The impact of ambivalence on recovery from non-suicidal self-injury: considerations for health professionals

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Abstract

Purpose

Non-suicidal self-injury (NSSI) is a growing public health concern. Continued NSSI is often associated with negative outcomes, yet the behaviour usually serves a purpose for individuals who self-injure (e.g. emotional relief). As such, individuals who self-injure often experience ambivalence about the behaviour. The purpose of this paper is to highlight the importance of recognising ambivalence as a natural and expected part of the recovery process.

Design/methodology/approach

This paper draws on literature regarding NSSI recovery, ambivalence towards stopping the behaviour and challenges for both clients and health professionals.

Findings

This paper argues that ambivalence towards self-injury can be challenging for both clients and health professionals. Clients may feel shame and sense of failure if they experience a setback; health professionals may experience frustration towards clients who continue to self-injure despite treatment.

Originality/value

Validation of the clients' experience can have significant positive outcomes in treatment and help-seeking behaviours. Acknowledgement of client ambivalence during the recovery process will serve to validate clients' experience and facilitate rapport. Health professionals who accept ambivalence as a natural part of the recovery process may experience less frustration with clients who continue to self-injure.

Non-suicidal self-injury (NSSI) is the deliberate, self-inflicted damage to one's own body tissue without suicidal intent, for reasons not socially or culturally sanctioned (International Society for the Study of Self-Injury, 2018). In clinical samples, approximately 20% of adults and 40%–80% of adolescents report having ever engaged in NSSI (Kaess et al., 2012; Klonsky and Muehlenkamp, 2007). Rates are also high in community samples; international pooled prevalence rates suggest approximately 17.2% of adolescents, 13.4% of young adults and 5.5% of adults report a history of NSSI (Swannell et al., 2014). Further, approximately 17%–20% of undergraduate university students have reported self-injury (Kelada et al., 2016; Swannell et al., 2014), with 8%–12% reporting NSSI in the past 12 months (Ammerman et al., 2017; Kiekens et al., 2018).

Individuals who self-injure describe a range of reasons for the behaviour, including self-punishment, expression of distress where language feels insufficient, avoidance of suicidal impulses and most commonly, to regulate emotion (Edmondson et al., 2016; Taylor et al., 2018). As such, NSSI can be maintained through negative reinforcement; the behaviour serves to avoid or distract from unwanted emotional experiences and the resulting emotional relief reinforces the use of the behaviour in times of distress (Chapman and Dixon-Gordon, 2007; Hasking et al., 2008; Hodgson, 2004; Taylor et al., 2018).

The benefits and barriers model (Hooley and Franklin, 2017) provides a theoretical framework for understanding why individuals may or may not engage in self-injury. Hooley and Franklin (2017), propose that there are a number of perceived benefits associated with engaging in self-injury including improved affect, the gratification of self-punishment, affiliation with peers and expression of distress or strength. Numerous studies confirm the affect regulatory function of NSSI (Taylor et al., 2018) and the role of self-criticism and self-punishment in maintaining the behaviour (Fox et al., 2017; Hooley and St. Germain, 2014). These effects have been noted across adolescent and young adult samples and in both clinical and community contexts (Fox et al., 2017; Hamza and Willoughby, 2014; Hooley and St. Germain, 2014; Tan et al., 2019). Young people who self-injure are more likely to affiliate with other young people who self-injure (Muehlenkamp et al., 2013) and peer bonding is a less common, but noted, function of NSSI (Taylor et al., 2018). Finally, NSSI can be used to express distress when words are insufficient. Some individuals who self-injure also report ongoing scarring can be a sign of strength and resilience (Lewis and Mehrabkhani, 2016).

These benefits could be perceived by any individual, yet certain barriers may exist preventing access to these benefits: the absence of exposure to the behaviour, desire to protect the body, aversion to physical pain, aversion to NSSI stimuli (e.g. blood) and social norms through which NSSI is perceived as shameful. Hooley and Franklin (2017) propose that any of these barriers may be sufficient in preventing self-injury. In addition to these barriers, NSSI is often associated with a range of psychological concerns including depression, anxiety, substance use disorder and suicidal thoughts and behaviours (Bentley et al., 2015; Kiekens et al., 2018; Whitlock et al., 2013). This association has led to the idea that NSSI is symptomatic of psychiatric illness (Bentley et al., 2015; Fox et al., 2015). While this may be true in some cases, not all those who self-injure experience psychiatric illness (Kiekens et al., 2018). NSSI can also be associated with the presentation to emergency departments, scarring, shame/guilt, unhelpful judgement/labelling and stigma (Lewis, 2017; Staniland et al., 2020). It is not surprising then that individuals who self-injure report experiencing ambivalence towards complete cessation of the behaviour (Kelada et al., 2017). In this paper, we propose the importance of acknowledging that NSSI serves a purpose for those who self-injure and thus individuals may be ambivalent about changing their behaviour.

Non-suicidal self-injury recovery

A number of recovery frameworks have been applied to understanding how individuals come to cease self-injury. The transtheoretical model is often applied to behaviour change, including in the context of NSSI, whereby change or cessation is indicated by the absence of the behaviour for a minimum of six months (Grunberg and Lewis, 2015). In research, recovery is often conceptualised as no engagement in NSSI over a 12-month period (Kelada et al., 2017). In these conceptualisations, recovery is seen as something individuals achieve through demonstrating the absence of the behaviour over a defined timeframe.
More recently there has been a shift towards quality of life as a determinant of recovery. In this approach, substantiated by research, engagement in self-injury has reduced when the individual takes responsibility and control for their lives and health, returns to fulfilling their own basic functions, redefines themselves to hold an identity, improves their lives by incorporating support and relationships and recognises triggers, resources and strategies (Buser et al., 2014; Kress and Hoffman, 2008; Shaw, 2006; Tofthagen et al., 2017). In the most recent conceptualisation, NSSI recovery is seen as multifaceted and involving more than just cessation of the behaviour but also addressing any underlying mental health concerns, identifying strengths, addressing disclosures and fostering self-acceptance (Lewis and Hasking, 2020a, 2020b). Thus, while cessation of NSSI is an important part of the recovery process, cessation alone does not constitute recovery. However, ambivalence about wanting to stop self-injuring can be one of the primary barriers to NSSI recovery efforts.

The experience of ambivalence

Ambivalence, the experience of simultaneous opposing or contradictory beliefs, feelings or behaviours, is a recognised core component of decision-making and behavioural change, including in the context of self-injury (Grunberg and Lewis, 2015). In outlining both benefits and barriers to self-injury, Hooley and Franklin (2017) also illustrate how individuals may hold competing cognitions towards self-injury. For example, someone may report a desire to continue to self-injure, holding an expectation that NSSI will improve negative affect (benefit). However, they may also report a desire to stop self-injuring to avoid scarring and other adverse outcomes or because social norms indicate that self-injury is shameful and they will be judged for self-injuring [barriers; Hooley and Franklin (2017)]. Further, people who self-injure often report wanting to stop, but worry about how they will cope with distress if self-injury is not in their 'toolkit' (Kelada et al., 2017). These conflicting cognitions are a hallmark feature of ambivalence.

Ambivalence may also manifest in the very process of self-injury. Feelings of self-criticism, common amongst those who self-injure (Zelkowitz and Cole, 2019), may create beliefs that they deserve to be hurt (Tan et al., 2019). This may lead to an urge to self-injure as a form of punishment or emotional release, where the preceding pain reduces momentarily (Tan et al., 2019). Guilt and shame may then increase when the individual and/or onlookers criticise their re-engagement, compounding the self-criticism (Tan et al., 2019). Thus, self-injury is experienced as both a source of emotional relief and a source of emotional distress.

Additionally, given the significant stigma associated with self-injury, some individuals who self-injure may not only be ambivalent about the behaviour but also be ambivalent about disclosing their self-injury (Staniland et al., 2020). Disclosure may be a first step in securing support, from loved ones or health professionals (Hasking et al., 2015; Kelada et al., 2017; Park and Ammerman, 2020; Simone and Hamza, 2020). Disclosure to health professionals, in particular, may be beneficial and associated with stress reduction, social support, psychological growth and resilience (Simone and Hamza, 2020). Conversely, disclosure may lead to further harm including potential prejudice and possible further self-injury (Simone and Hamza, 2020). The anticipation of being labelled mentally unwell, attention-seeking or treated poorly is a significant barrier to disclosure (Staniland et al., 2020). Moreover,

adopting an identity embedded in a stigmatised group can harm one's psychological well-being (Rosenrot and Lewis, 2020; Simone and Hamza, 2020). As such, individuals may experience ambivalence about seeking professional support. Even individuals seeking professional support for other mental health concerns may be reluctant to disclose their self-injury in therapy; only 8.9% disclose their self-injury to a mental health professional (Whitlock et al., 2011). For those who do choose to seek help, ambivalence about ceasing NSSI and its potential for success may continue, impacting the relationship between themselves and the treating clinician (Mackay and Barrowclough, 2005; Saunders et al., 2012).

Given the many components involved in NSSI recovery, it is understandable that some individuals are uncertain about the extent they wish to embark on the recovery process (Grunberg and Lewis, 2015; Kelada et al., 2017). Perceptions regarding the difficulty of the recovery process may result in differing expectations of recovery, experiences of ambivalence towards recovery as a process and varying recovery trajectories across individuals (Lewis and Hasking, 2020a, 2020b; Tofthagen et al., 2017). Lewis and Hasking (2020a, 2020b) note that NSSI recovery encapsulates accepting ongoing thoughts and urges, promoting self-efficacy to resist urges, identifying strengths, and fostering self-acceptance. Further, some individuals may experience mental health concerns alongside their self-injury. Addressing these during the recovery process may be confronting and effortful and for some, may necessitate lengthy psychological treatment (Lewis et al., 2019). The idea of engaging in the self-reflective processes necessary to foster self-efficacy and self-acceptance, the trial and error required to adopt alternative coping strategies and the potential for a sense of failure or rejection from others, when recovery goals are not met, may result in ambivalence towards broad NSSI recovery. These simultaneous and competing expectancies can be confusing for an individual, and hinder both behavioural cessation and broader recovery efforts (Kelada et al., 2017; Tan et al., 2019). Experiencing opposing desires to both continue and cease self-injuring may appear inconsistent. However, if an individual expresses a desire for cessation or NSSI recovery, yet continues to engage in NSSI, this is not an indication that they are being dishonest, have lost control or have failed. Recognising ambivalence provides validation to the client, improves rapport and likely improves treatment outcomes (Shaw, 2006; Tan et al., 2019; Tofthagen et al., 2017).

Clinical implications

Autonomy and independence are recognised catalysts for reductions in NSSI (Kelada et al., 2017; Sandy and Shaw, 2012; Shaw, 2006). In treatment contexts, adolescents who reported negative experiences felt as though clinicians misunderstood them, forced them into treatment approaches and treated them like a "small child" (Kelada et al., 2017, p. 432). This can lead to disengagement from treatment (Shaw, 2006; Kelada et al., 2017). In contrast, by adopting a person-centred approach and recognising that ambivalence is a normal part of the recovery process, clinicians may enhance a sense of control, autonomy and self-efficacy, reduce resistance to change and potentially reduce self-injury amongst clients (Buser et al., 2014; Kress and Hoffman, 2008; Sandy and Shaw, 2012; Shaw, 2006).

Given this, it is important to understand how experiences of ambivalence contribute to client/clinician tension. Some clinicians and other health professionals perceive those who self-injure to be time-consuming, with illegitimate reasons for needing care and have reported feelings of irritation, anger, frustration, helplessness, failure, anxiety, fear and insecurity (Cook et al., 2004; Long, 2018; Sandy and Shaw, 2012; Saunders et al., 2012). Clinicians may exhibit hostile reactions in response to these emotional experiences, which is likely to diminish trust between the client and clinician (Long, 2018). In particular, repetitive self-injury increases distress for health professionals, as they see continuing behaviour with no apparent change (Mackay and Barrowclough, 2005; Saunders et al., 2012). This may also damage rapport between clinicians and their clients; as feelings of hope

and optimism are reduced in clinical staff, so too are helping behaviours, resulting in clients feeling unsupported (Mackay and Barrowclough, 2005; Wadman et al., 2018). Individuals who engage in self-injury may internalise these attitudes and beliefs, increasing shame and self-criticism (Staniland et al., 2020). This is perhaps where ambivalence is most important to consider. Both the frustration felt amongst health professionals and the shame felt by clients are understandable reactions when the behaviour is viewed solely in the context of long-term consequences (e.g. scarring, social isolation). Adopting a more complete, realistic understanding of the experience, to acknowledge immediate benefits for those who self-injure (e.g. emotional relief), may validate the client, reduce frustration amongst clinicians and allow space for more balanced communication around treatment (Hasking et al., 2019).

Some individuals have noted that when they re-engaged in self-injury following periods of abstinence, helpful health professionals understood the pain rather than condemning the behaviour as a failure. Clients recall being given space and allowed to experience setbacks during the "prolonged process" (Tofthagen et al., 2017, p. 2314) of recovery. The acceptance of ambivalence led to valuable therapeutic relationships during the recovery process. Through this alliance, clients learned to also accept support in their outside relationships, eliciting long term treatment benefits (Tofthagen et al., 2017). A recognition that ambivalence is common may allow space for clients to self-identify disadvantages of continuing to self-injure and advantages of reducing the behaviour; reducing shame, ambivalence and building self-efficacy to resist urges to self-injure. Viewing ongoing self-injury through a framework of ambivalence, rather than relapse or failure, may reduce frustration, increase empathy and promote further help-seeking behaviour in the client. Shifting focus from engagement in the behaviour to the subjective experience of the individual, may help resolve ambivalent cognitions (Lewis and Hasking, 2020a, 2020b).

Lewis and Hasking's (2020a, 2020b) multifaceted recovery framework allows clinicians to understand their clients on a level beyond just their frequency of NSSI. Clinicians have a framework to identify personal strengths of their clients, explore alternative coping strategies that hold value to the client, work through issues around disclosure, understand and address the clients attitudes towards their scarring, foster self-efficacy and self-acceptance, address any underlying adversities or psychopathology that may be related to their self-injury, and finally, normalise setbacks, thoughts, and urges throughout the process (Lewis and Hasking, 2020a, 2020b). A health professional may approach this by asking their client about any recent urges, explore what was done to resist urges and emphasise the success of the client to build self-efficacy to resist self-injury (Lewis and Hasking, 2020a, 2020b). In times that the client was unable to resist the urge, it may be beneficial for health professionals to normalise re-engagement as a part of recovery, validate the client to harbour self-acceptance and discuss what could be done differently when experiencing an urge to self-injure. Goals may be re-set based on the client's experiences. Through monitoring this process, health professionals can guide their clients to maintain realistic targets involved in the recovery process (Lewis and Hasking, 2020a, 2020b).

A person-centred recovery framework emphasises the importance of understanding individual differences in ambivalence. For example, a client may be ambivalent towards disclosing/discussing their self-injury, yet accept their scarring as a personal reminder of their strength. It may serve clinicians to be aware of these components within the recovery process, alongside varying (and fluctuating) levels of ambivalence towards each.

Conclusion

Ambivalence is a natural part of autonomous decision-making and behaviour change. Accommodating for this in treatment of NSSI will allow for more compassion towards behavioural

and cognitive inconsistencies, build client/clinician rapport, reduce frustration and contribute to the achievement of desirable outcomes. We encourage clinicians to be attentive to the experience of ambivalent clients who continue to engage in NSSI. We advocate for ambivalence towards self-injurious behaviours to be recognised as a principle component of the recovery process. Acknowledging client ambivalence will provide validation for their experience and help make sense of behaviours and cognitions which may appear inconsistent, but are central in the recovery process.

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