“I Do Want to Stop, At Least I Think I Do”: An International Comparison of Recovery From Nonsuicidal Self-Injury Among Young People

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Abstract
Phenomenological and cultural understandings of recovery from the perspective of individuals who engage in nonsuicidal self-injury (NSSI) are rare. The primary study objective was to understand similarities across three samples in (a) how young people define recovery from NSSI and (b) what they consider helpful approaches taken by parents and professionals to assist their recovery. Using a cross-national sample of young people (n = 98) from Australia (n = 48), Belgium (n = 25) and the United States (n = 25), we assessed their perspectives on NSSI. Consistent across all samples, young people defined recovery as no longer having the urge to self-injure when distressed, often displayed ambivalence about recovery, and reported it was helpful when parents and professionals were calm and understanding. Acceptance of

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recovery as a process involving relapses may need to be emphasized in NSSI treatment, to ease the pressure young people often place on themselves to stop the behavior outright.

**Keywords**
self-injury, recovery, young people, parent, professional

Nonsuicidal self-injury (NSSI) is the intentional destruction of body tissue through means such as cutting, burning, and excessive scratching (Nock, 2009). NSSI typically onsets in early adolescence and prevalence rates among young people range from 10% to 23% across Europe, the United States, Australia, China, and the Middle East (Baetens, Claes, Muehlenkamp, Grietens, & Onghena, 2011; Giletta, Scholte, Engels, Ciairano, & Prinstein, 2012; Hanania, Heath, Emery, Toste, & Daoud, 2014; Liang et al., 2014; Martin, Swannell, Harrison, Hazell, & Taylor, 2010). This high rate of NSSI is concerning as the behavior is associated with psychological symptomology and an elevated risk of suicide (Muehlenkamp, Williams, Gutierrez, & Claes, 2009; Whitlock et al., 2013). Consequently, early interventions which facilitate recovery from NSSI are essential. Yet, recovery is a nonlinear and complex issue that can have different meanings for young people and the adults in their lives (Alexander & Clare, 2004; Buser, Pitchko, & Buser, 2014; Shaw, 2006). In the current studies, we sought to better understand recovery from NSSI and how adolescents believe parents and mental health professionals can best assist in this process.

**Defining NSSI Recovery**

Since NSSI is not a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013)—it is included as a condition which requires further research (Section 3)—and no criteria are provided for what constitutes recovery, it is difficult to define what constitutes recovery from NSSI. Previous research has focused on the “cessation” of NSSI, often defined as no episodes of NSSI over the previous year (e.g., Andrews, Martin, Hasking, & Page, 2013; Rotolone & Martin, 2012; Tatnell, Kelada, Hasking, & Martin, 2013; Whitlock, Prussein, & Pietrusza, 2015). This work has led to the observation that while many young people cease or decrease their NSSI of their own accord, those who continue to self-injure report more severe NSSI early in adolescence, face greater risks of psychopathology and suicide, and the
NSSI becomes more severe over time (Andrews et al., 2013; Whitlock, Muehlenkamp, & Eckenrode, 2008; Yates, Carlson, & Egeland, 2008). Conversely, those who cease their NSSI report improved self-esteem and greater resilience than those who continue with the behavior, suggesting resilience might be important in facilitating recovery (Rotolone & Martin, 2012; Tatnell et al., 2013; Whitlock et al., 2015).

While this research improves understanding of the important psychosocial factors associated with stopping NSSI, it fails to take into account the individual’s perspective on recovery. Specifically, there is no consideration of why the behavior has ceased, if it has been replaced by alternative behaviors, or whether the individual has recognized NSSI as a problem behavior. Understanding NSSI recovery from the young person’s perspective is important so as to identify the individual’s readiness to change their behavior and what potential barriers to recovery need to be addressed in interventions—information to which the professional would otherwise not be privy (Grunberg & Lewis, 2015; Lewis, Heath, Michal, & Duggan, 2012; Prochaska & Velicer, 1997). Further, recovery is not a finite state; individuals have expressed ambivalence toward recovery, recognizing that NSSI should be reduced but also feeling dependent on it for emotion regulation (Shaw, 2006). How recovery is defined—and by whom (i.e., clinician or person who self-injures)—has implications for treatment and help-seeking. Though researchers or clinicians may consider an individual as being at risk of further NSSI, clients may view themselves as recovered, thus reducing help-seeking or resulting in treatment drop-out. Conversely, an individual may perceive a need for ongoing support for NSSI urges or emotion regulation, but be classified as “recovered” according to a researcher-defined lack of NSSI in the last 12 months (e.g., Andrews et al., 2013; Rotolone & Martin, 2012; Tatnell et al., 2013; Whitlock et al., 2015).

Family Environments

Young people report that responses to NSSI from parents that are judgmental, impatient, or angry can exacerbate the behavior (Rissanen, Kylmä, & Laukkanaen, 2009; Yip, Ngan, & Lam, 2003). Similarly, lack of emotional support from parents and parental criticism are related to more frequent NSSI (Baetens et al., 2015). As such, fear of negative reactions from parents deters young people from disclosing their behavior to adults (Muehlenkamp, Brausch, Quigley, & Whitlock, 2013). Yet, it is also detrimental when parents ignore the behavior (Rissanen et al., 2009; Yip et al., 2003). Appropriate responses from parents are therefore important, and may assist their child’s NSSI recovery.
Not surprisingly then, Tatnell et al. (2013) found that adolescents who ceased NSSI reported better family support and parental attachment than those who maintained the behavior over a 1-year period. Qualitative studies echo the importance of the family to recovery. Specifically, in three separate interview studies with young adults who had either stopped NSSI or were in the process of reducing their NSSI, participants attributed their recovery or cessation to perceived improvements in family environments or having removed themselves from unsupportive family environments (Alexander & Clare, 2004; Buser et al., 2014; Shaw, 2006). Most of the research in this area has focused on parental negative reactions to NSSI, but examining appropriate parental responses, from the perspective of young people, is equally important. This information can be utilized in parental education programs, and help reinforce to parents—who report not knowing how to best respond to NSSI (Oldershaw, Richards, Simic, & Schmidt, 2008)—how they can help their child recover from NSSI.

**Mental Health Professionals**

While some parents might arguably lack the clinical skills to effectively respond to NSSI, prompting responses that are viewed negatively by young people, young people also report negative experiences with mental health professionals (Muehlenkamp et al., 2013), which deter further professional help-seeking (Hawton, Rodham, & Evans, 2006). This is concerning as professional help is recommended for NSSI, especially when it is prolonged and severe (Walsh, 2012). Few studies, however, have assessed what young people feel are helpful interactions with mental health professionals, that facilitate recovery and ongoing help-seeking; the current study will address this.

**The Current Study**

Given the importance of recovery in the course of NSSI and its treatment, we used a qualitative approach to better understand the concept of recovery as viewed by young people in Belgium, the United States, and Australia. Further, we sought to determine what young people thought parents and health professionals do that is helpful to the recovery process. Given that the course of NSSI appears to be similar among youth worldwide (Muehlenkamp, Claes, Havertape, & Plener, 2012), we expect conceptualizations of recovery to also be similar. However, taken together, data from the three samples will provide international insight into the recovery process for young people, and identify cross-national commonalities and differences.
Method

Participants

A sample of 98 young people were recruited from Australia ($n = 48$), Belgium ($n = 25$) and the United States ($n = 25$) as part of a larger study on family experiences of NSSI. Australian and Belgian young people completed questionnaires, while American young people participated in interviews. Participants were initially asked whether they had ever intentionally hurt themselves without the intention of killing themselves to which they could respond “yes” or “no.” Participants were then asked to list the methods they had used to self-injure; only those who indicated a history of NSSI were included in the current study. Of the Australian sample, 48 young people (17.6% of the broader Australian sample), aged between 12 and 18 years ($M = 15.15$ years, $SD = 1.64$ years), reported a history of NSSI. Most participants were female ($n = 32, 66.7$%) and born in Australia ($n = 38, 79.2$%) and none identified as Indigenous Australian. Of the Belgium sample, 39 young people (17.6% of the broader Belgium sample) reported a history of NSSI, but failure to answer open-ended questions by 14 participants resulted in data from 25 being included in the current study. The young people were mostly female ($n = 20, 80.0$%), aged between 17 and 19 years ($M = 17.32$ years, $SD = 0.56$ years) and the majority of the sample were Belgian nationals ($n = 24, 96.0$%).

The American interviewee sample comprised 25 young people aged 15 to 26 years ($M = 20.24$ years; $SD = 2.83$ years) with a history of NSSI. Most of the participants were female ($n = 23, 92$%). Other demographic information was not available for two of the participants. For the remaining 23 participants, 18 (78.3%) identified as European American or Caucasian, three (13.0%) as biracial or mixed, one (4.3%) as African American, and one (4.3%) as Asian American. Five participants (21.7%) were enrolled in high school, 12 were enrolled in college (52.2%), two were enrolled in technical school (8.7) and four (17.4%) were not currently in school.

Australian young people were significantly younger than Belgian or American participants, and the Belgian participants were significantly younger than the American participants, $F(2, 95) = 6.26, p < .001$. The samples did not significantly differ according to gender, $\chi^2(2) = 6.1, p > .05$.

Measures

In the questionnaires and interviews, the participants were asked questions addressing three areas of interest: (a) conceptualizations of recovery$^1$ (e.g.,
“How will you know when you have recovered and what does recovery mean to you?”), (b) parental helpfulness (e.g., “What were the most helpful things your parents did after finding out about your self-injury?”), and (c) helpfulness of professional help (e.g., “In your opinion, what has worked best during therapy?”). Young people in all three samples were also asked whether they had ever been diagnosed with a mental health disorder and if so, to list the disorder. The American sample was asked follow-up questions related to their self-injury in the interviews.

Procedure

Overall ethical considerations. Relevant ethics committees in each country approved the study and permission from participating secondary schools in Australia and Belgium was granted. Students in Australia and Belgium completed the questionnaire in the presence of a researcher. Young people required, on average, 45 to 50 minutes to complete the questionnaires. American young people participated in interviews which lasted 60 to 90 minutes. Participants from all three samples were aware of the aims of the study and their withdrawal rights, and were provided with information about mental health services after participation.

Australian procedure. Over 400 secondary schools across Victoria, Australia were invited to participate and five agreed. As the Australian study was part of a larger, longitudinal project young people in their final year at school were ineligible. Consent forms were mailed to 2,255 parents of the eligible students attending participating schools, and 483 were returned (21.4%), of which 353 (73.1%) provided consent (rates consistent with other Australian research on NSSI which seeks active parental consent; Tatnell et al., 2013). Young people with parental consent were then invited to complete the questionnaire at school; 77 students were absent due to illness and school excursions and four declined to participate. A total of 272 young people then completed the questionnaire with their schoolmates under test conditions. As noted above, the 48 reporting NSSI were included in this study.

Belgian procedure. Seven secondary schools in the Flemish speaking region of Belgium were invited to participate and three independent Catholic schools agreed. Passive parental consent was used. Consent forms were distributed to the parents of 245 students and five parents refused consent (2.0%). On the day of questionnaire administration, 19 students (7.9%) were absent due to illness; 221 students participated. Of these, 39 (17.6%) reported a history of NSSI, but as noted above, 14 did not complete open-ended questions. Young
people who did not complete the open-ended questions were more likely to be male than female, $\chi^2(1) = 12.73$, $p < .001$; no other differences were observed. Young people completed the questionnaires in Flemish and responses were translated to English for analysis, by the last author.

**American procedure.** Young people were invited to participate in the interviews via flyers and advertisements posted around school and college/university health provider organizations in New York State. The advertisements invited young people aged 15 to 26 years, with a history of NSSI, and where at least one parent knew about the NSSI, to participate in the interview. Twenty-five young people contacted the researchers to participate in the interviews. All interviews were preceded by a survey and parents were invited to participate in a survey and interview as well. Only youth data are included here.

**Results**

**NSSI Descriptives**

A summary of NSSI behaviors is provided in Table 1. More than one third of the Australian sample ($n = 17$) had seen a mental health professional for their NSSI, most commonly a school counselor ($n = 11$, 22.9%), or external psychologist ($n = 10$, 20.8%). Only three (12.0%) Belgian young people had seen a mental health professional for their NSSI, while all the American participants had seen a mental health professional, most commonly a therapist. Americans were more likely to have received professional mental health help (standardized residual = 4.0) than Belgians (standardized residual = −2.5), $\chi^2(2) = 43.16$, $p < .001$.

As can be seen in Table 1, Belgian young people were more likely to have started NSSI when they were 15 or older and less likely to have self-injured during the previous year than the Australian or American young people. In terms of NSSI behaviors, Belgians were more likely to carve than Australians. Belgians were more likely to have self-injured between 1 and 5 times over their lifetime, while the American sample was more likely to have self-injured over 50 times. Americans were more likely to report a prior diagnosis by a mental health professional than Australians. Assessing the three samples together, the most common diagnoses were depressive disorder ($n = 27$, 79.4%) and anxiety disorder ($n = 16$, 47.1%).

Six Belgian young people (24.0%) and 21 Australian young people (43.8%) reported that at least one parent knew about their NSSI, which did not significantly differ between the groups, $\chi^2(1) = 2.75$, $p > .05$. Of the
Table 1. NSSI Behaviors for Australian, Belgian and American Adolescents and Young Adults.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Community samples</th>
<th>Purposive sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Australia (n = 48)</td>
<td>Belgium (n = 25)</td>
</tr>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Age first self-injured&lt;sup&gt;a,b&lt;/sup&gt;</td>
<td></td>
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<tr>
<td>11 years or younger</td>
<td>13 (27.1)</td>
<td>1 (4.0)</td>
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<tr>
<td></td>
<td>1.6</td>
<td>−1.6</td>
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<tr>
<td>12 years</td>
<td>4 (8.3)</td>
<td>2 (8.0)</td>
</tr>
<tr>
<td></td>
<td>−0.2</td>
<td>−1.1</td>
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<tr>
<td>13 years</td>
<td>9 (18.8)</td>
<td>1 (4.0)</td>
</tr>
<tr>
<td></td>
<td>0.2</td>
<td>−1.6</td>
</tr>
<tr>
<td>14 years</td>
<td>10 (20.8)</td>
<td>6 (24.0)</td>
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<tr>
<td></td>
<td>0.1</td>
<td>0.4</td>
</tr>
<tr>
<td>15 years or older</td>
<td>11 (22.9)</td>
<td>14 (56.0)</td>
</tr>
<tr>
<td></td>
<td>−1.3</td>
<td>2.0</td>
</tr>
<tr>
<td>NSSI severity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requiring medical aid</td>
<td>13 (27.1)</td>
<td>3 (12.0)</td>
</tr>
<tr>
<td></td>
<td>0.8</td>
<td>−1.1</td>
</tr>
<tr>
<td>Not requiring medical aid</td>
<td>35 (72.9)</td>
<td>23 (88.0)</td>
</tr>
<tr>
<td></td>
<td>−0.4</td>
<td>0.6</td>
</tr>
<tr>
<td>NSSI within previous year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42 (87.5)</td>
<td>15 (60.0)</td>
</tr>
<tr>
<td></td>
<td>0.5</td>
<td>−1.1</td>
</tr>
<tr>
<td>No</td>
<td>6 (12.5)</td>
<td>10 (40.0)</td>
</tr>
<tr>
<td></td>
<td>−1.1</td>
<td>2.3</td>
</tr>
<tr>
<td>Method of NSSI</td>
<td></td>
<td></td>
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<tr>
<td>Cutting</td>
<td>33 (68.8)</td>
<td>14 (56.0)</td>
</tr>
<tr>
<td></td>
<td>−0.2</td>
<td>−0.9</td>
</tr>
<tr>
<td>Burning</td>
<td>7 (14.6)</td>
<td>1 (4.0)</td>
</tr>
<tr>
<td></td>
<td>−0.3</td>
<td>−1.5</td>
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(continued)
<table>
<thead>
<tr>
<th>Variable</th>
<th>Community samples</th>
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<th>Purposive sample</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Australia (n = 48)</td>
<td>Belgium (n = 25)</td>
<td></td>
<td>American (n = 25)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n (%)</td>
<td>Standardized residual</td>
<td>n (%)</td>
<td>Standardized residual</td>
<td>n (%)</td>
<td>Standardized residual</td>
</tr>
<tr>
<td>Scratching</td>
<td>15 (31.3)</td>
<td>0.6</td>
<td>8 (32.0)</td>
<td>0.5</td>
<td>3 (12.0)</td>
<td>−1.4</td>
</tr>
<tr>
<td>Carving</td>
<td>2 (4.2)</td>
<td>−2.4</td>
<td>14 (56.0)</td>
<td>4.2</td>
<td>3 (12.0)</td>
<td>−0.8</td>
</tr>
<tr>
<td>Hitting and bruising</td>
<td>20 (41.7)</td>
<td>0.8</td>
<td>9 (36.0)</td>
<td>0.1</td>
<td>5 (20.0)</td>
<td>−1.2</td>
</tr>
<tr>
<td>Frequency(^a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 times</td>
<td>17 (35.4)</td>
<td>0.4</td>
<td>14 (56.0)</td>
<td>2.0</td>
<td>1 (4.0)</td>
<td>−2.5</td>
</tr>
<tr>
<td>6-10 times</td>
<td>9 (18.8)</td>
<td>1.3</td>
<td>3 (12.0)</td>
<td>−0.1</td>
<td>0</td>
<td>−1.8</td>
</tr>
<tr>
<td>11-20 times</td>
<td>5 (10.4)</td>
<td>−0.1</td>
<td>5 (20.0)</td>
<td>1.3</td>
<td>1 (4.0)</td>
<td>−1.1</td>
</tr>
<tr>
<td>21-50 times</td>
<td>7 (14.6)</td>
<td>0.3</td>
<td>2 (8.0)</td>
<td>−0.7</td>
<td>4 (16.0)</td>
<td>0.4</td>
</tr>
<tr>
<td>More than 50 times</td>
<td>9 (18.8)</td>
<td>−1.3</td>
<td>1 (4.0)</td>
<td>−2.4</td>
<td>19 (76.0)</td>
<td>4.2</td>
</tr>
<tr>
<td>Diagnosed with mental illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8 (16.7)</td>
<td>−2.1</td>
<td>7 (28.0)</td>
<td>−0.6</td>
<td>19 (76.0)</td>
<td>3.5</td>
</tr>
<tr>
<td>No</td>
<td>40 (83.3)</td>
<td>1.5</td>
<td>18 (72.0)</td>
<td>0.4</td>
<td>6 (24.0)</td>
<td>−2.6</td>
</tr>
</tbody>
</table>

Note. Boldface indicates standardized residual greater than ±2. NSSI = nonsuicidal self-injury.

\(^a\)Australian \( n = 47 \).

\(^b\)Belgian \( n = 24 \).

\(^*\)\( p < .05 \). \(^{**\text{p} < .01}\). \(^{***p < .001}\).
American sample, participants were only eligible to participate if at least one parent knew about their NSSI, and this was most commonly their biological mother (n = 21, 91.3%), and/or biological father (n = 11, 47.8%).

Thematic Analysis

The responses to the open-ended questions in the survey and the interview transcripts were analyzed using thematic analysis, in accordance to Braun and Clarke’s (2006) six phases of thematic analysis. Thematic analysis was chosen as it is a useful technique to examine the shared experiences of individuals and the reality and meaning of the experiences from the participants’ perspective, and it is appropriate with both written and interview data (Braun & Clarke, 2006). The questions were designed to address the three areas of interest: (a) conceptualizations of recovery, (b) the most and least helpful responses from parents, and (c) the most and least helpful interactions with professionals. Given that the purpose of the current study was to investigate the participants’ responses to these three areas of interest, a semantic approach to the thematic analysis was used; patterns in the data were organized and interpreted for their significant contribution to the three areas (Braun & Clarke, 2006). Responses to the open-ended questions and the interviews were transcribed and coded for patterns within the data by the first and last author, and two research assistants. First the codes were compared between the three samples. Where identical questions were asked of young people, no thematic differences were detected between the countries, and Australian and Belgian responses were analyzed together (quotations indicate the sample of origin). The codes were then categorized under overarching themes for each area of study. Themes were determined based on how well they addressed the three areas of interest, as well as how frequently they appeared in the data. A psychological perspective was used to determine these themes and previous research on NSSI recovery also informed this process. The responses were then reread to ensure the themes accurately reflected the data and selected quotes are displayed in Table 2.

Plan of Analyses

Each theme is first presented with the percentage of Australian and Belgian young people who identified with that theme—where relevant quotation from the data is presented. This is followed by the American data where a longer quotation is presented to allow for a deeper analysis of the theme.

Conceptualizations of recovery. Only the Australian and American participants were asked questions regarding their conceptualizations of recovery.
Table 2. Themes and Exemplars With Australian, Belgian and American Adolescents and Young Adults.

<table>
<thead>
<tr>
<th>Area of study</th>
<th>Theme</th>
<th>Exemplary quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceptualizations</td>
<td>Urges</td>
<td>“I don’t feel the need to do it anymore and I’ve got a good support system and feel like I can now live a healthy normal life.” (Australian female, 17)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I guess [recovery will be] when I don’t really get the urges to do it anymore, where it’s not the, you know, first or second thing to pops into my mind. And I think that once I stop going to that place in my head, then it’ll be a good sign that you know I’ve moved on.” (American female, 22)</td>
</tr>
<tr>
<td></td>
<td>Negative reinforcement</td>
<td>“I am so so so tempted to cut and it lingers on my mind, I can’t think of anything else that will give me a release, and I just want to see the blood.” (Australian female, 13)</td>
</tr>
<tr>
<td></td>
<td>Ambivalence</td>
<td>“As I’ve become more and more into the cycle of self-injury, it’s not something that I even have to think about doing, it’s something that I do. It is my coping mechanism.” (American female, 15)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I stopped for about 2 months and I was fine but then I relapsed, so I’m not really recovered now?” (Australian female, 14)</td>
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<td></td>
<td></td>
<td>“I’m not sure I might do it again.” (Australian female, 14)</td>
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<td></td>
<td></td>
<td>“I mean it still comes to mind, if do get upset and worked up… I’d like to think that I’ve stopped? But I think it’ll be a while before I can really tell for sure.” (American female, 22)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I don’t think there’s ever gonna be a full recovery . . . it’s never gonna be like cured in a way.” (American female, 22)</td>
</tr>
<tr>
<td>Parents: Most</td>
<td>Supportive and calm</td>
<td>“Tried to help, treat me better, see things from my point of view.” (Australian female, 17)</td>
</tr>
<tr>
<td>helpful</td>
<td>communication</td>
<td>“My mother helped me [by] talking with me.” (Belgian female, 17)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“[Parents] were willing to listen to anything I had to say. Like they were willing to understand what it was - what I was feeling like in order to make me want to cut.” (American female, 24)</td>
</tr>
</tbody>
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Table 2. (continued)

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<thead>
<tr>
<th>Area of study</th>
<th>Theme</th>
<th>Exemplary quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents: Least helpful</td>
<td>Anger, ignoring, and sadness</td>
<td>“They said they were disappointed in me and that just made everything worse. I was clearly already feeling depressed so why make it worse?” (Australian female, 15)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“She [mother] always cried when she saw my scar, this hurt me.” (Belgian female, 17)</td>
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<td></td>
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<td>“She [mother] was just kind of like ‘Oh my god you’re freaking cutting yourself, great’ . . . And her face . . . she kinda just raised her eyebrows, just like, ‘Oh’ And that was it . . . it almost tore me down the way her face was.” (American female, 19)</td>
</tr>
<tr>
<td>Professionals: Most helpful</td>
<td>Feeling supported, engaged, and not judged</td>
<td>“Ask what you want to talk about. When they were very realistic with me and weren’t too sympathetic or negative, when they educated me about alternatives and why everything happens—external/internal factors.” (Australian female, 13)</td>
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<td></td>
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<td>“Talking in an understanding and listening manner.” (Belgian female, 17)</td>
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<td></td>
<td></td>
<td>“They sat there and they listened and they were supportive of me. And, they- I’m not saying that they condoned it or anything but, they supported my recovery and that I could trust them and everything.” (American female, 21)</td>
</tr>
<tr>
<td>Professionals: Least helpful</td>
<td>Lack of empathy, comfort and trust</td>
<td>“Made me feel worse, like somehow I wasn’t sad enough to be doing it, which made me feel worse. And him telling me I will get better. Until I experienced feeling better I hated it [be]cause it made me feel like I wasn’t trying hard enough to be better/happy.” (Australian female, 16)</td>
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<td>“She [therapist] could not understand me.” (Belgian male, 19)</td>
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<td>“With my mom and me in the room [the therapist] asked me to describe [my mom] in two words. And like that broke our trust immediately because he put me on the spot in front of my mom, who I was already upset with . . . it just kind of like set up this negative atmosphere the whole time . . . I just like- I could not trust anything he said after that.” (American female, 20)</td>
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*The Belgian participants did not complete this item.*
Recovery means few or no urges. Over half the Australian sample indicated that they were recovered from NSSI ($n = 25, 52.1\%$). When asked how they knew they were recovered, most participants said they no longer had the “urge” or need to self-injure ($n = 17, 68.0\%$). The young people who reported not being recovered, or were unsure about their recovery ($n = 23, 47.9\%$), were also asked “how will you know when you are recovered?” Similar to the recovered group, these young people most commonly ($n = 11, 47.8\%$) cited recovery as when they no longer have the urge to self-injure (e.g., “When I can embarrass myself and not feel the urge to hurt myself. When I’m normal and don’t even think to hurt myself when agitated,” Australian female, 17). The American interviewees agreed that the end stage of the recovery process would occur when they no longer had the urge or impulse to self-injure. No longer having the urge or impulse would mean that NSSI would not occur to them as an option in triggering situations.

If you’ve already broken the habit of self-cutting and you just need the impulse to go away . . . when the impulse stops I think that’s when I’m recovered . . . when it’s not even an option anymore. (American female, 26)

Negative reinforcement. Eleven Australian young people (22.9\%) indicated they were not recovered from NSSI. Of these young people, seven (63.6\%) cited that NSSI helps reduce their distress, thus negatively reinforcing the behavior (e.g., “It’s just an automatic reaction now when I feel embarrassed/stressed/angry/agitated,” Australian female, 17). The American interviewees also discussed the reinforcement properties of NSSI as a barrier to recovery. In the following excerpt, the young person describes how she has come to associate NSSI with relaxation.

I’m not ever going to want to like totally stop, like there’s something—like I said—it’s just classic conditioning, I’m just doing it over and over and over and I’m getting a response so my body’s already conditioned to, like, associate, like, that with, like, relaxing. (American female, 17)

Ambivalence. Twelve Australian young people (25.0\%) were ambivalent about their recovery. These adolescents were aware that NSSI should be stopped, but that it was also an effective distress-reduction technique (e.g., “I do want to stop, at least I think I do, but I don’t want to think about the stuff I did when I self-harmed,” Australian female, 14).

The theme of ambivalence toward recovery also emerged in the interview data. Specifically, participants acknowledged that NSSI is a maladaptive behavior that they ideally should no longer engage (“I know I shouldn’t be
doing it. I know in my mind that you know it—it’s not healthy,” American female, 22). However, she also reported that NSSI is an effective emotion regulation strategy for her, and since it works she is reluctant to stop.

In a way my mind still is hindering in that self-injury is what works and I know it works so why would I want to give it up? But then I also know I need to give it up because it’s not healthy. (American female, 22)

Here the young woman describes her “mind” as a barrier to recovery, which was a common sentiment expressed by the participants. Specifically, participants described their experiences of not being able to stop thinking about NSSI, and because they continued to think about NSSI, they were reluctant to endorse themselves as recovered (e.g., “I don’t really know how to say you have fully recovered. Because I still think about it sometimes, but I haven’t done it in a long time,” American female, 20).

Additionally, the participants questioned whether they would ever stop thinking about hurting themselves, or having the urge to hurt themselves. This left them wondering whether recovery was ever possible, as demonstrated in the following excerpt.

I don’t know if I’ll ever “have recovered.” I get the feeling that whenever it is that I stop, I’m still gonna get urges. But I’m just gonna know of better ways of dealing with it than to cut. I don’t think I’ll ever have been fully recovered. I don’t think these feelings I have are ever gonna go away. (American female, 22)

Here the young woman is reluctant to refer to herself as “recovered” because she knows that if the feelings behind NSSI and the urge to self-injure remain present, then she may relapse in triggering situations. This constant possibility left the individual reluctant to identify as recovered as well as uncertain as to whether recovery is ever possible.

Also contributing to ambivalence toward recovery were failed attempts to stop the behavior or “relapses.” The young people described recovery from NSSI as a process, where they would make attempts to stop the behavior for a period of time, but would then relapse (e.g., “I thought I’d stopped and that I wanted to stop but then I started back again,” American female, 21). In the excerpt below, the young woman explains the process of trying to stop self-injuring and the relapses she has experienced.

I’m actually not [self-injuring] at this point right now and at some point things could get overwhelming again and I’ll probably do it and then I’ll feel guilty so I [laughs] won’t self-injure for a couple months and then stuff will get
overwhelming again so I can go several months and then things can get out of control . . . There was a period of time where I had gone for close to a year and half without cutting. So that was the longest time that I had ever gone and I was really proud and then I screwed up. But it’s kind of a work in progress, you know? (American female, 22)

Unsuccessful attempts to stop self-injuring left one young person feeling reluctant to try to stop again. The young woman below describes how she perceives her relapse as a failure. As a result, she no longer tries to stop as she believes this sets herself up to fail.

Putting yourself in that position kind of puts you up to fail like you do have a slip up or something. It just means this whole big bad thing. I dunno so I kind of tried to stop putting myself in that position “well I’m just gonna stop now” ’cause it didn’t really work out. (American female, 22)

When discussing recovery, participants frequently mentioned triggers to NSSI episodes. Specifically, the participants described NSSI as becoming more frequent during difficult times; they would self-injure several times a day when they were distressed but could otherwise refrain for months or years (e.g., “I’ve been good for a while but, I dunno if something big happened, if that would necessarily be the case,” American female, 22; “It’s kind of gonna be a struggle, you know, if I have a rough day . . . I need to make a conscious decision that I’m not going to self-injure,” American female, 22). As such, the young people reiterated that recovery is being able to face triggering situations without turning to NSSI. The participants most commonly described triggering situations as conflict with family and friends. As the young woman below describes, she was able to refrain from NSSI because she did not face triggering situations:

When I was . . . 17 to 18, I thought that I had managed to stop and I think what 5 years down the road I’m now realizing, it wasn’t so much that I managed to stop so much as there wasn’t ever a moment where I ever felt the need to self-injure. So if I, in the future came up to a point where I would self-injure and I didn’t, then I think that would be a success. (American female, 22)

Most and least helpful responses from parents

Supportive and calm communication. From the questionnaires, \( n = 27 \) (37.0%) of the young people’s parents were aware of the NSSI. The most helpful response from parents was providing support and understanding (\( n = 11 \), 40.7%). Similar to being supportive, young people found it helpful when parents calmly talked and listened to them about NSSI and their emotional
experiences ($n = 8, 29.6\%$). For example, one Australian female (aged 13 years) reported it was helpful when her parents did not “react negatively and dramatically” and when her parents were “supportive, treated me as they did before.” Young people also found it helpful when parents enlisted outside help, including mental health professionals ($n = 8, 29.6\%$; for example, “We looked for help together,” Belgian female, 17).

The interview data also revealed that supportive, understanding and non-judgmental responses from parents were the most helpful to their recovery. In the following excerpt, the young woman describes how she was helped by her parent’s support when they first discovered her NSSI and then later when she relapsed.

> They were just supportive and pretty much just listened and tried to help . . . The fact that they were very supportive is what helped me get through it. Like being able to talk to them, I mean after I was hospitalized . . . I stopped cutting for like five years. And then when I went back to it and like I hid it from them and then they found out again and it was more of kind of like them listening and being like, “Okay you’ve done it before, you’ve gone through the process of not doing it, how can we help you.” And just having them be that support system before anybody else was definitely helpful. (American female, 24)

**Anger, ignoring, and sadness.** In the questionnaires, young people most frequently reported that it was detrimental to their recovery when their parents displayed overwhelming negative emotions such as anger, disappointment, and sadness ($n = 9, 33.3\%$). Ignoring either the NSSI or the young person was also considered unhelpful to recovery ($n = 8, 29.6\%$; for example, “When they ignore me and are angry at me . . . thinking it’s the end of the world and telling me I will never get better,” Australian female, 13). A further four young people (14.8\%) reported that it was unhelpful when parents did not attempt to understand why they had engaged in NSSI and simply demanded it stop. This was supported by the interview data:

> When I would tell her [mother] that I had cut myself she would go like crazy like screaming and swearing and stuff, and I know now that it was just out of fear and worry for us, you know, but at the time it just felt like I didn’t even wanna tell her about it you know, because she’s gonna freak out on me. (American female, 19)

> Because they [parents] didn’t understand like—like why I was doing it and what it was they couldn’t really give any sort of help that mattered . . . They wanted me to just stop and find some other way of release but like I said, since they didn’t know what it was, they didn’t understand why I couldn’t just stop. (American male, 20)
Most and least helpful responses from mental health professionals

**Feeling supported, engaged, and not judged.** Young people in Australia and Belgium who had seen a mental health professional cited that the most helpful outcome of these interactions was learning alternative coping methods \((n = 6, 30.0\%)\) and just being able to talk about NSSI with a nonjudgmental person \((n = 6, 30.0\%)\). Similarly, in the interviews, the young people reported that professionals who were supportive and tried to understand the behavior were helpful to the recovery process (e.g., “Having someone who was validating and nonjudgmental has been very helpful,” American female, 22).

**Lack of empathy, comfort, and trust.** Unfortunately, five young people who completed questionnaires (25.0%) revealed that nothing helpful came of their experience with a mental health professional. Young people also reported unhelpful interactions with professionals, including feeling as though they were being forced to talk and open up \((n = 5, 20.0\%; \) for example, “I found the sessions annoying as it brought up stuff I’d been trying to forget about,” Australian male, 15). Not trusting the professional and feeling uncomfortable and misunderstood was another problem young people experienced with their mental health professionals \((n = 5, 20.0\%; \) for example, “Nothing helped, they treated me as a small child,” Belgian female, 17). One young person attributed his lack of trust to a breach in confidentiality (e.g., “Them telling my parents. It was a long time ago. Because it makes you not want to tell them again,” Australian male, 14).

The interviewees perceived it to be unhelpful when professionals responded without empathy. In the following excerpt, the young woman describes her experience with a therapist who displayed disgust at her NSSI: “You could tell that she [therapist] was just disgusted by the look on her face and it was just kind of like, ‘Okay I probably don’t want to talk about this anymore’” (American female, 24). Here, the young woman reports that her therapist’s negative reaction to her NSSI made her not want to discuss it further in therapy. Importantly, when the young people perceived professional help to be unhelpful, they would disengage:

I first saw a psychologist when my parent found out. I was 19 . . . I did not like him at all. He did not help me, so I think I only went a couple of times, then I just stopped going. (American female, 22)

**Discussion**

In the current study, we assessed perceptions of recovery from NSSI among young people in Australia, Belgium, and the United States. We aimed to
assess how young people conceptualized recovery from NSSI and how the conceptualizations compared cross-nationally for young people, with a view to informing interventions. Despite differences in methodology, sample age, and country of origin, responses from the Australian, Belgian, and American sample were similar. Specifically, young people defined recovery as no longer having the urge to self-injure when distressed, displayed ambivalence about recovery, and reported it was helpful when parents and professionals were calm and understanding. The American samples were specifically targeted for the current study because they engaged in self-injury while the Australian and Belgian young people were recruited from school-based samples. Therefore, the American young people’s NSSI was more frequent and they were more likely to report a history of mental illness. Yet, experiences of perceived recovery were comparable across the samples—implications of this are discussed below. Additionally, the prevalence rates among Australian and Belgian young people were equal at 17.6%, which is also in line with current international estimates (Muehlenkamp et al., 2012; Swannell, Martin, Page, Hasking, & St John, 2014).

When discussing recovery—either achieved or not—young people defined recovery as not having the “urge” or “impulse” to self-injure anymore, where they no longer thought of NSSI as an option when they were distressed. Additionally, the American interviewees referred to recovery as a process whereby they could consciously refrain from NSSI. The prospect of relapse when confronted with a triggering situation was also documented. Their accounts of relapse—including relapse after several years of abstinence—demonstrates that researcher-defined cessation as no self-injury over 12 months (e.g., Andrews et al., 2013; Rotolone & Martin, 2012; Tatnell et al., 2013; Whitlock et al., 2015) does not capture the real world experience of the recovery process. Of the Australian sample, 87% had self-injured within the previous year, yet more than half of the sample declared they were recovered from NSSI. This too points to the importance of assessing recovery from the perspective of the young person, rather than with arbitrary definitions posed by researchers.

This process of stopping and relapsing left the young people unsure about whether recovery was possible because they reported they would always have the urge to self-injure when they were distressed. As such, recovery may feel unattainable to some young people. In support of this, the young people in the current study were unsure about recovery—what it meant, how to achieve it, and whether they wanted it, which is consistent with prior work regarding the nature of NSSI recovery (Buser et al., 2014). This ambivalence may reflect the success of NSSI as a distress-reducing action in the short term and its reinforcement properties. As one young person stated, in time NSSI becomes an “automatic reaction” to distress. Young people who were
ambivalent about recovery reported efforts to reduce their NSSI but looked to NSSI as an “option” when they were experiencing distress. This sentiment suggests that particular episodes can be prevented, but stopping the behavior altogether is more difficult. Yet, recent research suggests NSSI and the urge to self-injure can be reduced with psychoeducation, teaching of alternate coping strategies and emotion regulation techniques (Andover, Schatten, Morris, & Miller, 2015; Gratz, Bardeen, Levy, Dixon-Gordon, & Tull, 2015). However, while these findings are promising, NSSI interventions have often had modest success rates (e.g., Fischer & Peterson, 2015). Perhaps, as the current results indicate, the emphasis for interventions should be on accepting that recovery from NSSI is a process involving relapses, rather than placing an emphasis on stopping the behavior outright. Urges to self-injure should be measured when determining recovery or cessation. Motivational interviewing may be helpful with such an approach as it places agency for change on the young person, allowing them to develop their own motivations to stopping NSSI, while keeping the professional mindful of the young person’s ambivalence toward stopping (Kress & Hoffman, 2008). Further research assessing this approach to NSSI treatment is needed.

Young people were able to identify interactions with their parents that assisted and deterred their recovery. Specifically, support and patience from parents were the most helpful things they could do to assist recovery. The young people wanted their parents to respond calmly and to express love and support. Alternatively, invalidating responses from parents, such as expressing anger or disappointment, or ignoring the behavior were the least helpful responses, findings that can be relayed to parents as a standard part of NSSI treatment. Additionally, when the young people perceived their parents’ responses to NSSI to be invalidating, they became less likely to open up about NSSI in the future.

A similar pattern was observed with professionals. Consistent with previous research, the young people indicated that negative interactions with professionals discouraged them from seeking further help and from staying in treatment (Hawton et al., 2006). The main concerns reported by the young people in the current study were that they felt uncomfortable in treatment, felt misunderstood, and did not perceive the professional to be empathetic. As will be discussed below, these results have implications for the training of mental health professionals.

**Implications**

The emphasis on urge to self-injure in conceptualizing recovery highlights that recovery from NSSI is not simply a matter of ceasing to engage in the
behavior. In fact, many young people noted that recovery was not possible as they would always have the urge to hurt themselves when they were upset. Assessments which measure NSSI thoughts exist (e.g., Cloutier & Nixon, 2003) but have rarely been used when examining NSSI cessation. Research and clinical assessments should utilize such measures of NSSI to attain more accurate accounts of the individual’s recovery process. Evidence had previously been found for the use of a Stages of Change Model (Grunberg & Lewis, 2015), which when combined with the current results, asserts the importance of validating the individual’s perspective of their recovery (Kress & Hoffman, 2008). That young people in our samples also expressed ambivalence about recovery underscores the complex nature of NSSI and the inherently reinforcing value of the behavior. While ongoing urges to self-injure, and ambivalence about recovery might suggest poor treatment outcomes, interventions can reduce urges (Andover et al., 2015), a finding that could be better conveyed to young people. By educating young people about recovery, recovery can become less daunting and more achievable, thereby reducing the uncertainty they feel. To this point, self-efficacy may be an important factor in recovery from NSSI. The belief that one has the capacity to stop NSSI likely influences whether an individual attempts to stop the behavior and their attitude toward recovery. Similarly locus of control, or whether individuals believe they can control events in their life (Rotter, 1966), may affect attempts to stop self-injury. Further research may assess how these internal structures relate to recovery from NSSI.

Assisting parents to respond to NSSI in supportive and calm ways and to avoid invalidating or angry reactions may also facilitate recovery. Seminars have been successfully presented at schools to educate parents about how to assist their child in the event of substance use, depression, and anxiety (e.g., Sanders, Prior, & Ralph, 2009). The current results suggest that including strategies for assisting a self-injuring young person into such seminars could be beneficial to young people attempting recovery, as well as their parents. Parenting is also affected by the discovery of NSSI—parents become hyper-vigilant and more authoritarian, while also doubting their parenting abilities (Baetens et al., 2015; Ferrey et al., 2016; Oldershaw et al., 2008). Therefore, prevention or intervention initiatives that teach parents appropriate skills for interacting with their child after NSSI may be particularly beneficial to parents and young people.

The perceived lack of empathy and understanding from some professionals is concerning. Since the majority of the young people in the current studies sought help from school counselors or college-based therapists, appropriate NSSI training may be required for such professionals particularly in school settings. This might include a focus on allowing the young person to set the
pace or agenda for the sessions, so they feel at ease in discussing NSSI. Future research with mental health professionals is needed to provide a clinician’s perspective of the challenges faced by professionals treating NSSI.

The experiences of recovery were similar in Australia, Belgium, and the United States, which has implications for the development of NSSI interventions. Specifically, interventions developed to facilitate recovery among young people may be applicable in different, yet culturally similar, countries. Additionally, responses were comparable for the different age groups, which suggests the same factors are important for recovery across ages. Rather than age per se, maturity may be more salient to recovery, including the development of better coping skills (Whitlock et al., 2015). Research investigating the efficacy of NSSI treatment cross-nationally and over different age groups is needed to confirm this.

Finally, further research is currently needed to determine effective NSSI treatment (Turner, Austin, & Chapman, 2014). Recent research has found that family-based interventions are an important avenue for further examination (Glenn, Franklin, & Nock, 2014) as are interventions that directly address the ambivalence young people may feel toward recovery (Andover et al., 2015). The current results support further investigation of such interventions including integration of methods, for example, family-based treatment which also addresses ambivalence and emphasizes that recovery as a process that may involve relapses.

**Limitations**

The current study was limited by its retrospective methodology. Participants were asked to recall their parents’ initial reactions to the behavior, which for some young people was up to 10 years prior, limiting the reliability of the results. Responses to questionnaire items were used verbatim, and given the questionnaire design, were not member checked; similarly, we did not perform member checking of interview data, precluding the chance for participants to reflect on, and provide context to their answers. Future research would benefit from a longitudinal methodology, which would be able to track the course of recovery, including potential relapses, and could also member-check the results to help improve accuracy.

The two samples from Australia and Belgium were community, adolescent samples, while the American sample was purposively selected young adults. Therefore, NSSI reported by the American sample was more severe and frequent than the two adolescent samples. Nevertheless, consistency in emerging themes lends confidence to the reliability of the current studies. Additionally, the interviewee sample was not representative of American
demographics (United States Census Bureau, 2014) and Indigenous Australians were not represented within the Australian sample, so future research would also benefit by examining cultural differences regarding recovery within countries as well as between. Such research is important to the development of interventions which can be used with different cross-sections within society and between countries.

Finally, the current study assessed recovery only from the perspective of young people. Considering the important role that parents play in the recovery process, future research would benefit from also attaining the parent’s perspective of NSSI recovery. This research could determine whether the perspectives of young people and their parents regarding parental helpfulness and unhelpfulness align, as well as establish the areas parents need further assistance when coping with a self-injuring child.

**Conclusion**

The current results support and extend the limited literature on recovery from NSSI. Across the samples, young people defined recovery as no longer having the “urge” to hurt themselves when they are distressed and often reported ambivalence about recovery. Preliminary findings show that interventions can reduce the urge to self-injure, and this information may help build self-efficacy to make recovery seem more attainable to young people and ease some of the uncertainty. Additionally, parents and professionals may require training to ensure they offer helpful responses to young people who self-injure, such as offering support and making an effort to understand the behavior.

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**Note**

1. This question was not asked of the Belgian sample.

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