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Nonsuicidal self-injury disorder: Clinician and expert ratings

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ABSTRACT

Nonsuicidal self-injury (NSSI) is a growing clinical and public health problem that affects individuals from all age groups, most prominently young adults. NSSI involves numerous methods and functions. NSSI has long been associated with borderline personality disorder (BPD), and in fact, it is only referenced among the diagnostic criteria of BPD in the DSM-IV-TR. However, recent studies have provided strong evidence that NSSI occurs outside of BPD. For these reasons, a diagnosis of nonsuicidal self-injury is included in DSM-5 Section-III as a condition that requires further study. The primary purpose of the present study was to identify whether the proposed DSM-5 NSSI criteria adequately reflect the symptoms of a prototypic individual who engages in self-injury. Clinicians in private practice and expert NSSI researchers ($n=119$) were asked to describe their familiarity and agreement with the proposed DSM-5 NSSI criteria, as well as the degree to which each proposed criterion is a prototypic symptom. Overall, most participants reported that the proposed DSM-5 criteria for NSSI accurately captured the behavior of the prototypic self-injurer. The results of this study provide incremental support for the proposed DSM-5 NSSI diagnostic criteria.

1. Introduction

Nonsuicidal self-injury (NSSI) is a clinical problem of growing significance. NSSI presently is defined as, "the direct, deliberate destruction of one's own body tissue without suicidal intent" (Nock, 2009, p. 9). Important to its conceptualization, NSSI does not include behaviors that are socially sanctioned (e.g., body piercing, tattoos) or behaviors that are "of a common and trivial nature, such as picking at a wound or nail biting" (Shaffer and Jacobson, 2009, p. 4). There have been at least 14 NSSI methods recognized, of which skin cutting is the most common (Klonsky, 2007). Other prominent methods include skin carving, puncturing, scratching, or burning, as well as hitting oneself and ingesting harmful substances. Notably, many individuals engage in more than one method of NSSI (Nock, 2009).

NSSI prevalence rates vary by age group. Data suggests lifetime prevalence rates between 4% and 38% within adult populations (Shaffer and Jacobson, 2009), between 13% and 23% in adolescents (Jacobson and Gould, 2007) and 12% and 38% (Brown, 2009) among college students. Young adults between the ages of 18 and 25 are believed to be at the greatest risk for engaging in NSSI (Rodham and Hawton, 2009).

The occurrence of self-injurious behaviors appears to be increasing, especially among adolescents and college students (Muehlenkamp, 2005). Of further concern, approximately 50 to 75% of individuals with an NSSI history later make a suicide attempt at some point (Nock et al., 2006). Risks of suicidality or accidental death are not the only dangers associated with NSSI. Additional medical problems can arise from the destruction of tissue, infection, and poisoning, to name a few. NSSI also may obstruct social relationships as well as medical treatment and psychotherapy (Fliege et al., 2009).

The reasons that individuals engage in NSSI are quite diverse. Some of those functions include, but are not limited to, affect regulation, self-punishment, sensation seeking, interpersonal influence, and autonomy (Klonsky and Glenn, 2009). Notably, self-injurers often endorse that their self-harm serves multiple functions (Klonsky, 2009).

1.1. NSSI and DSM

NSSI was not well represented in the DSM-IV-TR (American Psychiatric Association, 2000). In fact, the only place that NSSI previously was referenced was within the diagnostic criteria for borderline personality disorder (BPD), a disorder characterized by "a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity" (APA, 2000, p. 706). Specifically, NSSI is included within criterion 5 of BPD, "recurrent suicidal behavior, gestures, threats or self-mutilating behavior" (APA, 2000, p. 710). As a result, NSSI has long been conceptualized as, and often limited to, a symptom that is pathognomonic to BPD (APA, 2012).

However, NSSI also occurs within individuals who do not meet the criteria for BPD (see Shaffer and Jacobson, 2009; Selby et al., 2012).

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NSSI also is related to other maladaptive mental health outcomes, such as depression, anxiety, and suicidality (Glenn and Klonsky, 2010). Accordingly, professionals have suggested for at least the past three decades that NSSI should stand alone as a distinct diagnosis (Selby et al., 2012). In February 2010 it was proposed that a nonsuicidal self-injury disorder be officially considered for entry into the DSM (see APA, 2012). While NSSI disorder was not adopted as an official diagnosis in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), it is currently represented in DSM-5's Section III: Emerging Measures and Models as a condition that requires further study.

The support for NSSI as a standalone diagnosis in future diagnostic manuals is compelling. In their proposal for an NSSI diagnosis, Shaffer and Jacobson (2009) asserted, "any new disorder in DSM must be common, impairing, and distinctive, both with respect to clinical presentation and antecedent and future characteristics" (p. 10). Shaffer and Jacobson (2009) provided evidence that NSSI meets all of these criteria. NSSI has significantly high prevalence rates among various age groups and can lead to physical, social, emotional, and academic impairment. Additionally, NSSI behaviors can occur apart from and can be clearly distinguished from suicide attempts (Shaffer and Jacobson, 2009). Wilkinson and Goodyer (2011) suggested that an NSSI diagnosis in the DSM-5 would lead to improvements in treatment and research, communication among clinicians and researchers, prognosis regarding associated symptoms (e.g., being at increased of suicidality) and reduction in problems associated with the lack of an NSSI diagnosis (e.g., a clinician wrongly assuming a self-injurer has BPD).

Furthermore, Selby et al. (2012) found significant differences between individuals with BPD, self-injurers without BPD, and a clinical comparison group consisting of individuals without BPD or NSSI. Specifically, they found that the NSSI group had comparable levels of psychopathology and impairment to the BPD group, and more than the comparison group. Furthermore, the NSSI group reported higher depressiveness, anxiety, and suicidality than the comparison group. Such findings further suggest that NSSI may be considered a unique clinical condition.

Thus, there is mounting evidence that NSSI warrants its own diagnosis. Criteria for the diagnosis were posted in March 2010 (see Table 1) and have been included in DSM-5 Section III. The opinions and concerns of clinicians and NSSI researchers perhaps should be considered when assessing the criteria for the NSSI, as these are the professionals who would be using the diagnosis. For this reason, the current study surveyed practicing clinicians and expert NSSI researchers to obtain a better understanding of professionals' opinions regarding the validity of the proposed DSM-5 NSSI diagnostic criteria with respect to how well each describes the prototypic self-injurer.

2. Methods

2.1. Participants

The present study surveyed practicing clinicians as well as expert NSSI researchers. Clinicians in private practice were randomly selected from the American Psychological Association division whose members are involved primarily in private practice (e.g., Division 42). NSSI researchers were identified through electronic searches of the psychological and psychiatric literature by using NSSI-related search terms. To be included, an individual had to have at least one publication on the topic of NSSI in a peer-reviewed journal. In total, 1000 clinicians and 224 NSSI researchers were invited to participate.

Of the 1224 clinicians and researchers solicited, 16 declined to participate and 86 envelopes were returned as undeliverable. A total of 119 individuals responded (10.6% response rate); 22 participants had incomplete forms and were not included in the data analysis. Participants (53 male, 44 female) ranged in age from 24 to 89 (M=55.65, SD=13.65). Among the sample, 83.20% of the participants described themselves as Caucasian, 3.40% were Hispanic, and 7.60% reported "Other". Seven participants (5.90%) did not report their ethnicity. Most participants graduated with a Ph.D. (n=79, 81.4%). Participants' professional experience ranged from 1 to 56 years, with an average of 24 years since earning their degree (SD=12.52). Participants spent an average of 61.85% of their time engaging in direct clinical services (SD=39.73%) and 12.68% of their time engaging in empirical research (SD=25.06%).

Various professional subfields were represented (60.8% clinical psychology, 15.5% counseling psychology, 3.1% education, 2.1% psychiatry, 1.0% social work, and 3.1% other), as were various theoretical backgrounds (71.1% cognitive, 47.4% psychodynamic, 41.2% behavioral, 38.1% interpersonal, 23.7% systems, 19.6% humanistic/gestalt, 19.6% neurobiological and 12.4% other; each participant was allowed to endorse more than one orientation).

2.2. Materials

2.2.1. Demographic form

Participants completed a demographic survey that asked for gender, age, ethnic background, marital status, and highest degree completed. Participants were also asked to provide information regarding their sub-field (e.g., clinical, counseling), theoretical orientation, and the percentage of time they spend directing providing clinical services as well as engaging in empirical research. Moreover, participants were asked to indicate their familiarity with the NSSI construct and the proposed DSM-5 NSSI diagnosis (1=not at all, 2=vaguely, 3=average, 4=moderately, 5=very). Participants who were at least vaguely familiar with the DSM-5 proposal were asked to rate their general attitude toward the proposed approach to NSSI (1=very unfavorable, 2=moderately unfavorable, 3=average, 4=moderately favorable, 5=very favorable).

2.2.2. NSSI prototype survey

Participants were asked to describe a prototypic NSSI case in terms of the proposed DSM-5 NSSI criteria[1] (see Table 1). For Criterion A, participants were asked to indicate whether or not the four separate components represented a prototypic case of NSSI. The breakdown of Criterion A into respective components may be found in Table 2. Participants provided ratings for Criteria B and C (see Table 2) on a five-point Likert scale with respect to the degree in which each symptom represented the prototypic self-injurer (1=absent symptom, 2=subthreshold symptom, 3=threshold symptom, 4=moderate symptom, 5=prototypic symptom). Respondents also were able to provide open-ended comments for each of the questions.

2.3. Procedure

Practicing clinicians and NSSI expert researchers were contacted (on approximately 11/07/2011) via postal mail to ask them to participate in the survey. Included in the envelope were a letter introducing the study and inviting the individual's participation, a demographic form, the NSSI prototype survey, and a stamped business reply envelope. As a reminder, the sample was contacted via email (on approximately 01/24/2012) and offered the opportunity to participate in an online version of the study. Within the email, participants were provided with the survey's URL to a secure internet-based data collection service (SurveyGizmo). Participants completed the same materials in electronic form using SurveyGizmo. It is noted that those who had participated via postal mail as well as those who declined to participate were asked not to participate in the online version of the survey.

3. Results

Participants reported that they were "moderately" familiar with the NSSI construct (M=3.98, SD=1.13) and "vaguely" familiar with the proposed DSM-5 NSSI diagnostic criteria (M=2.28, SD=1.36). The participants that reported being at least "vaguely" familiar with

[1] The present study utilized the original NSSI disorder criteria proposed by Shaffer and Jacobson (2009), which is organized differently than the criteria published in DSM-5 Section III (APA, 2013) though the content was largely unchanged. Specifically, the clause "for purposes not socially sanctioned" of the proposed Criterion A is now expanded into Criterion D in DSM-5. Proposed Criteria B1, B2, and B3 have been revised to Criteria C1, C2, and C3, respectively (requiring at least one of the sub-criteria). DSM-5 Criterion C1 also includes "interpersonal difficulties" as a possible precursor to NSSI (along with negative feelings or thoughts). Criterion B4 has been expanded into its own criterion (DSM-5 Criterion B), with each aspect (i.e., to obtain relief from a negative feeling or cognitive state; to resolve an interpersonal difficulty; to induce a positive feeling state) serving as sub-criteria, requiring one or more for diagnosis. Finally, proposed Criteria C and D have been re-organized as Criteria E and F, respectively.