factors were slim, meaning they each explained very little of clinicians' attitudes. Notably, training about self-harm could not differentiate between more Sympathetic and more Antipathic scoring patterns.

This suggests that specific training, which has been the most consistent factor appearing in previous literature (Cleaver, 2014; Commons Treloar & Lewis, 2008; Gibson et al., 2019; Hodgson, 2016; Karman et al., 2015; Kilty et al., 2021; McHale & Felton, 2010; Patterson et al., 2007b; Ribeiro Coimbra & Noakes, 2022; Saunders et al., 2012), might play less of a role among Swedish public psychiatric clinicians at this point in time. Perhaps this could be indicative of relative success of the national guidelines and nation-wide educational efforts, ongoing since 2012, by the Swedish National Self-Injury Project (Swedish National Self-Injury Project, n.d.), an initiative bringing Swedish public healthcare together with researchers and people who self-harmed to improve equity and quality of care for who people who self-harm in Sweden. The Swedish National Self-Injury Project is in close collaboration with the Self-Harm and Eating Disorders Organisation (SHEDO; n.d.), which is a widely recognised non-profit, non-governmental organisation by and for people who self-harm and people with eating disorders, whose primary aim is to spread awareness, provide support to people with lived and personal experiences, and influence public opinion. SHEDO has existed in its current form since 2008 and some of their material has been integrated into public psychiatry, at least in the Skåne region.

Another interesting aspect of the current results is the role of relatedness, i.e. feeling close to and supported by others at work, which has previously been suggested to play a role in clinicians attitudes toward people who self-harm (Karman et al., 2015; McGough et al., 2022; McHale & Felton, 2010; Ribeiro Coimbra & Noakes, 2022; Rouski et al., 2017; Wilstrand et al., 2007) as well as more critical attitudes toward coercion in mental health settings (Hahn et al., 2024). The current result that higher degree of relatedness at work was related to more positive attitude scores is especially interesting when considered together with the recognition that the Sympathy and dedication subscale could be interpreted to support relational recovery (Price-Robertson et al., 2017). Given this, one might tentatively suggest that a more relational orientation in psychiatry at large – not just in clinician-user interactions but in collegial interactions and the overarching culture of psychiatry – could go hand in hand with promoting (relational) recovery of healthcare users who self-harm.

Importantly, as stated previously, we didn't explore clinicians' attitudes to claim an objective truth that the majority of Swedish psychiatric clinicians 'have' positive attitudes. Aside from methodological restrictions (which I will go into below), research in various fields has frequently noted that privately held opinions and

beliefs don't always translate into the behavioural component of attitudes (Ahmad et al., 2025; Bifarin et al., 2022; Borges-Tiago et al., 2024; Fletcher et al., 2018; Kim et al., 2025; Manzano-Bort et al., 2022). While it is likely that healthcare users would pick up on more 'antipathic' attitudes in clinicians' behaviours, the reverse doesn't necessarily apply. As we have seen, most of the 'sympathetic' items in the SHAS-SR could be interpreted within an understanding of personal recovery that still aligns with overarching biomedical perspectives where the clinician holds epistemic authority. Indeed, the very act of conveying acceptance of another is inherently built upon a power dynamic where the one who does the accepting is in a position of relative privilege over the one being accepted, and the clinician's stance of acceptance is seen as graceful and virtuous while it might actually be harmful to healthcare users (Brown, 2009; Brown et al., 2015; Collins, 2021; Lovell, 2017). Put differently, just because a clinician believes their own attitudes to be positive, that does not mean that healthcare users would characterise their clinical encounter as positive. Clinicians may very well 'be' well-meaning and non-judgemental, even as per the healthcare user's definition, but the absence of negative attitudes and presence of a will to understand and listen fully, still is not a very high bar for quality of care and says little about the extent to which healthcare users' needs are met. A firm grounding of psychiatry in rights-based perspectives and a commitment to social justice could help truly empower healthcare users, allowing them to define what helpful care looks and feels like.

Family perspectives on BA in CAP

The two qualitative papers have shown that BA can be experienced in widely different ways for parents and other adult family members. Their experiences can mirror those of the adolescent receiving access to BA, or they can be altogether different. Contentment among some family members with being relieved of responsibility (paper IV), letting go of the need for control and constant surveillance, and being relieved of feelings like fear, guilt, shame, and helplessness (paper III) mirror other qualitative research on relatives' experiences with BA for adults (Hultsjö, Appelfeldt, et al., 2023; Hultsjö, Rosenlund, et al., 2023). Promisingly, the current research echoes the potential of BA to support the whole family in their recovery process (Hultsjö, Appelfeldt, et al., 2023; Hultsjö, Rosenlund, et al., 2023; Lindkvist, Eckerström, et al., 2024). To realise this potential, certain considerations are necessary.

First, the degrees of involvement described by family members in paper IV varied but were rather low across the four themes. The family members who were content with not being involved in BA were able to trust that the adolescent had what they needed to fare well with BA. Family members who had yet to see any reason to put their trust in this, or whose trust was eroded during the adolescent's self-admissions,

did not feel involved enough and wished that CAP would take more responsibility. The most important lesson here is that family members' satisfaction with and trust in BA must not be left to chance. Measures need to be taken to *systematically* involve family members in the BA process, beyond inviting them to sit in on contract negotiations.

More specifically, family members may potentially struggle with psychiatry leaving much in the hands of adolescents, in favour of autonomy. A particularly recurring fear was that the adolescents would end up in harm's way as they were free to come and go unaccompanied from the unit during BA. The lack of control by adult family members at home *and* clinicians at the unit was, at times, perceived as alarming. This is hardly surprising, especially given the role of psychiatry at large in *normalising* parental control of self-harming and suicidal adolescents, urging parents to surveil their adolescents around the clock and clearing away any potentially 'risky' objects in the home environment. Such recommendations stood in stark contrast to affording the adolescents full freedom and autonomy, which could be baffling to family members who appeared to expect some form of middle step along the way.

At times, family members felt that adolescents on BA did not receive sufficient support and were left to their own devices, not really receiving the care they were entitled to. These experiences were occasionally accompanied by descriptions of BA as a budget alternative in an underfunded psychiatric system. This highlights the risk that BA may be understood to manifest neorecovery, as part of a neoliberal agenda to cut back on healthcare expenditure and erode psychiatric care (Cohen, 2025; Recovery in the Bin et al., 2019). Researchers from various fields have previously cautioned that, unless new interventions and person-centred care efforts confront underlying biomedical and neoliberal values and divorce from them, such initiatives run the risk of allocating disproportionate responsibility onto the individual for managing their own health, de-emphasising the person's needs and rights in the name of enhancing their autonomy, rendering large healthcare inequities (Cohen, 2025; Jansson, 2018; Sakellariou & Rotarou, 2017; Smith et al., 2022; Tieu et al., 2022). This illustrates the point that BA cannot be claimed to 'be' an inherently person-centred intervention, as much as giving (back) autonomy to healthcare users is in its foundation. As the two qualitative papers demonstrate, the way that BA is implemented, delivered, adapted, and matched to the needs of each family is crucial for how this intervention is received. The centrality of a rights-based framework (Stastny et al., 2020; United Nations Human Rights Council, 2017, 2020) for BA delivery is one important lesson from how family members talked about being responsibilised (Peters, 2017; Rose, 1996, 1999) for their adolescents' survival in a context where CAP was perceived to abandon them.

One fundament that human rights are built upon is the dignity of every human being, which is also a right in itself (United Nations General Assembly, 1948). In this respect, I would indeed suggest that BA 'is' inherently aligned with human rights,

given that its core tenet is that the healthcare user is assumed to be worthy of receiving care and capable of making decisions from knowing their own needs and best interests. User autonomy isn't merely *enhanced* with BA but is its very premise. The healthcare user isn't just *treated* with respect from clinicians working with BA; their basic human dignity reverberates through the foundation of BA and is enacted each time a user receives access or has their access renewed. As has been pointed out by the United Nations (United Nations Human Rights Council, 2017), freedom of choice does not exist unless there are alternatives to choose between, most crucially alternatives to coercive practices. In centralising the autonomy and dignity of healthcare users to its definition and implementation, BA introduced a radically alternative practice into psychiatric inpatient care.

Notably, the dignity of each healthcare user must be continuously reenacted to be preserved. From the perspective of family members in both the qualitative papers, the sense of dignity was robbed from the adolescent when they were felt to be treated as an object, deprived of connection with clinicians, as well as when the suffering of other children and the symbolic indignity of the physical space at the unit shone through. The advantages of offering BUCA in separate units are numerous (Swedish National Board of Health and Welfare, 2021), one such unit has already been implemented successfully in Lund, and research on BA has repeatedly problematised mixed settings and called for the expansion of separate BA units (Lindkvist, Eckerström, et al., 2024; Lindkvist et al., 2019, Lindkvist et al., 2021, Lindkvist et al., 2022, Lindkvist et al., 2025). Family members in the present papers suggested that this might be desirable in CAP settings also, as will be further discussed in the section on clinical implications. The trouble with this, from a human rights perspective, is that children on emergency admissions will still face the same, potentially problematic environment. However, as suggested in the present research, a bare environment does not per se equate indignity; parents in study III came to relate to the physical environment in that way in a *relational* process of evaluation. Such issues could favourably be addressed if clinical encounters within inpatient CAP, and psychiatry at large, would be guided by and infused with human rights and relational recovery perspectives. If the dignity of every human being would remain at the fore, it would render certain clinical practices unthinkable, and we would be forced to look around for better alternatives.

Another key point raised in the present papers is the potential of BA to widen our understanding of recovery to that of a relational phenomenon. The interdependent nature of human beings (Price-Robertson et al., 2017) is demonstrated through collectively held feelings and experiences within the family system both before and after the adolescent gains access to BA, and further in how family members navigate closeness and distance together with the adolescent to support their mutual recovery process. Study III specifically expands the budding discussion of how BA can be related to relational recovery (Lindkvist, Eckerström, et al., 2024), illustrating how BA may become a catalyst for connectedness, hope, identity, meaning, and

empowerment (Leamy et al., 2011) in a relational sense – *if* delivered in a way that makes sense and inspires trust for the entire family, where everyone is clear about its purposes and their own respective roles in the BA process. For this to work, as noted in study IV, it is essential that family involvement is not construed in opposition to adolescent autonomy but as a potential facilitator, and a cornerstone of the BA method in CAP settings.

Clinical implications

The fundament that BA is built upon may already align with human rights and lend itself to relational understandings of recovery, but it is imperative that these perspectives are carried consciously by clinicians throughout delivery. Clinicians working with BA – especially in a CAP setting – would benefit from receiving training and regular support in working relationally with the whole family system, to collaboratively navigate situations where adolescents and family members may not be on the same page concerning e.g. healthcare needs and safety. With a more conscious relational grounding, we could avoid inadvertently constructing family involvement as threatening adolescent autonomy, and family members would not have to feel that e.g. their concerns about safety were passed over, as mentioned in one of the current papers. In this regard, it could be helpful to view the adolescent and their family as existing in a relational space where they can all support their mutual recovery process. Parental scaffolding could be one key to the adolescent gaining autonomy and capabilities to recognise when they would be in need of BA, as well as being able to pick up the phone and make the request. Contextual and developmental considerations are already made with respect to granting access to BA; such considerations should also be part of ongoing service delivery, rather than rigidly imposing the same exact conditions for e.g. a thirteen-year-old who just received access to BA and a seventeen-year-old who has accessed and utilised BA for years.

Additionally, given the potential for relational recovery, BA at CAP should be explicitly framed as an intervention intended to benefit the whole family. This could facilitate moving family members from positions of passive onlookers or coincidental side-recipients, owing a debt of gratitude for any form of benefit or effort at involvement, to active rights-holders and co-producers of care. This could be a first step, with the need of additional follow-through, to mobilise parents and other family members in ways that some requested in paper IV.

Centralising the perspectives of human rights and relational recovery, in BA as well as in psychiatry at large, simultaneously requires and supports humility in clinical practice, such that healthcare users are empowered to define what is important to them and take the lead in psychiatric interventions intended to help them. Lewis and

Hasking (2023) make the point that the healthcare user's goal might not be to cease self-harming, which pinpoints the inadequacy of biomedical conceptualisations of recovery (Adame & Knudson, 2007; Crowe, 2022; United Nations Human Rights Council, 2017, 2020). Biomedical hegemony in psychiatry allows the clinician to define self-harm as the issue, individual emotion regulation difficulties as the mechanism, and interventions targeting this as the treatment of choice. It is easy to claim that we involve the healthcare user when discussing their goals and preferences, but by the time the clinician invites the user into the conversation, much of the road ahead has already been mapped out. Yet, such collaborative conversations are often how care involvement and person-centred care are conceptualised from the clinical point of view (Lewis & Hasking, 2023; McCance & McCormack, 2025; Tieu et al., 2022). The body of research in this dissertation implicate the need to move beyond the widely recognised view of the 'personal' in person-centred care and personal recovery, which remains subsumed under biomedical perspectives. This applies to the delivery of specific interventions such as BA, as well as to the general understandings, attitudes, and values perpetuated among clinicians across various psychiatric settings – issues that need to be addressed on a managerial level.

Recognising recovery as inherently relational would call for a psychiatry that does not individualise suffering. This necessitates thinking about a person's social context beyond 'risk and protective factors' that can influence their 'disorder' or 'condition', as the same person would not necessarily be said to have 'a condition' under more favourable circumstances. Considering the social determinants of health (United Nations Human Rights Council, 2017, 2020; WHO, n.d.), by extension, would move us to recognise the power relations inherent in psychiatric enactments of reality and the social injustices that are perpetuated by the status quo of psychiatric practice (Stastny et al., 2020; United Nations Human Rights Council, 2017, 2020).

Stastny et al. (2020) may inform efforts to break with systemic injustices in mental healthcare. The authors have synthesised nine critical elements for rights-based crisis response, including communication and dialogue, presence, continuity, a safe space offering respite, meaningful involvement of peer support, limited use of medications, and responding to basic needs. Together, these elements promote dignity as well as the right to health, autonomy in healthcare, freedom from coercion, and other rights such as non-discrimination, liberty, integrity, and participation in the community (Stastny et al., 2020).

Notably, when successfully implemented, BA may involve all the aforementioned principles, taking the separate BA unit in Lund as an example. This unit has no medication whatsoever on site, has a peer supporter working alongside the psychiatric aides to offer dialogue and presence, and has less staff turnover as compared to mixed/emergency settings, meaning that the BA unit offers greater continuity where healthcare users meet the same members of staff on each

admission and are able to develop meaningful relationships with them over time. Peer support in particular has the potential to empower users to lead service delivery, as well as enhance the acceptability and quality of BA services.

The current papers as well as other publications have generally described BUCA as valuable in terms of responding to healthcare users' basic needs, like adequate food, sleep, safety, rest and respite, social connections, escape from environmental/social stressors, and other social determinants of health (Eckerström et al., 2020; Enoksson et al., 2022; Helleman et al., 2014b; Helleman et al., 2018; Hultsjö et al., 2025; Lindkvist et al., 2021; Lindkvist et al., 2022; Moberg, 2025; Mortimer-Jones et al., 2019; Värnå et al., 2025). The ability to tailor clinicians' demeanour as well as the physical environment at the unit toward a preventive, (relational) recovery-based approach that strengthens users' autonomy and treats them with dignity, means that the elements of safe respite and basic need fulfilment are more consistently achieved in the separate BA unit, as compared to mixed settings (Swedish National Board of Health and Welfare, 2021).

The safe space issue is especially relevant as BA has been described precisely as a safe space offering respite for some users (Helleman et al., 2018; Lindkvist et al., 2021; Lindkvist et al., 2022), but also as a reminder of traumatising healthcare interactions in that same environment, when BA was offered in a mixed setting (Daukantaitė et al., 2025; Helleman et al., 2018; Lindkvist, Eckerström, et al., 2024; Lindkvist et al., 2021). Additionally, offering BA in mixed settings does not sufficiently differentiate it from 'locked or otherwise coercive mental health services' (Stastny et al., 2020, p. 112), thus failing to fully safeguard users' rights to autonomy, liberty, and freedom from coercion, and the critical element of safety. Indeed, coercive measures constitute inhumane, degrading treatment (United Nations Committee on the Rights of Persons with Disabilities, 2014, 2015, 2016; United Nations Human Rights Council, 2013) considered prejudicial to children's health (United Nations General Assembly, 1989). Even if adolescents self-admitted with BA do not personally run the risk of being subjected to coercion, the risk of experiencing coercion and violence being inflicted upon someone else could arguably be detrimental to one's sense of safety at the unit.

Additionally, respecting users' autonomy means they should have the right to choose what the care they receive encompasses (Stastny et al., 2020). With separate BA units, this right could arguably be expanded more easily such that users could be involved in decisions about what they can experience and receive at the unit while admitted to BA. This could potentially include everything from leisure activity options to peer-organised support sessions to practical issues like getting to keep chargers, headphones, etc. on one's person, as is the case in the Lund BA unit. As emphasised by Stastny et al. (2020), 'each person should be respected as […] a free person with equal rights to all others. People with psychosocial disabilities have the right to make decisions that others feel are unwise or with which they disagree' (p. 110). Respecting user autonomy to such a degree is a delicate balancing act in the

case of children and adolescents, and children's right to special protection as recognised in the UNCRC (United Nations General Assembly, 1989) carries weight in this context. This is a reminder of the need to further involve users in decisions regarding BA delivery, and that our own potential fears as clinicians do not justify revoking that right; rather, such fears could become guiding compasses, pointing to the special relevance of supported decision-making in these situations. However, the right to autonomy in healthcare cannot be fully respected while BA is delivered in mixed settings – at least not without radical transformation of current emergency psychiatric settings.

Hopefully, it is clear that this discussion should not be read as a call to throw out psychiatry with the bathwater. Rather, it is a call to centralise human rights, social justice, and relational recovery in how we understand and approach suffering and wellbeing in psychiatric practice. With this contribution, I am joining in with the growing calls for co-producing psychiatry and mental healthcare with users and their families (Grim et al., 2022; Grim et al., 2019; Moran et al., 2024; WHO, 2025) to propel 'a radical redesign of mental health care' which can 'fundamentally improve the lives of people who self-harm' (Moran et al., 2024, p. 1445).

Methodological limitations

One of the most severe limitations of the present project is that furthering social justice and effecting concrete social change was not explicitly built into the design of these studies in the way that it would be in, for instance, a participatory action approach (Mertens, 2007). At the time of initial project design, unfortunately we lacked the resources and knowingness to pursue such approaches. Throughout this dissertation, I have tried to further social justice and human rights by engaging with these frameworks, raising perspectives that are largely unrecognised in psychiatry, and being as clear as possible about the implications of the current research in these terms. For the qualitative studies, a representative from NSPH was involved in the design of the interview guide, but in no further phases of the research process. All four studies involved co-authors in managerial positions in psychiatry in the region, and some measures are already underway to improve the delivery of BA at the local CAP inpatient clinic. However, the lack of involvement of people with lived experience of self-harm and inpatient psychiatry in the present research is a major downside. This makes it impossible to claim with certainty that the current research has indeed produced meaningful change in the lives of affected healthcare users and families, hampering its transformative agenda.

Further, the quantitative papers are limited in their cross-sectional design. Collecting data from one sample at one point in time, with no experimental intervention in place and no control design, we could never make claims beyond the

level of correlation. For paper II, conducting analyses post hoc rather than carefully restricting them in a pre-specified data analysis plan further opened us up to drawing misleading conclusions about significant results identified from running multiple analyses. We tried to address this issue by applying the Bonferroni correction, though this is no failsafe and does not remove uncertainty from our final results.

Additionally, self-rating scales come with a number of problems, including extreme response bias, dissent bias – or acquiescence bias – and the social desirability effect, or demand characteristics. Beyond biased responses, there is the general problem that a response of '2' on a Likert scale likely does not represent the same thing to multiple responders, or even necessarily to the same responder at a different point in time. There is also the underlying question of whether the complexity of an abstract, multifaceted, interpersonal phenomenon such as attitudes could really be adequately represented through the intrapersonal activity of self-assessment. All of this compounds the issue that participants' questionnaire responses are likely poor indicators of what transpires in actual healthcare encounters; in other words, the ecological validity of our results is poor.

Perhaps an even bigger issue was the limited incorporation of rights-based and relational perspectives in the SHAS-SR questionnaire. This is regrettable, especially considering the *normative* potential of questionnaires to formulate and nudge clinicians toward more desirable behaviours. Considering this potential function, it would have been relevant to include more items explicitly recognising and committing to protect the rights of people who self-harm and prompting clinicians to deliberately mentalise with the experiences of people who self-harm, rather than basing decisions about item retention chiefly on statistics.

Also worth mentioning in this context, the matter of selecting indicator variables, interpreting the output of latent profile analysis, and naming the resulting profiles are highly subjective research processes. At this point, I want to clarify again that my co-researchers and I did not intend to make generalised truth claims about the attitudes of psychiatric clinicians in Sweden or globally. My main intention with the quantitative papers in this dissertation has been to obtain a picture of clinicians' self-rated attitudes that may resonate with the experiences of healthcare users and their families, and to use these responses to illuminate health equity and rights issues for people who self-harm.

As for the qualitative papers, one major shortcoming is that we weren't able to contact, inform and invite three adult family members who didn't speak Swedish nor English. This limits the transferability of our results to racially and ethnically marginalised populations, and beyond that, it means that the current studies exacerbate their exclusion from research. In this dissertation, I have addressed multiple dimensions of rights-based care using the AAAQ framework, and I have noted structural barriers specifically for people who self-harm, but I haven't gone into intersectional experiences of oppression among multiply marginalised

populations. However, among all adolescents currently holding a BA contract, non-white adolescents are seriously underrepresented.

In the current project, we intended to employ translation and interpretation services as needed to be able to invite everyone eligible and provide them with appropriate written information about the project and the same opportunity for informed consent as all the other participants. We intended to facilitate meaningful participation in the ways we could think of, including matching interpreter and participant characteristics where relevant and possible, and training interpreters beforehand to familiarise them with the topics of self-harm, suicidality, inpatient CAP and BA. We spent months discussing and preparing for this, emailing back and forth to try to sort out the infrastructure of interpretation and translation for the two languages identified. Out of concerns about privacy and potential fears that one's participation or opting out would have any sort of effect on their own or their adolescent's care, we wanted to minimise the risk that eligible participants would be faced with an interpreter known from previous healthcare interactions. Furthermore, Lund University had contracts with specific agencies and applied certain procedures for employing them, which there seemed to be a lot of confusion about, and I was unsuccessful in my efforts to locate the proper person to handle these matters. This process dragged out and soon we had already recruited and interviewed more participants than we would have needed and more than we were prepared to manage within the previous time plan for papers III and IV. Facing such logistical barriers and lacking time, resources and foresight in our planning, eventually we decided that it wasn't feasible to contact these individuals for this project.

This is regrettable and especially problematic considering the explicit research agenda to address social injustice for marginalised populations. Had we been able to invite and interview these individuals, it would have likely produced different accounts of lived experiences, involvement and responsibilities concerning BA. This would have probably affected the results, possibly enhancing their potential impact upon marginalised social conditions.

Conclusions

In this dissertation, I have sought to explicate the power relations present in the current body of research, situated in the specific, local context of public psychiatry in the southernmost region of Sweden, while also considering its wider international and historical context. I have shown how even seemingly sympathetic ideas of personal recovery with respect to self-harm, and efforts to involve healthcare users and their families in BA, frequently rest upon biomedical understandings and hierarchical power dynamics where clinicians ultimately define the delivery and desired outcomes of interventions, and what is in the healthcare user's best interest.

The perspectives of human rights and relational recovery both require us to interrogate such biomedical assumptions and divorce them from our clinical practice. The current body of research holds these perspectives to be relevant in clinical encounters with people who self-harm, though seldom explicated in research on clinicians' attitudes toward people who self-harm. The current papers also suggests that BA foundationally aligns with human rights. BA can be considered one of several rights-based methods diametrically opposed to coercion (Griffiths et al., 2022; Stastny et al., 2020).

However, healthcare users' rights to dignity, health, autonomy in healthcare, freedom from coercion, among others, cannot be considered 'achieved' simply by granting access to BA; they must continuously be upheld. BA can be further developed by safeguarding critical elements and underlying principles for rights-based crisis response (Stastny et al., 2020), for instance by attending to continuity, presence, and dialogue in the care environment and by expanding meaningful peer support. In a child and adolescent psychiatric context, family members need to be systematically involved to have their own concerns and needs met and their roles clarified, in such a way that they are continually given reasons to trust the method. Such involvement should be regarded a cornerstone of BA and integral to supporting adolescent autonomy, considering the developmental, emotional and relational needs of the whole family.

Hopefully, BA will exist alongside a plurality of appropriate, acceptable alternatives in the future of rights-based psychiatry. Such psychiatry should robustly support people who self-harm 'to lead and participate in the design, delivery, leadership, and evaluation of care' (Moran et al., 2024, p. 1446).

Suggestions for future research

To further research into clinicians' attitudes toward people who self-harm, it would be relevant to explicitly frame people who self-harm as rights-holders. This could be done with questionnaires as well as qualitative observations of healthcare encounters and/or interviews/focus groups with healthcare users/survivors. Future research utilising clinician-rated questionnaires would do well to take advantage of their normative potential, building an item base which requires clinicians to imagine themselves in the shoes of people who self-harm, asking them to critically self-assess whether certain attitudinal-behavioural responses would likely be experienced as therapeutic, nudging them to work with their own reactions and respond helpfully to people who self-harm. Importantly, healthcare users who self-harm should be considered the authorities on helpful attitudes and should also be invited to assess clinicians' attitudes and behaviours in healthcare interactions.

A suggestion for interdisciplinary theory-expansion came from unexpected insight from the current qualitative interviews, as parents who had their own lived experiences with self-harm and institutionalisation in inpatient psychiatry were able to draw on these experiences to better understand their child as well as help them navigate the psychiatric system in a CAP setting. This dissertation had its epistemological basis in standpoint theory, positing that people can attain unique standpoints from experiences of marginalisation, providing them with a more complete perspective of the world (Friesen, 2022; Haraway, 1988; Harding, 1992; Rose, 2017). This position shares some similarities with Paulo Freire's notion of *critical consciousness*, or *conscientisation*, a process by which people who are oppressed in certain social contexts develop awareness of and the ability to analyse and challenge such oppression (Freire, 1972). Based on this work, research is developing in critical race studies on *critical resilience*, a process of experiencing resilience from critical consciousness, whereby people can gain a wish to help others and contribute to social transformation (Campa, 2010; Morgan, 2023). The spontaneously shared experiences by some participants in the present research tentatively suggest that the notion of critical resilience could be relevant to explore in psychiatry and the field of self-harm research. Importantly, though, researchers exploring this avenue should be mindful of its historical roots and beware of the risk of watering down powerful social justice concepts, as has been done with recovery (Harper & Speed, 2012; Howell & Voronka, 2012; Hunt & Resnick, 2015; McWade, 2016) as well as the concept of intersectionality (Buchanan et al., 2020), to name a few.

Whether targeted as a specific research focus or used as a lens in other research endeavours, future research would do well to recognise that people who self-harm, like other people with experiences of marginalisation in healthcare or society at large, may feel strengthened from making social injustices visible and collectively engaging in efforts to rectify them.

It would be interesting to see future self-harm research make use of transformative, participatory designs, to move away from neorecovery and toward making meaningful impact for the people affected. Specifically, barriers to accessing and being involved in BA should be further explored with populations who are known to be systemically disadvantaged, underserved, and underrepresented in research. Strategies to address such social injustices should preferably be embedded in the research design. Generally, there is a substantial need for more mental health research with an agenda of 'transformative human rights action' (United Nations Human Rights Council, 2020, p. 4).

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