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Article 6

Therapy on the Cutting Edge: Supportive Perspectives of the Inclusion of Self-Injury in the DSM-V

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Introduction

Currently, there is no formal diagnosis for self-injury to be found in the most prominent source for mental health professionals, the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, [*DSM-IV-TR*], 2000). Self-injurious behavior may be the newest teen disorder sweeping the nation and support to include a formal diagnosis of self-injury in the newest manual, the *DSM-V*, is growing. Research continues to support the belief that non-suicidal self-injury is growing among teenagers, reaching younger students, and often continuing to be an issue for young people throughout early adulthood. For the mental health professional, accurately diagnosing and treating can be especially difficult, particularly since self-injury is not listed as a stand-alone diagnosis in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (2000). Currently, this diagnostic manual includes self-injury as a symptom of or associated with Borderline Personality Disorder (BPD), as shown in Table 1. Yet many practitioners find their clients do not easily fit into that diagnostic category. This article will seek to examine the significance and implications for the inclusion of self-injury in the *DSM-V*. Attention will be given to rationale for the diagnosis, contemporary issues facing therapists and clients, and practical suggestions for effective therapeutic intervention strategies. The inclusion of self-injury as a diagnosis in the *DSM-V* will assistant professionals as they seek to define

the problem of self-injury, describe the profile of self-injurers more clearly, and develop a plan for education, intervention, and prevention as it relates to the disorder.

Defining the Problem

There are a variety of titles and definitions when it comes to self-injury. Self-injury is referred to as non-suicidal self-injury (NSSI), self-injurious behavior (SIB), self-mutilation (SM), self-cutting and/or cutters, and self-injury (SI). According to Lloyd-Richardson, Perrine, Dierker, and Kelley (2007):

> Non-suicidal self-injury (NSSI) is most commonly described as deliberate, direct destruction or alteration of body tissue without conscious suicidal intent (Pattison & Kahan, 1983; Favazza, 1998). NSSI is deemed socially un-acceptable (as opposed to ear piercing, for instance), direct (and thus differentiated from indirect self-harm, such as drinking and driving), repetitive (Briere & Gil, 1998), and leads to minor or moderate harm (Suyemoto, 1998). NSSI is commonly encountered in in-patient (Favazza, 1989) and out-patient (Esposito *et al.*, 2003) psychiatric and other institutionalized settings (Penn *et al.*, 2003) and most of what is known about NSSI is derived from these populations. (p. 1183)

While defining the problem of self-injury is the initial step, assessing the problem is the key to intervention and treatment. Assessing the very presence of self-injury is often a task in itself. Whitlock, Eckenrode, and Silverman (2005) concluded in their research "medical providers and therapists see a significant number of adolescents and young adults that they may fail to recognize as self-injurious" (p. 1946). Without a guide for diagnosing self-injurious behavior, the therapist is often left trying to determine the type and severity of the behavior.

Calculating self-injury's severity is difficult because of the lack of significant studies targeting population types, regions, causes, and contemporary issues affecting mental health in general. Attempting to assign numbers for statistics is a complex task. It is safe to assume, however, that self-injury continues to grow in popularity and intensity as well as including younger people. Galley (2003) concluded "the behavior is becoming more prevalent among teenagers, forcing administrators, teachers, and other school staff members to confront the disturbing issue" (p. 1). And it seems technological advances within our contemporary culture only exacerbate the problem of self-injury. Whitlock, Powers, and Eckenrode (2006) found that the internet and other forms of contemporary communications have not only served to increase the number of self-injurers, but provided them with a forum which tends to "normalize and encourage self-injurious behavior and add potentially lethal behaviors to the repertoire of established adolescent self-injurers and those exploring identity options" (p. 407).

As to severity, self-injury is more than a fad. Research has found self-injury is typically learned from someone who is already engaged in self-injurious behavior. What may be a rational alternative for one may likely become a tragedy for another. Many self-injurers commit suicide either intentionally or accidentally. Nock, Joiner, Gordon, Lloyd-

Richardson, and Prinstein (2006) discovered "70% of adolescents engaging in NSSI reported a lifetime suicide attempt and 55% reported multiple attempts" (p. 65). Others place themselves in at-risk situations. Brown, Houck, Hadley, and Lescano (2005) found "that those who self-cut were three and a half times more likely to report infrequent condom use than those who did not self-cut…and that self-cutting is strongly associated with sexual risk behaviors." Having a stand-alone diagnosis that accurately delineates the factors involved in self-injury could also preface the realization of other psychological problems.

Describing the Profile

Attempting to find constant correlations, profiles, definitions, and strategies relating to self-injury is extremely difficult. Some studies have attempted to generalize the key components of a self-injurer's profile. Many studies that have been conducted on teen self-injurers have been done in the northeastern part of the nation or the west coast. Conducting their study in Rhode Island, Brown et al. (2005) found "among a large sample of adolescents who were in intensive psychiatric treatment, self-cutters were significantly more likely to be female, to be white, and to have histories of sexual abuse" (p. 218). Lloyd-Richardson et al. (2003) conducted a survey of Mid-western and Southern students and concluded "fifty-seven per cent of the sample was female. The average age was 15.5 years (S.D.=1.18). In terms of racial/ethnic composition of the entire sample, 50.9% were African-American (*n*=317), 43.7% (*n*=272) Caucasian" (p. 1185). Summing up many of these studies, the classic silhouette of a self-injurer tends to be a cutter, teenaged, female, middle class, and having some form of clinical mental health issue.

But working with this kind of profile is becoming critically more problematic because this profile does not lend itself to a blanket application overall. Whitlock et al. (2005) found little research to substantiate the claim that self-injurious behavior was most prevalent among Caucasian females from middle to upper middle class families (p. 1940). An ongoing study by these authors has found in South Texas the profile to be more likely Hispanic, to include both male and female, and to be more closely related to community oriented than demographic or socio-economic factors. Additionally, those students engaging in self-injury in the coastal bend regions of South Texas are not likely to be of the clinical population. The task of developing and implementing intervention and treatment strategies becomes problematic as certain questions arise:

- How does culture affect both the cause and cure of self-injury disorder?
- Is it possible that intervention and treatment strategies are to be considered from regional and cultural perspectives?
- Particularly in rural or urban clustered areas or in places where mental health services are not readily available, can the existing school districts play an important role in delivery of treatment services?
- How effective would proactive measures be in these communities/regions particularly in the younger school aged populations and their families?

Given these types of questions, it becomes imperative to the mental health professional and the clients whom they serve to have a diagnostic model that transcends the current *DSM-IV-TR*'s perspective of self-injury. Table 2 exemplifies the proposed revision for the *DSM-V* to include self-injury as a standalone diagnosis. Research indicates self-injury does not exclusively pertain to clinical populations of clients. Klonsky, Oltmanns, and Turkheimer (2003) proposed that self-injury could occur in non-clinical populations as well.

> Although research findings are consistent with the idea that deliberate self-harm is an important symptom of borderline personality disorder, studies have also indicated that self-harm occurs across a variety of diagnoses, as well as in nonclinical subjects. As a result, many researchers study deliberate self-harm as a behavioral phenomenon in its own right, rather than as a symptom of borderline personality disorder… At present, a basic understanding of self-harm, including its classification, diagnosis, and treatment, is still lacking. (p. 1501)

The inclusion of self-injury in the *DSM-V* has far reaching implications. First, practitioners will have a more efficient way of diagnosing self-injurious behavior. Second, mental health professionals will be more likely to detect the presence of self-injury as they work with clients with other presenting issues. Third, this very existence of a diagnostic tool may help researchers understand in more detail the profile of the self-injurer. It may very well come down to a contemporary enigma that cannot be contained in mere demographic, ethnic, or racial terms. Rather, self-injury may be evolving into a contemporary disorder brought on by a dynamically changing series of societal, technological, economical, and sociological stressors.

Developing a Plan

Awareness and Education

The necessity of self-injury as a stand-alone diagnosis in the DSM-V is imperative to creating a sense of awareness of the problem, developing strategies for intervention and prevention, and guiding further research into this emergent phenomenon. Klonsky (2007) noted "we continue to lack a sufficient understanding of the functions of self-injury. This understanding would inform treatment, and provide a meaningful context for research on the etiology, classification, prevention, and treatment of self-injury" (p. 227). Awareness and education is the pivotal and key next step if and when the disorder of self-injury is embraced diagnostically. Education of parents, students, counselors, teachers, administrators, and community leaders is essential if effective treatment and intervention can be developed. Even many counselors are not well equipped to work with self-injurers. Roberts-Dobie and Donatelle (2007) discovered that while most school counselors admitted to being the appropriate persons to contact when a student self-injures, "they did not self-report high levels of knowledge on the topic" (p. 260). According to Carlson, DeGeer, Deur, and Fenton (2005), concern with this "growing phenomenon" is perplexing school administrators, teachers, and mental health practitioners as they search for answers to their questions, as very little concrete information has been found in the last seventy years of research:

> The lack of knowledge of cutting behavior within the field of mental health is a cause for alarm. As many schools are beginning to recognize the increased number of self-cutting students, it is important for clinicians to assess teachers' and staff members' understanding of the behavior, help teachers and staff become more educated about self-cutting behavior, and create and implement strategies for identifying and serving adolescent self-cutters. (p. 2)

Without an official diagnostic guide, school and mental health professionals struggle to find effective strategies for helping clients and communities address the growing self-injury phenomenon. With the beginning of the adolescent stage beginning earlier than in recent past, it is vital that research, education, and implementation about this illness be brought to light at not only the high school level but also middle school (Carlson et al., 2005). White Kress, Gibson, and Reynolds (2004) argued there is a desperate need to educate teachers, counselors, school administration, parents and the general public, as there is little to nothing known about the treatments let alone the correct identification of the behavior. Therefore, it is especially important to educate the school counselors in the areas of identification and intervention strategies since these behaviors begin in the early adolescent stage and the counselors (along with their teachers) see the students on a regular basis.

Prevention

According to the Cornell Research Program on Self-Injurious Behavior (2010), the subject of prevention as it relates to self-injury is an area begging for more research. The lack of an identifiable diagnostic criterion may have contributed this lack. Without identifiable patterns of behavior, research has no clear focus. Most of the discussion concerning prevention is qualitative in nature and often vague. White Kress et al. (2004) stated:

> prevention efforts can include helping students to express and identify their feelings, while also developing healthy behavioral coping skills. Group counseling and counselor outreach activities that encourage at-risk students' development of these aforementioned skills may be helpful in preventing self-injury. Prevention efforts can also occur by providing pamphlets and handouts to students. Materials concerning self-injury can be distributed through health classes or directly through the school counseling office. (p. 9)

Most counseling professionals would agree that self-injury is rarely seen in the elementary school years. Hence, prevention plans could involve working with the parents, students, teachers, and counselors preparing the elementary students for transition to the older grades where self-injury predominately manifests itself.

Conclusion

Clearly, research has shown that non-suicidal self-injury has grown significantly among teenagers and the trend is reaching younger students. With this in mind, it is vital that mental health practitioners be given the tools in which to diagnose this disorder and

begin intervention and treatment for a disease that has been a silent predator in our young people's lives for many years. It is imperative to develop educational strategies for awareness, intervention and prevention for the parents, students, counselors, teachers, administrators, and community leaders. Therefore, the necessity of self-injury as a stand-alone diagnosis in the *DSM-V* is imperative to creating a sense of awareness for the individuals in a position to aid these young victims of this disorder that is becoming so prevalent in today's world.

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Table 1. *Criteria for Borderline Personality Disorder*

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

3. identity disturbance: markedly and persistently unstable self-image or sense of self

4. impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

5. recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

6. affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

7. chronic feelings of emptiness

8. inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

9. transient, stress-related paranoid ideation or severe dissociative symptoms

Note. Adapted from Diagnostic and Statistical Manual of Mental Disorders. Borderline personality disorder (2000). Fourth edition text revision (DSM-IV-TR). Washington, DC: American Psychiatric Association (2000), p. 710.

Table 2. *Non-Suicidal Self Injury (Proposed Revision)*

A. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body, of a sort likely to induce bleeding or bruising or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), for purposes not socially sanctioned (e.g., body piercing, tattooing, etc.), but performed with the expectation that the injury will lead to only minor or moderate physical harm. The absence of suicidal intent is either reported by the patient or can be inferred by frequent use of methods that the patient knows, by experience, not to have lethal potential. (When uncertain, code with NOS 2.) The behavior is not of a common and trivial nature, such as picking at a wound or nail biting.

B. The intentional injury is associated with at least 2 of the following:

1. Negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.
2. Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to resist.
3. The urge to engage in self-injury occurs frequently, although it might not be acted upon.
4. The activity is engaged in with a purpose; this might be relief from a negative feeling/cognitive state or interpersonal difficulty or induction of a positive feeling state. The patient anticipates these will occur either during or immediately following the self-injury.

C. The behavior and its consequences cause clinically significant distress or impairment in interpersonal, academic, or other important areas of functioning.

D. The behavior does not occur exclusively during states of psychosis, delirium, or intoxication. In individuals with a developmental disorder, the behavior is not part of a pattern of repetitive stereotopies. The behavior cannot be accounted for by another mental or medical disorder (i.e., psychotic disorder, pervasive developmental disorder, mental retardation, Lesch-Nyhan Syndrome).

Potential NOS Categories if DSM-5 adopts subtyping NOS categories:

Non-Suicidal Self-Injury Disorder, Not Otherwise Specified (NOS), Type 1, Subthreshold: The patient meets all criteria for NSSI disorder, but has injured himself or herself fewer than 5 times in the past 12 months. This can include individuals who, despite a low frequency of behavior, frequently think about performing the act.

Non-Suicidal Self-Injury Disorder, Not Otherwise Specified (NOS), Type 2, Intent Uncertain: The patient meets criteria for NSSI but insists that in addition to thoughts expressed in B4 also intended to commit suicide.

Note. Adapted from American Psychiatric Association (2010). *DSM-5 development*. Retrieved from http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=443