Experiences of how brief admission influences daily life functioning among individuals with borderline personality disorder (BPD) and self-harming behaviour

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Abstract
Aims and objectives: The aim of this study was to explore experiences of how brief admission influences daily life functioning among individuals with borderline personality disorder (BPD) and self-harming behaviour.

Background: Brief admission (BA) is a crisis nursing intervention designed to reduce long hospitalisations and the risk of suicide. The intention of the intervention is to develop autonomy and to encourage the patient to take responsibility for and control over their own care and treatment. There are studies in the area that target individuals with psychosis and bipolar disorders, but no previous studies have been found examining how BA impacts upon daily life functioning among people with BPD who self-harm.

Design: A descriptive qualitative design was chosen.

Methods: Data were collected using qualitative individual interviews with 16 patients with BPD and self-harming behaviour who had been assigned to BA. The data were analysed using conventional content analysis. The study was conducted in accordance with COREQ guidelines.

Results: The results show that BA was perceived as a functioning nursing intervention that promoted self-determination and self-care. This contributed to increased security in daily life. BA made it possible for individuals to maintain everyday routines, employment and relationships more easily.

Conclusions: Our findings suggest that BA was experienced to have a positive impact on daily life functioning.

Relevance to clinical practice: Brief admission enabled the balance of power to be shifted from the nurse to the patient, and provides conditions for patients to take responsibility for their mental condition and to become aware of early signs of deterioration, in line with the basic ideas of person-centred care.
1 | INTRODUCTION

Psychiatric care has changed considerably in Sweden since the mid-20th century, and this shift is often referred to as deinstitutionalisation (Bülow et al., 2021). The old mental hospitals were downsized, and mental health service users now live outside institutions and receive psychiatric outpatient care and community-based care (Tansella & Thornicroft, 2001). An important part of this deinstitutionalisation process is that hospitalisation should be reduced and, when inpatient care is needed, patient participation and self-determination should be strengthened (Berwick, 2009).

Central aspects of the crisis nursing intervention known as brief admission (BA) include increasing autonomy, promoting the constructive self-regulation of emotions and reducing stress and anxiety, thereby preventing self-harm (Helleman et al., 2014a) without the use of traditional psychiatric inpatient care (Helleman et al., 2018; Liljedahl et al., 2017; Thomsen et al., 2018). During BA, the patient has the opportunity to self-refer to hospital for a limited number of days and admissions per month in order to avoid escalation in their deteriorating mood (Westling et al., 2019). The intention of BA is to increase responsibility, coping and quality of life (Rise et al., 2014). In Sweden, a randomised clinical trial found improvements in daily life functioning among a BA group with severe mental illness compared to a control group (Westling et al., 2019). In Norway, a study found that individuals with psychosis and bipolar disorder who self-referred seemed to live closer to a “normal” life than those without access to self-referral (Rise et al., 2014). However, no previous qualitative studies have been found concerning the experiences of daily life functioning of individuals with borderline personality disorder (BPD) and self-harming behaviour during BA.

2 | BACKGROUND

Self-harm is a destructive behaviour that occurs in people with several psychiatric diagnoses, as well as in individuals without symptoms of mental illness (Bjärehed et al., 2012), and consists of repeated actions with the aim of injuring oneself (McKenzie & Gross, 2014). Self-harm and borderline personality disorder (BPD) are closely linked, and it is estimated that 65%–80% of patients with BPD have engaged in some form of self-harm (Brickman et al., 2014). Borderline personality disorder is characterised by emotional instability which often manifests as difficulties in dealing with emotions, leading to impulsive actions which over time can contribute to difficulties in maintaining social relationships and ordinary activities of daily life (Biskin & Paris, 2012a; Coyle et al., 2018; Perseius et al., 2005). Often, self-harm is triggered by negative life events, trauma and/or psychological factors (Miller et al., 2019). The increased stress and the changed emotional state can lead to impulsive actions such as suicide attempts or self-harming behaviour (Biskin & Paris, 2012a). Among young people, 13%–45% state that they have performed some form of self-harm (Swannell et al., 2014). Among adults, with a mean age of 20, approximately 4%–5% reported a history of self-harm (Koyanagi et al., 2015). Women are 1.5 times more likely to self-harm than men, which may be due to men being less likely to seek help (Bresin & Schoenleber, 2015). Only a small proportion of individuals who self-harm are treated in hospital, and then often due to self-harm with attributed suicidal intent, in combination with other motives such as escaping an unmanageable situation or expressing how bad they feel (Hawton et al., 2012). It is common, however, for BPD patients to have courses of emergency room visits and hospitalisations for attempting or threatening suicide or failed suicide attempts (Lundahl et al., 2018). However, previous research does not provide evidence-based guidelines that confirm prevention of death by suicide among persons with BPD (Goodman et al., 2012).

From a longer-term perspective, hospitalisation can contribute to a person being deprived of the ability to handle difficult situations and emotions on their own, which can result in increasing self-harm and surveillance (Liljedahl et al., 2017). It is common for hospitalisation to include coercive measures, compulsory medication and patients constantly having to be supervised by staff to prevent self-harm, which in turn can affect patients’ self-determination and autonomy (James et al., 2012; Perseius et al., 2005). Self-harming behaviour tends to persist over time, which can have various consequences, including financial consequences (Coyle et al., 2018). It is therefore important that the person can achieve a rapid return to outpatient care after hospitalisation in order to be able to maintain social relationships and ordinary daily activities, such as work (Biskin & Paris, 2012a).
BA. A good outcome of care need not consist of an untroubled experience for the patient in their ordinary life (Paris, 2015), and it is therefore important to explore how the outcomes of care and treatment appear in patients’ daily lives.

2.1 | Aims and objectives

To explore experiences of how brief admission influences daily life functioning among individuals with borderline personality disorder and self-harming behaviour.

3 | METHOD

3.1 | Design

A descriptive qualitative method was chosen because it gives participants a chance to shed light on their experiences of a phenomenon using their own words (Polit & Beck, 2021). Data were analysed using conventional content analyses, in accordance with Hsieh and Shannon (2005). The research process and the presentation have followed the consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007)—see Supplementary File 1.

3.2 | Data collection

A purposive sample was used to gain as much information as possible (Patton, 2015). To ensure that all the participants had experiences of brief admission, participants were recruited from three psychiatric hospitals within a single region in southern Sweden, which offers BA. After permission was received from the senior managers of the psychiatric hospitals, healthcare staff working with BA identified individuals who met the inclusion criteria—diagnosed with borderline personality disorder and self-harming behaviour who had been assigned to BA—and gave them information about the study. Those who were willing to participate signed a written informed consent form and had their contact information forwarded to the second author, who was responsible for the research project. Twenty people gave their informed consent and were contacted by phone by the first and last authors to arrange a time and place for the interview. During this phone call, the authors checked that the participants did not match either of the exclusion criteria of being in crisis or being hospitalised. In total, 16 chose to participate in an interview. Of those who chose not to participate, two were hospitalised, one was no longer interested and one could not be reached. Among the participants, brief admission had been used from zero to more than 15 times. Those who had not undergone BA were included because they had a written assignment and could use BA if needed (Table 1).

To create a good and safe environment within which a positive interaction could occur, the participants chose the time and place for the interviews (Patton, 2015). Seven interviews were carried out at
the clinic, eight were carried out in the participants’ homes and one was carried out by telephone due to the COVID-19 pandemic. Data were collected between November 2020 and January 2021. A semi-structured interview guide with open-ended questions was created to capture open answers and descriptive stories (Hsieh & Shannon, 2005). The following questions were asked during the interviews: *What are your experiences of BA? Has access to BA influenced your everyday life? Has access to BA influenced your daily routines? Do you feel that BA has influenced your relationships?* In order to get the participants to deepen their reasoning, follow-up questions were asked, such as *In what way? Can you develop that? Can you give an example?* Two test interviews (included in the study) were carried out, leading to minor revisions to the interview guide. The interviews lasted between 15 and 90 min in free-flowing discussions. No new information appeared after 13 interviews, and hence, the data were considered to be saturated (Patton, 2015). The interviews were recorded digitally and transcribed verbatim.

### 3.3 Analysis

Content analysis is used when large quantities of qualitative data need to be reduced to smaller units (Patton, 2015). The analysis followed conventional content analysis, in accordance with Hsieh and Shannon (2005). First, the interviews were read through by all the authors in order to obtain a sense of the whole and to correct any errors in the transcripts. The second step was conducted by the first and last authors together, and involved identifying and marking the most significant statements in the text that concerned the purpose of the study. The text was coded, and notes were kept about any impressions and thoughts that arose in order to facilitate further analysis. Codes that could be linked were sorted together into subcategories. These were then sorted into more general categories, based on their content. During this phase, all the authors came together to evaluate the data analysis and confirm its relevance. They discussed the categories until agreement was reached. The analysis was a dynamic process that shifted from the whole to parts to be reconstituted into a new whole. Examples in the form of quotations from the text data were gathered from the various units for use later in the results section. Trustworthiness is based on how well the themes covered what the respondents said, and the extent to which relevant data are included and irrelevant data excluded (Polit & Beck, 2021). In order to strengthen the credibility of the results, the categories we identified were strengthened with quotations. The two co-authors who were trained in qualitative content analysis evaluated the data analysis to confirm its relevance, which enhances the credibility of the study (Patton, 2015).

### 3.4 Ethical considerations

The study was approved by the Ethical Review Board in Linköping, Sweden, Dnr 2018/260-31. Before each interview, the participants were given verbal information about the aim and implementation of the study, the voluntary nature of their participation, and the fact that they could withdraw at any time without giving a reason. Written, informed consent was obtained in accordance with the ethical principles of medical research involving human subjects (WMA, 2013). All data were handled in accordance with the General Data Protection Regulation (Troeth & Kucharczy, 2018).

## 4 RESULTS

The main results are presented in three distinct categories, together with their associated subcategories (see Table 2). The main content

### Table 1 Characteristics of the study population

<table>
<thead>
<tr>
<th>Variable</th>
<th>N = 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (n)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td>Age (year)</td>
<td>32.5 (21–44)</td>
</tr>
<tr>
<td>Level of education (n)</td>
<td></td>
</tr>
<tr>
<td>Upper secondary education</td>
<td>14</td>
</tr>
<tr>
<td>University education</td>
<td>3</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>2</td>
</tr>
<tr>
<td>Part time</td>
<td>4</td>
</tr>
<tr>
<td>Student university</td>
<td>1</td>
</tr>
<tr>
<td>Sickness compensation</td>
<td>4</td>
</tr>
<tr>
<td>Activity compensation</td>
<td>3</td>
</tr>
<tr>
<td>Other compensation</td>
<td>2</td>
</tr>
</tbody>
</table>

### Table 2 Overview of the categories and subcategories, produced using Hsieh and Shannon (2005) conventional content analysis

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>A contribution to everyday life</td>
<td>Creates a feeling of security</td>
</tr>
<tr>
<td></td>
<td>Enables a break from everyday life</td>
</tr>
<tr>
<td></td>
<td>A strategy to avoid destructive actions</td>
</tr>
<tr>
<td>Promotes sense of self-determination</td>
<td>Increases participation and control</td>
</tr>
<tr>
<td>Maintain structure</td>
<td>Maintain daily routines</td>
</tr>
<tr>
<td></td>
<td>Maintain employment</td>
</tr>
<tr>
<td></td>
<td>Maintain relationships</td>
</tr>
<tr>
<td></td>
<td>Increases personal responsibility</td>
</tr>
</tbody>
</table>
of each category is illustrated by anonymous quotations followed by
the participant number.

4.1 | A contribution to everyday life

The knowledge that one had access to BA was perceived as a contri-
bution to everyday life and gave a sense of security. It was also a tool
for dealing with destructive thoughts and allowed for a break from
stressful situations.

4.1.1 | Creates a feeling of security

It was found that access to BA contributed to a feeling of security
among participants. They described how knowing they always had
access to self-referral if needed made them feel safe, and for some,
it could help to break out of destructive thoughts and help to pre-
vent an act of self-harm. It further emerged that BA did not always
have to be used, as the knowledge that the opportunity was there
encouraged participants to dare to try harder to solve the situa-
tion by themselves at home. The participants said that this mostly
"worked out" and thus admission could be avoided, with everyday
life continuing as usual. This was also found among those who had
never used BA.

Like I said, I've never undergone BA. I really think
it's just the knowledge that it's there, you don't al-
ways have to use it, but it just feels safe knowing it
exists.

(P16)

Despite the fact that the participants said they were sometimes
denied admission due to a lack of access to rooms, BA was considered
significant. The majority of the participants believed that accessibility
created security and contributed to giving them strength to maintain
the mood at home.

Some days can just be crap and I feel horrible, and I
have to focus on managing what is at home. Then I can
call them and discuss what to do and sometimes that's
enough for me to calm down so I can take care of my
horse and stuff like that. So it's good to know that you
have BA, just in case.

(P7)

It also appears that the process of BA was smoother than general
admission. Avoiding long waiting times in the psychiatric emergency
department and the uncertainty about when discharge would be al-
lowed also contributed to a sense of security.

4.1.2 | Allows for a break from everyday life

It emerged that BA is a form of "time out", a way to take a break from
a stressful life situation. Changing environment for a few days was
said to be an effective way to reduce stress, and was something that
helped participants to manage difficult and destructive thoughts in
everyday life.

It's nice to just come in and change your environment,
get away from stress and difficult thoughts.

(P6)

Being able to change environment and spend a few days in
the hospital helped to reduce stress and hastened recovery. Participants described how a long hospitalisation with its long in-
terruption to everyday life was avoided, and shorter admissions
improved the possibility of faster recovery, as well as a quicker re-
turn home. Several participants had previous experiences of long
periods of voluntary or compulsory inpatient care. They described
how difficult it could be to resume their daily routines and regular
life after these admissions.

Earlier it could be like a month in patient care. When
you have BA, you still have the opportunity to stay
in the real world... I can go to the university, I can
go home to the cat, I can meet my sister for an hour
or so and it's like you don't drop everything else as
well. It's so easy to do that when you're on a regular
admission. Then it's difficult to get discharged and
it's a difficult process to get back to routines and
everyday things.

(P9)

4.1.3 | A strategy to avoid destructive actions

Brief admission was emphasised as a strategy for managing one's
mood and was part of the participants' crisis plan established in out-
patient care. BA thus became a tool to help manage impaired mood.
One strategy mentioned was calling the department to avoid de-
structive patterns and to get help with breaking away from destruct-
tive thoughts. This could be enough to alter a person's mood, which
affected self-esteem positively and encouraged the participants to put energy into other important things in life.

In general, it still helps me even though I’ve not been admitted through it. It has kind of saved me in some situations, to know I can call or something. And then it’s helped when having self-harm impulses.

(P3)

The participants said that being able to break away from destructive thoughts contributed to the feeling of being able to take care of themselves. Another strategy to break away from destructive thinking was to seek BA instead of regular care. Compared to regular hospitalisation, participants experienced BA as lasting for a shorter, limited period of time, which they controlled themselves and which did not affect their daily routines to the same extent.

With regular hospitalisation you don’t know when you can go home or when you’re allowed to... it’s a bit difficult... BA... then I have control and then it’s me who decides, not someone else who decides for me.

(P4)

However, in some situations, participants had found that BA was not a useful strategy. For example, sometimes they applied for BA and, when they entered the department, staff made a different assessment and considered that they were too mentally unstable for BA and therefore suggested regular admission.

4.2 | Promotes a sense of self-determination

This category highlights how participants themselves are allowed to plan the content of BA and retain responsibility even while they are admitted. Being the person who decides when one is in need of BA requires an awareness of one’s own health status, which promotes increased personal responsibility.

4.2.1 | Increases participation and control

Most participants had bad experiences of compulsory care and the coercive measures involved, and felt that trust and confidence in care were improved through BA. Compulsory care had led to a significant reduction in the feeling of being in control. They said that they felt a sense of control in knowing that they would not be admitted under compulsory care when applying for BA. Instead, they said that BA gave them the opportunity to control and influence their own care by being involved and self-determining regarding when to be cared for, and also by being able to decide which activities to perform during their stay. Furthermore, it emerged that it was the participants themselves who decided when they were in need of care.

They experienced an open, welcoming atmosphere when applying for BA and were offered daily conversations with the nurse, which led to feelings of increased security. This was perceived as positive and contributed to the motivation to make other changes in their lives. It also encouraged an increased sense of responsibility for their own health for some of the participants.

It’s a way to take oneself seriously, it’s me who feels, it’s me who decides, no one else should evaluate how I may or may not feel, but it’s me who decides.

(P1)

Being able to influence and determine the number of care days and the time of discharge was appreciated, and increased the perception of having control over one’s life. In connection with the predetermined care period, this contributed to being able to plan everyday life and increased the feeling of control.

These long hospitalisations when you don’t know when you’ll be discharged have been very tough. So in that sense it has been easier at home. And also that my husband knows, so he gets on with work and so on, because when I’m hospitalised he takes care of everything.

(P2)

4.2.2 | Increases personal responsibility

The results show that the design of BA led the participants to experience themselves as taking more responsibility. They said that it was up to them to decide the content of the care, and when BA was needed. Furthermore, it emerged that the participants had to take more personal responsibility during their hospital stay. They were in charge of their own medication and would only ask for help from the nurses when the need arose. Furthermore, the care was voluntarily designed, which increased their motivation to ask for and receive help. Maintaining responsibility for their care created the opportunity to more easily return home and take responsibility for daily chores. It emerged that BA led to increased personal responsibility for one’s own mental health. Being responsible for seeking help meant that the participants needed to get to know themselves better and be aware of early signs of deteriorating mood so they could seek help in time. This led to the participants maintaining and developing the tools that are necessary to cope with everyday life.

Advantages are having to take responsibility. And so it’s good because if I feel I need help, I can practise applying myself, make that contact myself.

(P10)
4.3 | Maintaining structure

This category illustrates that the opportunity to be able to decide when to use BA, as well as the opportunity to come and go as they wished on the ward, helped the participants to continue their daily routines, remaining at university or in other employment, as well as maintaining relationships with family and friends.

4.3.1 | Maintaining daily routines

At times when the participants did not feel very well, they found it difficult to maintain routines for the most basic things in life, such as eating, sleeping and physical activities. The results show that BA made it easier to maintain and return to normal routines for physical activity and continuity in terms of food and sleep. The department’s routines and fixed times for food, showering and daily walks, which they could continue to use at home, were described as helping to balance the participants’ own routines. The short care period provided by BA created a greater opportunity to return to previously functioning routines and thus be able to return home more easily.

You eat more regularly, I think that’s good. Because I don’t do it at home when I feel bad... that’s probably why I feel a little better too.

(P15)

One participant said that she sometimes used BA to return to a normal sleep rhythm. Another participant saw it as providing security at times when she was having nightmares at home. The opportunity to be able to come in and stabilise their sleep for a few days meant that they could break a pattern that could have led to a longer period of care.

I can come in and kind of sleep one night, and then I kind of sleep much better because I kind of have nightmares. I can get up as well, and then there are night staff there who can help me.

(P16)

4.3.2 | Maintaining employment

The participants who were in employment said that BA made it possible for them to continue their work or studies despite admission. The opportunity to come and go as they wished on the ward meant that several participants had been able to continue going to work or university without having to take sick leave.

The same thing with the university, so if I have a self-selected admission, I can go to university as well, and if I have a lecture, I can go to it for two hours and then I can come back to the hospital again.

(P10)

Some were unable to go to work or perform daily activities during BA because they did not feel that they had the strength or were stable enough to cope with it. However, they appreciated knowing that the opportunity existed. Even those who were on sick leave during BA found that it helped them to return more quickly to their employment. However, there were difficulties for some in managing their employment because the distance between the hospital and the workplace was too great. For others, routines and meals at the hospital did not match their work schedule, which was a barrier to continued work.

If I start working at half past seven, I would have to leave by seven at the latest. Er, and there would be no breakfast or anything. Er, and the hospital times don’t really fit.

(P2)

4.3.3 | Maintaining relationships

Controlling their own admission made it easier for participants to maintain social relationships. Those who had children said that BA made it possible for them to spend time with them despite their admission. They could plan to go home in time to take their children to preschool. BA also allowed them to plan to stay at home and spend time with their family. They also said that it was easier to explain the situation to their children when they knew how long the admission would last. Being a parent was described as easier during BA since they were not away from home so much as during regular hospitalisation.

It’s also easier to explain to my children that now your mom is going to be at the hospital for, er, three days, but I will be home during the day and then from Sunday I will sleep at home again... These long hospitalisations I had when you don’t know when you will return home have been very tough, especially for my youngest.

(P2)

Being able to maintain contact with relatives and friends was presented as positive, with the opportunity to plan for events. This in turn simplified and improved the participants’ lives. In turn, simplifying and facilitating everyday life, as well as maintaining important relationships, reduced the participants’ feelings of powerlessness and stress.
Depending on what level I am at, I can go out, I can take a walk, I can have a coffee with someone even though I feel that I can't live at home alone at night.

(P12)

5 | DISCUSSION

The main results from this study illustrate that the patients experience BA to be an intervention that promotes self-determination and self-care and contributes to increased security in everyday life. The knowledge to be able to seek and receive care at any time reduced feelings of stress. The results also show that BA had a positive impact on the everyday structures of the lives of people who self-harm. It made it possible for them to maintain their everyday routines, employment and relationships more easily.

A repeated finding in this study is that the process of admission to BA was easier than the regular process of hospital admission. The knowledge that one would be admitted for no longer than three days created a feeling of security that contributed to applying for BA to break the pattern of destructive thoughts. Regular admission was described in terms of long waiting times, uncertainty about how long the admission would last, and the fear of being admitted to compulsory care. Patients at risk of self-harm are high consumers of psychiatric care (McHale & Felton, 2010), the main purpose of which is the prevention of suicide or escalating self-harming behaviour (Paris, 2004). Regular admissions have been found to escalate self-harming behaviour and suicidal feelings because compulsory treatments may be used, which worsen the condition (Lundahl et al., 2018). In this study, the patients expressed feelings of security knowing that the nurse is responsible for BA, that this care is predetermined by its nature, and that compulsory care thus does not become relevant. Previous studies illustrate that nurses perceive psychiatric inpatient care as more meaningful and constructive during BA (Eckerström et al., 2019), and that power struggles between patients and nurses in caring situations can be avoided (Strand & Von Hausswolff-Juhlin, 2015). Thus, BA as a nursing intervention can be seen by both patients and nurses as empowering patients and providing meaningful and constructive psychiatric inpatient care (Eckerström et al., 2019).

The results also indicate that health professionals are in a position to act as gatekeepers and are therefore able to decide whether regular admission may be necessary, for example if patients seek BA when they are in a condition where they need medical treatment or other services beyond what is included in BA. Participants in this study mentioned that regular admissions often become long-lasting and deprive individuals of their autonomy and self-determination (Paris, 2004; Perseius et al., 2005), which is why they preferred BA. The purpose of BA is to manage self-harming impulses, and to reduce isolation and fear of long care periods involving coercive measures (Helleman et al., 2018).

The results of this study illustrate how BA was used to break destructive thinking and seek care at an early stage. Voluntary admission increased participants’ motivation to change other things in their daily lives. In other studies, it has been shown that BA is a tool that can be used to avoid losing control in the event of deterioration (Eckerström et al., 2020; Lindkvist et al., 2021). People who use BA describe having become aware of how their emotions change, and state that this has improved their ability to control these emotions (Eckerström et al., 2020). In this study, it was found that being able to have control over when and how to use BA, as well as being in charge during admission, had a positive impact on participants’ self-determination and sense of personal responsibility, which was transferable to their ordinary life situation. They described how having the ability to handle difficult situations and emotions on their own improved their ability to become aware of early signs of deteriorating mood. This in turn made them want to try a little harder to handle daily chores, which was subsequently perceived to increase their confidence. Self-determination and personal responsibility have been shown to result in fewer admissions and faster recovery (Rise et al., 2014). Suffering from self-harming behaviour and suicidal thoughts is a stressor that the individual needs to cope with and adapt to. Based on the results of this study, the patients experienced that BA provided the conditions for them to be able to function in daily life despite destructive thoughts. Quality of life is experienced differently by people with the same medical conditions (Rohani et al., 2015). Many individual factors come into play, and one of the most important factors is the person’s ability to handle stressful situations, called a sense of coherence (SOC) (Antonovsky, 1987). SOC reflects a person’s approach to how understandable, manageable and meaningful life looks, where a high SOC is associated with perceived good health and is predictive of positive health outcomes (Eriksson & Lindström, 2005). Our findings indicate that BA helps participants to integrate these concepts, and also helps them learn how to live with and manage destructive thoughts and behaviours at home in their ordinary life.

The results show that, when participants were given the responsibility for seeking BA when needed, they were able to take responsibility for their mental condition and became aware of early signs of deterioration. Nurses working with BA have also experienced how BA promotes a patient’s sense of personal responsibility. They describe a shift in responsibility from staff to patient, which in itself leads to more responsible behaviour among patients who are cared for during BA than among patients undergoing regular hospitalisation (Eckerström et al., 2019). The shift in balance of power in the nurse–patient relationship can be seen as a recognition of the patient as an equal actor to the nurse, which is in line with the basic ideas of person-centred care (Galvin et al., 2019). Participants in this study described the increased responsibility as something positive that helped them to return home more quickly. Participation and self-determination are important factors for achieving an SOC (Antonovsky, 1987).

The results illustrate that if everyday life was stressful, the participants used BA to take a break and experience an environmental change. The basic idea of BA is to offer the opportunity for a break from everyday life, to reduce everyday demands and to provide an opportunity to rest up (Eckerström et al., 2020; Ellegaard
et al., 2020; Lindkvist et al., 2021). BA also helped participants to maintain important relationships and the structure of everyday life, and to get help with establishing continuity in their routines for food and sleep when those routines degenerated. The department’s routines, which can remain even after discharge, helped the patients to regain their own routines (Ellegaard et al., 2020). Improving the balance of everyday life, with regular structures for food, physical activity and social relationships, is crucial for reducing stress and thereby reducing self-harming actions (Toft Hansen et al., 2017).

The findings also show that patients in this study experienced that BA promoted shorter stays with less interference to daily routines compared to regular admissions, which were usually perceived as long-lasting. Even though it was not possible to demonstrate from the results of this study that BA resulted in any reduction in the number of care days, other studies have reported that the number of days of compulsory care and self-harming behaviour both decreased during BA (Ellegaard et al., 2020; Westling et al., 2019). Another study showed that patients felt they had learned to live more independently, and that BA reduced self-harm outside the ward and also reduced the number of days admitted (Mortimer-Jones et al., 2019). The same study also describes the way in which the opportunity to come and go during BA made it possible to maintain a regular work schedule, which was said to be a positive thing (Mortimer-Jones et al., 2019). This also emerged as an important opportunity for the participants in this study.

Suffering from a mental illness can create doubt in one’s own abilities and a sense of poor self-esteem (Frauenfelder et al., 2018). This requires all healthcare professionals, and nurses in particular, to recognise the significance of a dialogue that comprises a genuine consideration for the person, and acknowledging what he or she has to say (Shields et al., 2019). Recognising the patient’s experience is vital for person-centred care, because patients are stakeholders with a unique insight into what really does constitute quality of care (Galvin et al., 2019).

5.1 Limitations

There is variation between and within countries regarding how accessible and structured mental health care is (Patel, 2011). Even though the basic ideas behind BA tend to be the same worldwide, there may be differences in how it is performed in practice, and thus, the transferability of the results may be limited. To make it possible for the reader to decide whether the results are transferable to a similar context, clear descriptions are given of the participants, the environment in which the data collection took place, and the process of analysis (Patton, 2015).

The sample consisted of two men and 14 women. The difference in number may be due to the fact that self-harming behaviour occurs mainly in women (Connor et al., 2009). However, in future research the gender perspective needs to be taken into consideration. There is variation in the background demographics concerning age, work situation, level of education, family relationships, length of the BA contract and use of BA. Based on the broad range of backgrounds and demographics of the participants and the rich data collected, we would argue that our sample includes a sufficient range of participants (Polit & Beck, 2021).

6 CONCLUSIONS

Brief admission was perceived as promoting self-determination and self-care, which contributed to increased control over everyday life. BA was emphasised as important for getting help to organise daily routines. Assessing one’s own need for BA increased insight into one’s own mood and helped promote vigilance for early signs of deterioration. BA helped participants to make their everyday lives and relationships work despite destructive thoughts, which provided a chance for personal development.

7 RELEVANCE TO CLINICAL PRACTICE

Nurses are responsible for the implementation of BA. This creates security for the patient who knows that compulsory care or long-term inpatient care is not relevant in the context.

When the patient instead of the nurse has responsibility for their own care, people grow and thus take responsibility for other parts of their lives as well. When BA is used to break out of destructive thoughts before deterioration, or as a break from a stressful situation, this leads to a more rapid return to daily routines. In order to live an independent life and achieve good health, it is necessary that daily routines function well. BA provides conditions for this to occur because it promotes self-determination and control over everyday life in line with person-centred care.

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CONFLICT OF INTEREST

The authors report no conflicts of interest.

CONTRIBUTIONS


DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions.

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