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Nonsuicidal self-injury disorder: The path to diagnostic validity and final obstacles

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HIGHLIGHTS

- Non-suicidal self-injury (NSSI) disorder is a condition for further study in DSM-5.
- We highlight evidence supporting NSSI disorder and barriers to its validity.
- A major barrier includes distinguishing NSSI disorder from existing conditions.
- Other barriers include determining its longitudinal stability and its clinical utility.
- Current evidence provides a strong foundation for the validity of NSSI disorder.

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ABSTRACT

After decades of researchers calling for the creation of a self-injury syndrome, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* listed Nonsuicidal Self-Injury (NSSI) disorder as a condition for further study. The purpose of this review is to provide information about the current status of research on NSSI disorder, current arguments for and against the disorder's creation, and areas that require further research. Specifically, we address the five biggest obstacles to validation: the need for clear delimitation from other psychiatric disorders as well as suicidal behavior, the need to fully explore the developmental course of the disorder, empirically establishing the most appropriate diagnostic criteria, and the potential clinical utility of creating a new disorder. With further research in these key areas, we expect that there will soon be enough evidence for the validity of NSSI disorder to warrant its inclusion in a future edition of the *DSM*.

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1. Nonsuicidal self-injury disorder: the path to diagnostic validity and final obstacles

The publication of the most recent revision of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013) constituted a significant step forward in the establishment of Nonsuicidal Self-Injury (NSSI) disorder by identifying it as a "condition for further study," indicating that it may eventually be adopted as a disorder in future versions of the *DSM*. Researchers have been calling for the creation of NSSI disorder since the early 1970s, although not without controversy. There is a growing set of problems with our current diagnostic system, as well as a potentially excessive expansion of unnecessary diagnoses (Frances, 2013). These issues notwithstanding, it is our opinion that existing evidence supports the potential inclusion of NSSI disorder in a future version of the *DSM*. However, the creation of a new disorder in the *DSM* requires sufficient and compelling evidence supporting such action.

In order to justify the inclusion of NSSI disorder in future versions of the *DSM* as a fully validated psychological disorder, several areas of further research are needed. The path toward validity for NSSI disorder is stymied, however, by the absence of a clear outline and discussion of the remaining obstacles. The purpose of this review is to: 1) highlight the current understanding, history, and status of NSSI disorder; 2) explicate and address remaining obstacles to the establishment of this disorder; 3) examine the clinical utility of the diagnosis; and 4) outline what further evidence is needed to validate NSSI disorder. In these ways, this review provides a scaffolding to investigate NSSI disorder, and ultimately makes the case that the disorder should be included in future versions of the *DSM*.

2. Current and historical understandings of NSSI

In order to ground our discussion on NSSI disorder, for which the current DSM-5 proposed diagnostic criteria are displayed in Table 1, it is essential to briefly present some background on the nature and function of NSSI.[1] NSSI is defined as the direct and deliberate destruction of one's own body tissue in the absence of lethal intent (Nock, 2010, p. 340). The most common method is skin cutting (70%–90%), followed by head banging or hitting (21%–44%) and burning (15–35%; Klonsky, 2007), however most individuals who engage in NSSI employ multiple methods (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Other forms of NSSI include scratching to the point of drawing blood, pinching, hair pulling, and breaking one's bones purposefully (Gratz, 2001). Some research suggests that NSSI is more common and more stable in women than in men, (Bjärehed, Wångby-Lundh, & Lundh, 2012; Moran et al., 2012; Zetterqvist, Lundh, Dahlström, & Svedin, 2013), but other studies have failed to find differences in rates of NSSI by gender (Nock et al., 2006). Research examining the effects of race on NSSI is similarly inconsistent (Andover, 2014; Jacobson, Muehlenkamp, Miller, & Turner, 2008; Klonsky & Olino, 2008; Muehlenkamp & Gutierrez, 2004), although the literature is limited by the dearth of non-Caucasian samples.

Epidemiological research consistently indicates high prevalence rates of NSSI. Prevalence rates of NSSI fall between 13% and 45% among adolescents (Bentley, Nock, & Barlow, 2014; Muehlenkamp, Claes, Havertape, & Plener, 2012). Among adults, prevalence rates range from 4% to 28% (Bentley et al., 2014; Briere & Gil, 1998; Shaffer & Jacobson, 2009). These potentially high rates of NSSI are alarming, given that the behavior is associated with numerous deleterious consequences, including severe scarring, nerve damage, risk for contraction of infectious diseases, and accidental death (Doshi, Boudreaux, Wang, Pelletier, & Camargo, 2005). NSSI is also associated with academic difficulties, rejection and stigmatization by peers, interpersonal problems, emotional distress, and increased risk of suicide (Asarnow et al., 2011; Favazza, 1998; Klonsky, 2009). Furthermore, NSSI has been found to be as strong, or almost as strong, of a predictor of future suicide attempts as past suicide attempts (Cox et al., 2012; Guan, Fox, & Prinstein, 2012; Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, 2011).

Although a detailed discussion of the functions of NSSI is beyond the scope of the current paper, extensive research has been conducted on

Table 1
Summary of *DSM-5* (APA, 2013) Criteria for Nonsuicidal Self-Injury Disorder.

A. In the last year, the individual has on 5 or more days engaged in NSSI that was severe enough to cause minor or moderate damage, but without suicidal intent
B. The individual engages in NSSI with one or more of the following expectations:
1) to obtain relief from a negative feeling or cognitive state
2) to resolve an interpersonal difficulty
3) to induce a positive feeling state.
C. NSSI is associated with at least one of the following:
1) interpersonal difficulties or negative feelings or thoughts immediately precede engagement in NSSI
2) a period of preoccupation with NSSI precedes the NSSI
3) NSSI urges or thoughts occur frequently even if not acted upon.
D. The behavior is not socially sanctioned or restricted to picking a scab or nail biting
E. NSSI causes significant distress or impairment in important areas of functioning
F. NSSI does not occur exclusively in a state of psychosis, delirium, or intoxication and cannot be accounted for by another medical or psychological disorder

[1] Self-injury has been given a variety of names over the past few decades including: cutting, self-mutilation, parasuicidal behavior, deliberate self-harm, and self-injurious behavior. For the sake of consistency and distinguishing between suicidal and nonsuicidal behavior, we will use the term "NSSI" throughout this review, although other studies discussed may have used different terminology.