Self-injurious behaviour in Anorexia nervosa: a phenomenological study

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Abstract

Aims To get insight into the lived experiences of self-injurious behaviour in patients with anorexia nervosa. This may contribute to more patient-centred care and finally to better treatment outcomes.

Background Little is know about the lived experiences of the participants under study. The existing literature is scarce and does not focus on anorexia nervosa explicitly. It is estimated that the self-injury rate is 45% in the population of eating disordered patients. Patients with anorexia nervosa have stressed the importance of a good therapeutic relationship, which may come under strain when misunderstandings in the communication occur because of a lack of understanding regarding the self-injurious behaviour.

Methods A phenomenological research design was used. Ten patients were included. The main research question was: what are the lived experiences of patients with anorexia nervosa who injure themselves? Data were collected between May 2011 and August 2011 using a semi-structured topic guide with five sub-questions related to the main research question.

Results Self-injury serves to cope with overwhelming feelings as well as a method of punishing oneself. Self-injury is used to suppress the overpowering feelings that can occur when participants are pressured to change their anorectic eating habits. Self-injury can also occur in interactions with others, to suppress feelings of guilt and shame. Patients tend to punish themselves to suppress feelings of self-hatred.

Conclusion The interviews indicate that the participants experienced self-injury as necessary, functional and autonomous behaviour to control overwhelming emotions and to better cope with the fear and anxiety that occur during treatment.

Relevance to clinical practice Five aspects may be helpful to improve nursing care for this patient group: (1) noticing the self-injury by assessment or observation; (2) communicating about the self-injury free from judgements and assumptions; (3) analysing the motives and reasons behind it; (4) agreements to decrease the self-injury in dialogue with the patient; (5) exploration of alternative interventions such that self-injury is needed less.

Keywords anorexia nervosa, self-injurious behaviour, nursing, interview, phenomenological research

Samenvatting

Doel Inzicht verkrijgen in de ervaringen en motieven van patiënten met anorexia nervosa die zichzelf verwonden. Deze kennis kan bijdragen aan patiëntgerichte zorg en verhoogt het succes op een geslaagde behandeling.

Achtergrond Er is weinig bekend over de ervaringen van zelfverwonding bij patiënten met anorexia nervosa. Geschat word dat 45% van de patiënten met een eetstoornis zichzelf verwondt. Echter, de bestaande literatuur over dit onderwerp is beperkt en concentreert zich op eetstoornissen in het algemeen. Patiënten met anorexia nervosa hechten waarden aan een goede therapeutische relatie. Deze relatie kan onder druk komen te staan als de zelfverwonding niet goed word begrepen.

Methode In deze onderhavige fenomenologische studie zijn tien patiënten geïnterviewd. De hoofdvraag in deze studie was: wat zijn de ervaringen en belevingen van patiënten met anorexia nervosa die zichzelf verwonden? Data zijn verzameld in de periode tussen mei 2011 en augustus 2011 met hulp van een semi gestructureerde interview gids waarin de hoofdvraag was onderverdeeld in vijf subvragen.

Resultaten Zelfverwonding kan dienen om gevoelens te minimaliseren of als een methode voor zelfbestraffing. Het wordt gebruikt om heftige gevoelens te reguleren wanneer patiënten worden gedwongen hun anorectische eetgewoontes op te geven. Zelfverwonding kan ook gerelateerd zijn aan interacties met anderen, of om gevoellens van schuld en schaamte te bedwingen.

Conclusie De interviews laten zien dat de participanten zelfverwonding als functioneel, noodzakelijk en autonoom gedrag zien dat dient om negatieve emoties te hanteren en om zichzelf te bestraffen.

Aanbevelingen (1) signaleren van de zelfverwonding door goede taxatie en observatie; (2) respectvolle communicatie met de patiënt over de zelfverwonding; (3) analyseren van de triggers en de achterliggende redenen; (4) reguleren door het maken van afspraken die de zelfverwonding verminderen in samenspraak met de patiënt; (5) het exploreren van minder schadelijke alternatieven zodat zelfverwonding niet meer nodig is om negatieve emoties te hanteren.

Key woorden anorexia nervosa, zelfverwondend gedrag, verpleegkunde, interview, fenomenologisch onderzoek

Introduction

Anorexia nervosa is an eating disorder predominantly affecting girls and young women aged between 15-29 years. In industrial countries, the disorder prevalence is 370 per 100,000 with the yearly incidence being approximately 8 per 100,000 (Continuous Morbidity Registration Sentinel Station, 2003; Hoek & van Hoeken, 2003). Anorexia nervosa is a serious and potentially deadly medical condition. Approximately 15% of all patients suffering from anorexia nervosa die from the disorder: two thirds from malnutrition, one third as a result of suicide (Dutch Committee for the Development of Multidisciplinary Guidelines in Mental Health Care, 2006).

Eating disorders and self-injurious behaviour are interrelated. In a recent study, carried out in a specialised treatment unit for eating disorders in Belgium, it was estimated that 45% of patients with an eating disorder had performed at least one type of self-injury in the last year (Claes, et al., 2010). This is in accordance with studies carried out in 2000 in Italy (Favaro & Santonastaso) and in 2002 in Germany (Paul, et al.) were a self-injury rate of 35% was found in patients with an eating disorder.

Two types of anorexia nervosa can be distinguished: the restricting type and the binging-purging type. Patients with the restrictive type maintain their low body weight purely by restricting food intake and by increasing physical activity. Patients with the binging-purging type show binge eating and purging to maintain their low body weight (American Psychiatric Association, 1994).

Several definitions of self-injurious behaviour exist in the literature. We use the definition of self injury by Claes, Vandereycken, and Vertommen (2003): ‘a direct, socially unacceptable behaviour that causes minor to moderate physical injury, while the individual is in a psychological distressed state but is not attempting suicide’.

Background

There is no qualitative research and limited quantitative research on self-injurious behaviour in patients specifically with anorexia nervosa. However, several authors have studied self-injury in eating disordered patients (that is: anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified) and therefore a brief summary of the most important studies is given. The most common forms of self-injury in eating disorders are cutting and scratching followed by bruising and burning (Claes et al., 2010; Claes et al., 2003; Favaro & Santonastaso, 2000; Paul et al., 2002). Patients report different functions of self-injuring. Several studies have highlighted the “affect regulation” function as the most important (Claes

et al., 2010; Paul et al., 2002), followed by “punishing oneself”, “reducing tension” and “feeling physical instead of emotional pain” (Claes et al., 2010). Social reasons such as “getting attention from others” or “showing others how strong I am” are rarely indicated as reasons to engage in self-injury (Claes et al., 2010; Klonsky, 2009; Paul et al., 2002). Health care workers generally tend to overemphasize the attention seeking function of self-injury (Gough & Hawkins, 2002).

Patients with anorexia nervosa have stressed the importance of a good therapeutic relationship. Important aspects include: empathy and understanding, being rated as equal, honesty, acceptance and attentiveness (Tierney, 2008; Van Ommen et al., 2009; Bakker et al., 2011). The fact is, however, that such a relationship may come under strain when misunderstandings in communication occur due to the occurrence of self-injurious behaviour and the misinterpretation of it by health care workers. For good quality of care these workers need to obtain a thorough understanding of the meaning of the self-injury for the patients. Therefore, the lived experiences of participants with anorexia nervosa are explored to facilitate a more in-depth understanding of the subject by health care workers.

Problem statement

Most of the above mentioned studies use quantitative research designs and little is known about the participants’ motives and reasons for the phenomenon under study. It is not known exactly why anorexia nervosa patients injure themselves, what they achieve with it and how they experience their self-injurious behaviour.

Aim

We assume that increased knowledge of the lived experiences can contribute to better therapeutic alliances and to more patient-centered care and finally to better treatment outcomes. As a consequence, we may expect that patients feel better understood and less rejected by professionals because of their self-injurious behaviour.

Research question

In the current study we address the following research question: what are the lived experiences of patients with anorexia nervosa who injure themselves?

This main research question is divided into five sub-questions:

(1) What are the specific factors and circumstances triggering self-injurious behaviour in patients with anorexia nervosa?

(2) Which emotions are dominant prior to self-injurious behaviour and how do they build up?

(3) How is the actual execution of self-injurious behaviour experienced?

(4) What are the positive and negative consequences of self-injury?
(5) What are the personal experiences of the patient with health care workers regarding their self-injurious behaviour?

The study

Design

In order to understand the lived experiences of the patients of our target group, van Manen's qualitative phenomenological research design was used (van Manen, 1990; Polit & Beck, 2008). A phenomenological research design is particularly suitable to understand the lived experiences and perceptions of the participants. It facilitates interaction between the researcher and the participant during the stage of data collection and, as a result, it is possible to gain a profound insight into the experiences and perceptions of the participant, and into the motives behind specific behaviour (van Manen, 1990).

Sample

The study was conducted in a mental health clinic specialised in the treatment of eating disorders. This clinic offers inpatient treatment as well as outpatient treatment to young people from the age of 12 who suffer from eating disorders, including anorexia nervosa. The clinic is recognized throughout the Netherlands as a centre that assures the highest level of eating disordered care.

Participants

This qualitative study is part of a larger research project that encompasses a quantitative study on the prevalence of generic and disease specific forms of self-injurious behaviour in patients with eating disorders. All three-hundred seventy-two (n=372) patients, who actually received treatment, or had received treatment in the previous year and were 16 years or older, were asked to complete the Dutch version of the Self-Injury Questionnaire (SIQ) (Claes & Vandereycken, 2007). At the end of the questionnaire they were asked if they were willing to participate in a subsequent qualitative study. Thirty-six (n=36) patients out of eighty-five (n=85) who returned the questionnaire (42%) agreed to participate in this qualitative study. We applied the following inclusion criteria for our study: participants aged between 18-30 years, who have been diagnosed with anorexia nervosa according to the DSM-IV criteria, who employed at least one form of self-injurious during the last year, and were able to converse in Dutch. There were no exclusion criteria. A total of eleven (n=11) participants met the inclusion criteria (13%). One participant was not included, as she was no longer physically able to participate.

Before the questionnaires were handed, inpatients and outpatients received oral and written information about both the quantitative as well as the qualitative study by the quantitative (EvH) and the qualitative researcher (SV). If they agreed to participate in the qualitative study, they filled in their name and telephone number at the end of the questionnaire. These participants were all contacted by telephone, received oral information and were given the opportunity for further questions. Finally, an appointment for the interview was made. There was no professional nursing relationship between the researchers and the participants.

The interview location was chosen on the basis of patients' preferences. Five interviews took place in the clinic where the patient resided; two interviews were held in a nearby university hospital, and three patients were interviewed at home.

Data collection

The data collection took place between May 2011 and August 2011. Each interview started with the interviewer discussing with the participants the individual scores on the Self-Injurious Questionnaire (Claes & Vandereycken, 2007). Following the discussion on the questionnaire, semi-structured interviews were used to collect data. An interview guide ensured that each different sub-question was explored in-depth. The interview guide contained four sub-questions that chronologically explored the process of self-injury: the first sub-question focused on the triggers and the circumstances, the second on the process of building up tension, the third on the actual execution of the self-injury and the fourth focussed on the positive and negative consequences of self-injury. Additionally, the last sub-question focused on the experiences of the participants with health care workers. Ten interviews, varying from 60 to 90 minutes, were recorded on audiotape and transcribed verbatim.

Data analysis

The data analysis and data collection were iterative (Boeije, 2008). As soon as the first four interviews were collected, a first initial analysis was performed. The results from this initial analysis indicated directions for further data gathering. Each different sub-questions in the interview was analysed in three phases according to Van Manen (1990): (1) The sententious expressions that possibly captured the fundamental meanings of the sub-questions were identified; (2) The text was read several times; (3) A close look was taken to every highlighted phrase and the question 'what does this phrase reveal about the process of self-injury?' was asked. Once the phases of the process of self-injury had been identified, they became the objects of reflection and interpretation in the following interviews.

Validity and reliability

The quality of the research was assured through peer reviewing: the interview techniques applied and the methodological aspects of the research were discussed after interview 5 in the research group. The supervisor (BvM) and the researcher (SV) met after respectively the 1st, 4th and 8th interview to discuss progress, monitor the interview technique, and analyse coded interviews. The primary researcher (SV) has experience for six years as a nurse on a psychiatric ward in a general hospital, with frequent professional contacts with eating disordered patients.

Ethical considerations

The Scientific Committee of the mental health hospital where the research was conducted reviewed and approved the protocol in terms of scientific merits and feasibility. Only the researcher and supervisor had access to the original data files and the tape-recorded interviews. All participants gave written informed consent. Patients received a gift of 25 euro for their participation in this study.

In order to reduce the burdening of the participants, the following preventive measures were undertaken. At the end of the interview, the burdening of the interview was discussed with each patient. Six participants explicitly mentioned the interviewer (SV) that there was no need for after care. All other patients were contacted after three days and asked if there was any need for subsequent after care: they all declined.

Results

The sample consisted of ten participants all were women. The mean age of the sample was twenty-two years, with a standard deviation of 4.

Participants were at various stages of their treatment: one participant was treated as an inpatient when interviewed, four were outpatients, two were discharged from treatment one year ago and two were discharged form treatment six months ago. The sample consisted of four patients with the binge-purging type and six patients with the restricting type of anorexia nervosa. See table 1 for an overview of the patient characteristics.

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Insert table 1 Characteristics of the patient sample

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The analysis shows that the process of self-injury can be divided into three phases. The phases and the analysis of the additional sub-question (regarding the experiences of health care workers) are briefly summarized before presenting the results of the interviews.

Phase 1: circumstances triggering self-injury. In this phase patients do not want to eat and are terrified of gaining weight. When pressured to eat, patients feel emotionally overwhelmed and are afraid of losing control.
Phase 2: losing control and the act of self-injury. In this phase the tension is building up until the tipping point is reached.
Phase 3: the consequence of the self-injury. Here, the positive and negative consequences become apparent to the participants.
Experiences with healthcare workers. Patients appreciate healthcare workers who bring up the topic in a respectful manner. Regulation rules laid out by health care workers to decrease the self-injury are considered effective.

Phase 1: Circumstances triggering self-injury

In phase 1 the participants had to learn to eat again. Before admission to the inpatient centre or before the start of the outpatient therapy, the participants physical condition was poor and as a result they felt numb and without energy. While the numbness and lack of emotions were satisfying, the nutritional advice that was given by the dietician in the initial treatment phase was severely disturbing. Participants experienced extreme stress during the first meals: in the inpatient setting they were accompanied with intensive supervision of the nurses and in the outpatient setting they were accompanied with supervision of parents or in some cases, friends. The forced food intake evoked much aversion. They did not want to eat and were terrified of gaining weight (R 2, 3, 4, 6, 10). When they were forced to eat, intense despair could arise (R 1, 2, 3, 4, 5, 6, 8, 10). The participants responded to these extreme stressful situations by injuring themselves. One of the participants described her despair as follows:

“At some point, I was living with friends and they pushed my to eat things I did not want. They told me why it was important for me to eat. But I thought, I cannot do this, and I do not want this. They were pushing more and more and as a result I was getting angry with myself for not being able to eat. Then I started hurting myself by bruising or hair pulling. I felt like I was losing all my control, because I was no longer able to make my own eating decisions (R 4, outpatient)”.

The participants emphasised that it was either the anorexia nervosa or the self-injury in the initial phase of treatment they could use to control their overwhelming emotions when confronted with the force to restore a regular eating pattern or when dealing with feelings of disgust after the obligatory meal (R 2, 3, 6, 8, 10). In the early stages of treatment, self-injury often occurred immediately after mealtime; it was used to suppress feelings of saturation, feelings that reminded them that they were increasing in weight (R 1, 3, 6, 10).

Besides the aim of controlling overwhelming emotions, self-injury was used for personal punishment. Self-injury was the perfect way to punish themselves for their (self-perceived) uncontrolled eating behaviour (R 1, 8). It was a reaction to feelings of self-hatred, which occurred, for example, when they felt they had let themselves run over by not refusing to eat (R 3). As one of the respondents stated:

"When I gained weight I was angry with myself. I thought: 'why do I permit others to do make me eat?" And I was pissed at myself that I agreed with something I did not want. As a result I had to punish myself for that (R 3, discharged)".

Self-injury was also used to deal with burdensome interactions with others (R 2, 4, 6, 7, 9, 10), e.g. in case of conflicts or misunderstandings at work or with friends. They blamed themselves for not being kind or friendly enough, or for making unintelligent comments. Again self-punishment appeared to be a strong motivator for self-injury, as illustrated in the following quote:

"I injured myself following social situations, when I believed I said the wrong things. Or when I believed I was not kind enough for others. Or when I insulted people, or hurt people. These are all reasons to me to self-injury (R 7, discharged)".

Phase 2: Losing control and the act of self-injury

The participants (R 1, 2, 3, 6, 7, 8) reported that they started the day with some tension, which built up gradually, until the tipping point was reached, e.g. when confronted with their compulsive eating habits (R 6, 7, 8, 9). In this situation it was impossible to withstand the powerful temptation of self-injury. Intense despair would arise without the self-injuring act (R 2, 3, 5, 8, 9). Sometimes they didn't have the opportunity to injure themselves because of others surrounding them. For example, the nurses forced the participants to be in eyesight after completing their meal and some participants stressed that their parents closely watched them. Therefore, the first opportunity to self-injure was seized. When they were not able to perform their self-injury act, the scratching and bruising form was used to temporarily reduce

overwhelming feelings (R 2, 8, 10). Although these forms were less powerful than the (desired) cutting form of self-injury, it was invisible for bystanders and relative easy to perform; it could be carried out under the table. If they were not able to perform the self-injury it was impossible to live with the overwhelming emotions and they feared they end up crazy. Participants envisioned self-injury as an 'emergency break'. It was the last straw with a prompt relief that prevented them from suicidal thoughts (R 3, 9).

The pain intensity and the sight of blood were considered as the most important factors influencing the effectiveness of self-injury. Participants stressed that a prompt relief is what is necessary in moments of overpowering feelings. Self-injury gives a much quicker relief than, for example, jogging or physical labour (R 2). If the pain intensity was high, the effect of the self-injury was experienced as greater. For example, when the physical pain caused by the self-injury lasted a couple of days, there was lesser need for injury the following days. If there was a lot of blood, this was considered as evidence for the self-punishment. As one participant puts it:

"Blood represents the visibility of hurting myself (R 6, outpatient)".

It was also evident from the participants' experiences that if they were able to undermine the dieticians advice, there was less need to self-injure. Instead there was an increase of anorexia nervosa symptoms:

"It was like: or the anorexia nervosa or the self-injury. So when I gave up the self-injury, I was losing weight again, it was a sort of searching for the right balance. Whenever I gave up one thing, the other thing would happen and vice versa (R 10, outpatient)".

Phase 3: The consequences of self-injuring

Here, the positive and negative consequences become apparent. Participants experienced the positive effect of self-injury as an autonomous way to regain control of their own eating pattern (R 1, 2, 3, 4, 5, 6, 7). When the food unexpectedly was more caloric, for example the menu changed from fish in pizza, or when they were confronted with a sauce that they were not familiar with, the self-injury was used as a way to control the compulsive feelings of the anorexia nervosa (R 4, 5). Also, the punishing effect of self-injury was experienced as positive: it gave an adrenaline rush (R 9, 10)

"It gave me some sort of strange kick, punishing myself (R 9, outpatient). Punishing myself made me happy (R 10, outpatient)".

Negative consequences were experienced, where the damaged body was considered the most dominant (R 1, 2, 3, 4, 5, 7, 8, 9, 10). Manifestation of scars and thinning of the skin, and therefore the need to carefully select clothing, for example to wear long sleeves, were mentioned. When others, for example parents, were faced with the visible injuries, this would cause burden in those close relationships. As one participant puts it:

"I considered it as very painful and difficult for my parents when they are faced with my self-injury, it was very stressful to see how much that affected them. That made me sad or angry with myself (R10, outpatient)".

Also, shame was mentioned as a negative consequence. For instance, shame of being seen as weak for not controlling emotions in a more constructive way (R 2, 6, 10). Or shame because of the fact that they needed the self-injury to overcome the anorexia nervosa (R 5) or for being seen as 'mentally strange' (R 7). Self-injury was initially envisioned as a short time solution, very powerful to control their fear of eating.

Another negative consequence emerged, as their awareness and self-esteem grew. That they realised that they had been misleading themselves to think they were able to control their emotions by self-injury (R 2, 3, 7). In fact, the act of self-injury did not change anything; emotions were not handled constructively and went only away temporarily:

"I realised that I actually wasn't in control. I was not able to resist the urge of self-injury and then it became apparent to me that self-injury did not solve anything. Nothing really happened. The cause does not disappear. You have to find other ways to solve your problems (R 2, discharged)".

Experiences with health care workers

Except two, none of the participants encountered negative experiences with health care workers. Self-injury was, simply, not an object of discussion. The majority of participants kept their self-injury hidden from heath care workers because it was seen as a secret solution for overwhelming feelings (R 1, 2, 3, 4, 5). Participants feared controlling interventions of the health care workers (R 2, 4, 5, 10):

"I think, when I do talk about it with health care workers, they are going to try to make me stop. They won't say: go on with that, girl (R 4, outpatient)."

But when the participants did raise the self-injuring issue, it was taken seriously (R 1, 2, 3, 6, 7, 8, 10). As a result they felt supported and were encouraged to talk about their feelings and to think about other -less harmful- strategies to control their feelings. Also, when the subject of self-injury was raised respectfully by the health care worker, it was valued by the participants (R 2, 6, 10). It enabled them to open up about it because they were confident that there story would be taken seriously:

"When the nurses do ask you about it in a respectful manner, you known they are interested. When you open up the topic yourself you do not known for sure how they would react on it (R 3, discharged)".

Towards the end of treatment, the negative consequences became to demanding and as a result they were more able to consider regulation rules laid out by healthcare workers, to reduce the frequency of the self-injury. For example, agreements were made to reduce the frequency of self-injury from four times to three times a week (R 6, 10). Nonetheless, it was felt that it was still a long road towards overcoming their fear of eating and therefore the need to control their feelings.

Specific nursing attitudes surfaced during the interviews. Attitudes such as involvement, reliability and insistence were frequently mentioned (R 1, 2, 3, 6, 7, 8, 10). Also a sense of humour (R 8, 10) was considered important because it took the weight of the delicate subject and was therefore easier to discuss. These attitudinal aspects contributed to a good alliance where the patients felt not rejected for their self-injury.

Discussion

The qualitative interviews conducted indicated that the participants experienced self-injury as necessary and functional behaviour. It serves to reduce negative emotions (such as anxiety related to feeling overweight) and as a method of punishing oneself. These motives are highlighted in several studies in other psychiatric patient groups (Klonsky, 2007; Layle-Ghindu & Schonert-Reichl, 2005; & Nock & Prinstein, 2004). The practical implications of the findings are discussed below.

Patient-centered care is a collaboration between the health care worker and the patient. Different aspects influence this relationship: the phase and severity of the eating disorder, the function of the self-injury, the motivation of the patient and the available alternatives. Nursing care should address these aspects. It is necessary in the initial phase of treatment (when patients are forced to eat) that self-injury is recognized. Health care workers can contribute to this by assessment or by observing signals of self-injury (eg, thinning of the

skin, bruises and cuts). The self-injury should be discussed with the patient free from assumptions and judgements. The circumstances that trigger it and the patient motives should be explored. This can be difficult in this phase of treatment for two reasons. First, the positive consequences are to dominant and the motivation to reduce self-injury is low. Second, due to numbness and lack of emotions it could be difficult for patients to reflect on their own motives. In this phase, in dialogue with the patient, agreements could be made to prevent the self-injury form getting worse. Laying out boundaries to stop the self-injury is not effective and may even be counter productive (Bosman & van Meijel, 2008; McAllister, 2003; Shaw, 2002). In the later phases of treatment, communication and exploring the motives behind the self-injury are prior to fully understand the behaviour. Agreements to increase the self-injury should be considered, again, in dialogue with the patient (Kool et al., 2009). Less harmful strategies that are an alternative for self-injury should be explored. In this context, the interviews revealed that having ambitions and goals in life were considered important to reduce both the self-injury and the anorexia nervosa. Treatment can be a sort of 'save harbour' where patients are able to experiment with their new strategies in a relative secure environment. It is emphasized that comprehensive treatment for anorexia nervosa should give sufficient attention to the emotional and psychosocial functioning as these are long term predictors for recovery (Ommen et al., 2009).

Some methodological limitations must be noted. The study was limited by the fact that all participants were women. This resulted in limited variation of the sample. It should also be noted that the sample size was quite limited, and only participants from one clinical setting participated in this study. Therefore, saturation of data could not be achieved. A strength of this study is that the interviews were the appropriate approach to provide an in-depth understanding in the motives and the emotions of the participants. Also the experience of the researcher (SV) made it possible to better understand the insiders view.

The interview itself was experienced as confronting, due to the personal questions and because of the fact that the subject was never discussed before in such detail. Sub-questions two and three about the tension and the actual execution of self-injury were difficult to answer for the participants. They felt ashamed when the self-injury was explored in such detail and they were afraid that they would not be recognised as meaningful persons by the researcher (SV). However, all participants valued the anonymity, which made it easier for them the to discuss the subject under study. Also noticeable, participating in this study gave them a feeling of appreciation: they were able to help others.

Clinical Implications

Given that our research findings show that self-injury in patients with anorexia nervosa serves as an autonomous way to control feelings as well as a method of punishing oneself, the nursing care needs to focus on these important functions. Five aspects may be helpful in this respect: (1) observance: appropriate assessment as well as the observation of signals related to self-injury should contribute to recognition of self-injurious behaviour; (2) communication: it should be discussed in a respectful manner, without assumptions, such that patients feel less rejected and better understood; (3) analysis: which triggers influence the self-injury and how are these perceived; (4) regulation; in dialogue with the patient, agreements to help regulate the self-injury (5) alternatives; exploration of less harmful strategies to control negative feelings.

Conclusion

The interviews indicated that the participants experienced self-injury as necessary, functional and autonomous behaviour to better cope with the fear and anxiety that occur when the anorexia nervosa is treated. Self-injury in anorexia nervosa is used to suppress the overpowering feelings that can occur when participants are pressured to battle their anorectic eating habits. Self-injury can also occur in interactions with others, to suppress feelings of guilt and shame. Self-punishment is the second function of self-injury in anorexia nervosa. Patients tend to punish themselves to suppress feelings of self-hatred. In dialogue with the patient nurses can approach self-injury by: appropriate assessment, respectful communication, analysis of triggers, agreements to decrease the self-injury and exploration of alternatives.

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Appendix 1

Table 1 Characteristics of the patient sample

	Age in years	Type of eating disorder + second diagnose	Treatment	Duration of eating disorder	Type of SIB
Respondent 1	19	AN-R Depression	Inpatient	2 years	Cutting
Respondent 2	20	AN- R	Discharged six months ago	4 years	Burning Scratching Cutting Bruising
Respondent 3	19	AN-P PTSS	Discharged one year ago	3 years	Burning Cutting Hot Showering
Respondent 4	28	AN-P	Outpatient	11 years	Hair pulling Scratching
Respondent 5	23	AN-P	Discharged one year ago	8 years	Scratching Bruising Biting
Respondent 6	19	AN-R Depression BPS features	Outpatient	5 years	Cutting Bruising
Respondent 7	25	AN-R Asperger syndrome	Discharged six months ago	10 years	Scratching Binge eating Vomiting
Respondent 8	18	AN-R PTSS BPS features	Outpatient	11 years	Bruising Cutting Scratching
Respondent 9	26	AN-P	Outpatient	10 years	Scratching Socially unacceptable use of alcohol and salt & pepper Binge eating Vomiting
Respondent 10	19	AN-R	Outpatient	4, 5 years	Scratching Cutting Knocking oneself

AN-R= anorexia nervosa restrictive type, AN-P= anorexia nervosa purging type, PTSS= post traumatic stress syndrome, BPS= borderline personality disorder.