Stepping Out of the Shadows: Non-Suicidal Self-Injury as Its Own Diagnostic Category

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Non-suicidal self-injury (NSSI) is the repetitive and intentional act of causing injury to one's own body without suicidal intent. NSSI is an extremely prevalent and pervasive phenomenon, affecting between 13.0 to 23.2% of individuals in the general population. There are significant negative outcomes that may result from engaging in NSSI including risk of serious physical injury, becoming addicted to the behavior, experiencing stigmatization and social rejection, and an increased risk for suicidality. There is also sufficient evidence in the literature supporting the distinction between NSSI and suicide as well as NSSI and Borderline Personality Disorder (BPD). Creating a distinct diagnosis of NSSI in the DSM has many positive clinical implications such as developing a tailored treatment for individuals who engage in such behaviors, stimulating further research about NSSI, improving communication regarding behaviors of self-injury, and bringing awareness to this widespread behavior. This article evaluates each of these benefits to demonstrate that NSSI deserves to be a distinct diagnostic entity in the DSM.

Introduction

Mary, a 14-year-old female, spends most of her time with her friends and boyfriend, Steve. On Monday, Steve cancelled on her, claiming that he was sick and wanted to go home and sleep after school. On the way home from school, Mary saw Steve walking down the block holding another girl's hand. When she arrived home, Mary ran through the kitchen, ignored her parents' greeting, and went straight upstairs to her bedroom. She locked the door and took out the razor blade that she had hid in her bottom drawer. Mary knew that she was not supposed to cut her arms, but it seemed like the only way to escape from the horrible knot inside her chest. She held the razor blade to her arm and sliced deeply into her skin, watching the bright red line slowly materialize. Mary felt an immediate warm sense of release, as if all of her anger and pain were bleeding out of her.

Non-Suicidal Self Injury (NSSI) is defined as the purposeful hurting of oneself without the conscious intent to die (Jacobson & Gould, 2007). The majority of individuals report that the function of NSSI, such as self-scratching or self-cutting, is to reduce tension and regulate emotions, such as anxiety, depression, fear, or anger (Favazza, 1998; Nixon et al., 2002; Ross & Heath, 2003). As illustrated by Mary's behavior in the case study, interpersonal difficulties often lead to NSSI. A study by Adrian, Zeman, Erdley, Lisa, and Sim (2011) found that interpersonal difficulties in the family and peer context increase the frequency and severity of NSSI through emotional dysregulation. Interpersonal influence, the use of self-injury to manipulate people in the environment, also has been found to contribute to NSSI (Klonsky, 2007). A minority of individuals assert that their motivations for engaging in NSSI are to arouse feelings when none exist and to terminate feelings of depersonalization (Jacobson & Gould, 2007; Klonsky, 2007).

When the American Psychiatric Association composed the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), NSSI was proposed for inclusion as its own diagnostic category. Ultimately, NSSI was added to Section III of the DSM-5 as a condition for further study, which means that criteria sets need to be further studied before NSSI can become an official diagnosis (In-Albon, Ruf, & Schmid, 2013). Given (a) the prevalence and pervasiveness of NSSI; (b) the problems that stem from engagement in such behaviors; (c) evidence in the literature distinguishing NSSI from both suicidality and Borderline Personality Disorder (BPD); and (d) the clinical utility of having NSSI as its own diagnosis, NSSI deserves to be a diagnostic category in the DSM. Furthermore, NSSI meets the criteria for a mental disorder according to the DSM-5.

Prevalence and Pervasiveness of NSSI

NSSI often starts during early adolescence, with an average age of onset of 12-14. NSSI peaks in mid-adolescence and decreases into adulthood. Prevalence of NSSI in males and females is nearly equivalent, and it is unclear whether there are ethnic differences in its incidence (Jacobson & Gould, 2007). In their critical review of NSSI literature, Jacobson and Gould (2007) found that the lifetime prevalence of the behavior in the general population ranges from 13.0%- 23.2%. An

adolescent community study, which used the proposed criteria for the DSM-5, found the prevalence of NSSI to be 6.7% among adolescents (In-Albon et al., 2013). In the inpatient population, approximately 21% of adults and 30%-40% of adolescents engage in NSSI (Hamza & Willoughby, 2013).

For individuals who have engaged in NSSI, the behavior is extremely pervasive. In a study that examined the frequency of NSSI over the lifetime, it was found that out of a sample of 171 people who had engaged in NSSI at some point during their lives, over 55% self-injured at least once a week (Turner, Chapman, & Layden, 2012). The high prevalence of NSSI in the population and the pervasiveness of this behavior in individuals' lives is a chief reason why NSSI is a behavior significant enough to be a distinct diagnostic category in the DSM.

Adverse Consequences of Engaging in NSSI

While NSSI provides relief from negative emotions in the moment, it can create long-term problems. First, NSSI may be a habit-forming behavior. Individuals who engage in NSSI report difficulty in controlling the urge to self-injure. A person can become physically addicted to self-harm as a result of the involvement of the endogenous opioid system. This system regulates pain perception and levels of endorphins, which are released when the body is injured and result in a feeling of pleasure. Repeated activation of this system may lead to a tolerance effect whereby individuals who self-injure develop a decreased sensitivity to pain while self-injuring over time (Mental Health Foundation and Camelot Foundation, 2006; The Cornell Research Program on Self-Injury and Recovery, 2013).

Social consequences, including peer rejection and stigmatization, are also important repercussions of NSSI (Favazza, 1998). Society's negative views of self-injurious behaviors cause people to avoid individuals who engage in such behaviors. Healthcare workers also possess stigma towards individuals who engage in NSSI, such as beliefs that people who self-injure are manipulative, attention seeking, untrustworthy, and uncooperative. Evidence suggests that this stigma may negatively impact services and treatment outcomes and lead to a growing sense of alienation amongst individuals who self-injure (Law, Rostill-Brookes, & Goodman, 2009). The stigma present in the general

population, the stigma among healthcare professionals, and the self-stigma that individuals possess towards themselves often discourage individuals from disclosing their NSSI behavior and seeking help. Resulting feelings of secrecy and the inability to reach out generate shame and guilt (Raymond, 2012).

Another adverse consequence of NSSI is the risk of physical injury. Infection and scarring often result from NSSI. People sometimes inflict more harm upon themselves than was intended, which can lead to severe and potentially life-threatening injuries that may require medical attention and cause lasting disfigurement (Turner et al., 2012). Lastly, individuals who practice NSSI have an increased likelihood of suicidal behavior when compared to individuals who do not practice NSSI (Hamza & Willoughby, 2013). Studies of older individuals who engaged in NSSI in the past indicate a greater risk for subsequent suicidal behavior (Hawton & Fortune, 2008). According to Joiner (2005), increased engagement in NSSI raises an individual's capacity for suicide via habituating the individual to the fear and pain linked with taking one's own life. Increased frequency and greater time spent engaging in NSSI, using multiple methods to inflict NSSI, and engaging in NSSI alone are all associated with a greater risk of future suicidality (Hamza & Willoughby, 2013). These many adverse consequences demonstrate why NSSI is significant enough to warrant its own diagnostic category.

NSSI and Suicide as Distinct Concepts

NSSI is often wrongly viewed as a manifestation of suicidality. This has made it difficult for researchers, clinicians, and the general public to view NSSI as a valid and distinct entity. While in the past suicidality and NSSI were seen as two points on the same continuum, recently, research has found a high prevalence of NSSI in individuals who clearly distinguish this behavior from suicidality (Jacobson & Gould, 2007). This growing research base is forcing researchers and clinicians to rethink their perspective and to begin to view NSSI and suicidality as distinct concepts.

The major difference between NSSI and suicide attempts is the intent of the behavior. While NSSI is a maladaptive behavior, it is a form of coping, and coping is a confirmation of a desire to live, not a desire to die. Typically, when individuals engage in NSSI, they have cognitions

centered on temporary relief while individuals engaging in suicidal behaviors have cognitions of permanent relief via death. Additionally, people engage in NSSI more frequently and with more diverse methods compared with suicidal behavior (Jacobson & Gould, 2007). While NSSI is a risk factor for suicide, these are distinct behaviors that do not necessitate the presence of the other. This differentiation between NSSI and suicide supports the diagnostic validity of NSSI.

Differentiating NSSI from BPD

Some clinicians argued that NSSI is primarily a function of BPD. However, while NSSI and BPD are frequently comorbid, they also frequently occur independently–a point that is largely misunderstood and overlooked. A growing number of adolescents do not meet the diagnostic criteria for BPD, are nonetheless distressed, exhibit NSSI, and are in need of help. In a recent study by In-Albon et al. (2011), it was found that 80% of the adolescents with NSSI did not fulfill the criteria for BPD. Results from a study conducted by Glenn and Klonsky (2013) indicate that the comorbidity of NSSI with BPD is comparable to that of BPD with mood and anxiety disorders. Substantial overlap has been found between NSSI and depressive disorders, anxiety disorders, Post Traumatic Stress Disorder, Conduct Disorder, and substance misuse disorders (Jacobson & Gould, 2007; Wilkinson & Goodyer, 2011). In addition, many individuals who engage in NSSI have no associated psychiatric diagnoses (Wilkinson & Goodyer, 2011). Thus, while NSSI and BPD do commonly overlap, NSSI is distinct from BPD, as evidenced by its frequent presence in the absence of symptoms of BPD.

Misconceptions about the relationship between NSSI and BPD lead to the assumption that NSSI does not have clinical significance beyond the context of BPD. Many studies have found that, on its own, NSSI is linked with clinical impairments such as depression, anxiety, suicidality, emotion dysregulation, and loneliness (Glenn & Klonsky, 2013; Wilkinson & Goodyer, 2011). The fact that NSSI frequently occurs independently of BPD and has clinical significance outside the scope of BPD, provides compelling evidence that NSSI is, in fact, a distinct condition that is not simply a symptom of BPD.

Clinical Utility of Including NSSI as a Diagnosis in the DSM

Creating a distinct diagnostic category for NSSI has significant clinical benefits. In the absence of an accompanying psychiatric diagnosis, there currently exists no place to record NSSI. It is especially difficult to provide treatment to individuals without a formal diagnosis within today's healthcare system, which will not pay for services provided to individuals without a diagnostic label. To ensure insurance reimbursement in the current healthcare system, many individuals are misdiagnosed with other psychiatric disorders without meeting the full criteria. If NSSI were an official diagnosis, insurance companies would reimburse for the treatment of NSSI, and the primary objective of psychotherapy could be treatment of NSSI (In-Albon et al., 2013). Imparting DSM status to NSSI will help individuals who engage in such behaviors to receive appropriate treatment before they begin to demonstrate suicidality.

The presence of an NSSI diagnosis would provide a research-based definition that would prevent clinicians and researchers from confusing NSSI with BPD or suicidal behavior. Furthermore, it would enhance inter-professional communication and communication between professionals and patients regarding this behavior (In-Albon et al., 2013). The presence of a separate diagnostic category would encourage NSSI research, particularly on NSSI-specific treatments. Unfortunately, there is scant research about the treatment of NSSI, probably in large part because it has not been its own diagnostic entity. Most research studies look at the treatment of NSSI under the umbrella of BPD and suicidality. In this regard, dialectical behavior therapy (DBT) has been found to reduce the frequency and severity of NSSI. DBT was originally designed to treat BPD, and its use has been expanded to treating adolescents with suicidal tendencies (Linehan et al., 2006; Washburn, Gebhardt, Styer, Juzwin, & Gottlieb, 2012). As discussed above, NSSI is distinct from BPD and suicidality, and therefore, approaches specific to NSSI must be studied. Last, creating a distinct diagnostic category for NSSI would elevate the visibility of this behavior, bringing awareness to the issue and ensuring that clinicians treat it seriously (Wilkinson & Goodyer, 2011). All of these clinical benefits present further support for the addition of NSSI as a disorder in the DSM.

Does NSSI Meet all the DSM Requirements of a Mental Disorder?

DSM-5 Working Definition for a Mental Disorder

The DSM-5 working definition defines a mental disorder as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (American Psychiatric Association, 2013, p. 20). Additionally, mental disorders cannot be an expectable or culturally accepted response to stress or loss or socially deviant behavior that is primarily a conflict between the individual and society (American Psychiatric Association, 2013).

NSSI is a disturbance in behavior that involves repetitive self-injuring. This behavioral pattern reflects an underlying psychological dysfunction, which centers on difficulties regulating emotions as well as preoccupation with self-injury and urges to self-injure (In-Albon et al., 2011; Klonsky & Glenn, 2008). There are possible biological correlates, such as altered serotonergic function and endogenous opiate function, which may increase an individual's chance of engaging in NSSI by affecting responses to stress and levels of pain tolerance (Jacobson & Gould, 2007). This behavior pattern is also associated with significant distress as evidenced by all of the problematic consequences that result from engaging in NSSI. It is important to note that NSSI is associated with levels of distress and impairment comparable to levels seen in individuals diagnosed with other Axis I disorders (Selby et al., 2012). Furthermore, it is not an expectable or culturally sanctioned response to stress or loss. Therefore, NSSI fulfills the criteria of a mental disorder according to the DSM-5.

Benefit versus Harm of Creating an Independent Diagnosis

In proposing the creation of a separate diagnostic category for NSSI, it is important that the potential benefits of doing so outweigh the potential harms. The creation of NSSI disorder has many benefits, including motivating new research and improving patient care through more targeted diagnosis and treatment (Selby et al., 2012). In addition, the creation of this new diagnostic category would help to further distinguish behaviors of suicidal intent from behaviors of self-injury.

The misclassification of NSSI as suicidal in nature, which is commonly reported by adolescents, leads to inappropriate and potentially unnecessary responses such as hospitalization. Clearly differentiating NSSI from suicide would result in decreased hospital admissions for individuals engaging in NSSI (Glenn & Klonsky, 2013).

A possible disadvantage of creating this new diagnosis is the potential for increased stigmatization of self-injurious behaviors (Zetterqvist, Lundh, Dahlstrom, & Svedin, 2013). While this is possible, individuals who engage in NSSI already experience stigma. Creating a new diagnosis will likely bring increased attention and awareness to the condition in the community at large. A second disadvantage is that by defining the condition as "non-suicidal," people may begin to perceive NSSI as less severe or important, decreasing the significance of treatment. However, it is also likely that the presence of an independent diagnostic category for NSSI will increase awareness, leading to improved assessment and treatment (Wilkinson, 2013). Thus, the potential benefits of creating a diagnosis of NSSI greatly outweigh the potential harms, further strengthening the case for the creation of a distinct diagnostic category for NSSI.

Conclusion

Recently, NSSI has gained attention in regards to its legitimacy as a diagnosis in the DSM. As discussed above, there are many reasons why NSSI deserves to be a distinct diagnostic entity: (a) the prevalence and pervasiveness of NSSI is extensive; (b) many problematic outcomes stem from engagement in NSSI; (c) NSSI is distinct from suicidal behaviors; (d) there is significant research indicating that NSSI is often present in individuals not diagnosed with BPD; (e) there is considerable clinical utility to having NSSI as its own diagnosis; and (f) NSSI meets the standards for a mental disorder according to the DSM-5. While more research is needed regarding the specific diagnostic criteria, there is no reasonable doubt that NSSI should be a diagnosable disorder.

The addition of NSSI as a diagnosis in the DSM has immense implications for the field of social work. This change in diagnosis would largely impact the work of clinical social workers that work with adolescents in psychiatric settings, as this is the population most likely to present with NSSI. It will bring awareness to and stimulate new research regarding NSSI, which will increase social workers' understanding of the

disorder. Additionally, establishing a diagnosis of NSSI will encourage research regarding NSSI-specific treatments. This will increase social workers' competence in regards to diagnosis and treatment, resulting in improved patient care. According to the NASW Code of Ethics "the primary mission of the social work profession is to enhance human wellbeing" (National Association of Social Workers, 2008). Creating an independent diagnostic category for NSSI in the DSM would be a crucial step in fulfilling this goal.

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