Defining intent

With preparations underway for DSM-5, is there a case for a new diagnostic category of non-suicidal self-injury?

The recently proposed diagnostic category for inclusion in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), ‘non-suicidal self-injury’ (NSSI), has generated extensive debate among clinicians and researchers with regard to the available evidence base and implications for assessment, treatment and prevention. It is timely to review the evidence base and highlight potential implications.

Background

In the US, preparations are underway for the next edition of the DSM (DSM-5) which will be published in 2013. One of the newly proposed diagnostic categories for inclusion is non-suicidal self-injury (NSSI). NSSI refers to intentional destruction of one’s own body tissue (eg. cutting, burning, hitting) without suicidal intent and for purposes not socially sanctioned.1-3

Researchers and clinicians working in the area of self-harm and suicide have expressed concerns about the lack of transparency in the development of new diagnostic categories for DSM-5.4 In addition, concerns have been reported in relation to the proposal to include a diagnostic category for NSSI due to lack of sufficient evidence4 and potential negative implications for assessment, treatment and prevention.5

Terminology and definition

Research into the epidemiology and aetiology of suicidal and self-harming behaviour is hampered by the lack of agreement on terminology and definitions. For example, over the years different terms, such as ‘self-injury’, ‘parasuicide’, ‘attempted suicide’, ‘deliberate self-harm’ and ‘self-harm’ have been used to indicate varying types of intentional self-harming behaviours (eg. self-cutting, intentional overdose) with varying degrees of suicidal intent and varying underlying motives. Reaching agreement on the terminology and definition is further complicated by the varying levels of suicidal intent and heterogeneity of motives reported by people engaging in self-harming behaviour.7,9

In many studies in Ireland and internationally the following definition of deliberate self-harm is used: An act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences.10 The definition includes acts involving varying levels of suicidal intent and various underlying motives, such as loss of control, self-punishment or cry for help.

Suicidal intent and motives

Varying levels of suicidal intent and motives are reported by people engaging in self-harming behaviour presenting to hospital10 and those with less lethal self-harm who do not come to the attention of health services.5,6 Motives associated with self-harming behaviour include wish to die, self-punishment, revenge, escape from an unbearable situation, seeking attention and tension relief.5,4

Recent research among young people engaging in self-harm revealed that the majority report multiple and often contradictory motives underlying this.8,9 The majority of young self-harmers reported both death-oriented and non-death-oriented motives (eg. seeking attention) at the time of their self-harm act, which reflects ambivalence rather than a static condition.8 Consequently, the need to improve assessment procedures to determine the degree of suicidal intent among people engaging in self-harm has been highlighted as a key priority rather than the need to distinguish between those with and without suicidal intent.7,9 This view is further supported by evidence that suicidal intent is a fluid rather than
NSSI. According to Nock et al (2006) and limited research has been conducted into research into non-suicidal self-injury contradicts a dichotomous concept. Reflects the complexity of self-harm and the dimensionality of self-harm severity. Consistent evidence on homogeneously significant and clinically meaningful self-harm subgroups has identified statistically validated interview schedules or questionnaires to obtain information on the degree of certainty that suicidal intent was not included. This raises questions about the degree of certainty that suicidal intent was absent during acts of self-injury that were classified as NSSI.

Implications

The research as summarised above does not support the inclusion of NSSI as a new diagnostic category. The available evidence indicates that NSSI is a behavioural phenomenon that may be associated with various psychiatric disorders, but there is no convincing evidence that NSSI in itself is a psychiatric disorder that requires inclusion in a classification system for mental disorders.

From a pragmatic point of view, it may be desirable and advantageous to have access to an NSSI diagnostic category. However, a patient receiving an NSSI diagnosis may conceal fluid suicidal intent which, by being labelled as NSSI, may increase the risk that suicidality may go undetected and consequently also increase the risk of not receiving the appropriate clinical attention which prevents low suicidal intent developing into moderate or high suicidal intent.

The assumption that all episodes labelled as NSSI are not suicidal behaviours cannot be tested at the epidemiological level. Therefore, such behaviours which have previously been included under the category of deliberate self-harm or self-harm would not be included. Given the association between NSSI and suicide attempts described above, this could prevent the identification of a significant group of people who are at risk for further suicide attempts and who could benefit from targeted interventions. On an individual level, identifying self-cutting as a coping mechanism can be very effective with adolescent self-harmers who are more likely to show problem-solving deficits. However, NSSI even without suicidal ideation is a marker for distress among people who have difficulty expressing emotions and care needs to be taken not to underestimate their distress and therefore induce higher-risk behaviours.

In summary, while the proposed NSSI category appears to be a pragmatic solution to a longstanding issue among psychiatrists regarding repetitive self-harming behaviour that clinically needs to be distinguished from suicide attempts, the distinction is not clear-cut, with significant overlaps in terms of past history and future risk of suicidal behaviour. In addition, the proposed category is likely to become intrinsically and probably excessively linked with borderline personality disorder, with consequent underestimation of the degree of distress and treatment needs of those involved. Therefore, at present the evidence would not support NSSI as a separate diagnostic category but it may have a useful place as a subtype of self-harm at an individual clinical level.

Declaration of interest: none.

Acknowledgements: The National Suicide Research Foundation is in receipt of funding from the National Office for Suicide Prevention.

References available on request.