CONSUMER ISSUES COMMITTEE

DSM-5 Update: Clinical Considerations for Proposed Criteria for Non-Suicidal Self-Injury

Clinical Challenges
Child and adolescent psychiatrists face many clinical challenges. However, the adolescent who presents with a history of non-suicidal self-injury can stir anxiety in even the most seasoned clinician. Counter transference can arise because adolescents may be resistant to stopping a maladaptive coping strategy that provides conscious and unconscious secondary gains. Helpless feelings can arise because caregivers and treatment team members are looking for solutions from the psychiatrist. In addition, the family’s reaction to the self-injury may cause additional distress for the adolescent, which can lead to an increase in self-injurious behaviors. Non-Suicidal Self-Injury (NSSI) has been added to DSM-5 under the section “Conditions for Further Study.” The objectives of this article are to delineate proposed DSM-5 criteria for NSSI and provide relevant clinical information pertaining to management of this condition in adolescents.

What is Non Suicidal Self-Injury?
NSSI is defined as “direct and deliberate destruction of body tissue in the absence of any observable intent to die” (Nock, 2010). The mean age of onset of NSSI reported in various studies is between 12-14 years (Nock, 2009). These behaviors have been the focus of treatment for many individuals. Therefore, proposed criteria for NSSI is included in the newly revised (DSM-5) in the chapter “Conditions for Further Study.”

Risk Factors
A history of anxiety, depression, alcohol misuse, cannabis use, tobacco use, and antisocial behavior were associated with self-injury in one study (Moran, 2011). NSSI was also associated with a history of abuse, poor verbal skills, poor problem-solving skills, poor distress tolerance, genetic predisposition of high emotional and cognitive reactivity, and identification with Goth subculture (Nock, 2010).

Over 90% of adolescents that engage in self-injury meet criteria for a psychiatric diagnosis. The most common diagnoses are depression, substance abuse and dependence, conduct disorder, phobias, and antisocial personality disorder (Ougrin, 2012).

Why Do Teenagers Engage in Self-Injury?
There are many possible explanations as to why adolescents engage in self-injurious behavior. However, talking to

Proposed Criteria for Non-suicidal Self-Injury in DSM-5

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, bruising or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent).

B. The individual engages in the self-injurious behavior 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. The intentional self-injury is associated with at least one of the following:
   1. Interpersonal difficulties or negative feelings or thoughts occurring immediately prior to self-injurious act.
   2. Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to control.
   3. Frequent thinking of self-injury, even when it is not acted upon.

D. The behavior is not socially sanctioned and is not restricted to picking a scab or nail biting.

E. The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic or other important areas of functioning.

F. The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In those with a neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypies. The behavior is not better explained by another mental disorder or condition.
the child or adolescent will be helpful in identifying precipitating and perpetuating factors to self-injury. Some possible explanations (Nock 2010):

- To regulate affect
- To avoid feelings of “numbness”
- To signal personal distress to others and request help
- Self-injurious behaviors are being sustained by positive or negative reinforcement
- Self-punishment after committing acts that have distressed or harmed others

**Suggestions for Intervention**

- Screen for NSSI in each patient.
- Be aware of your own affect and anxiety in response to disclosures of NSSI.
- Maintaining a respectful and curious attitude may elicit more information.
- Ask what factors led to the injury and how they were feeling before and after the self-injurious act.
- Identify high-risk situations where the patient is likely to use self-injury as a coping strategy.
- Introduce Replacement Behaviors: Replacement behavior seeks to substitute the thoughts and urges to self-injure with positive activities, thoughts, and skills. Examples include holding an ice cube or a rubber band around the wrist that is pulled when distressed. More adaptive skills such as talking to others, writing in a journal or other self-soothing techniques may be used (Walsh, 2012).

**Treatment Options**

Dialectical Behavior Therapy (DBT) improves emotional regulation, distress tolerance, and interpersonal effectiveness skills. Recently, DBT has been adapted for adolescents. In all studies, DBT was found to significantly decrease non-suicidal self-injury in adolescents (Nock et al., 2007).

A recent study compared high-quality treatment as usual (TAU) to Mentalization-based Treatment (MBT) for adolescents. MBT is a psychodynamic therapy that works by increasing awareness about an individual’s own mind, the minds of others and the actions that result. This awareness helps increase emotional regulation and relationships. In a study of eighty adolescents with depression and self-harm, it was shown that MBT was better than TAU in decreasing self-injury and depression scores (Rossouw 2012).

**Conclusions**

Although managing self-injury with patients can be anxiety-provoking, it is important to ask about self-injurious behaviors with every patient. Attempt to determine the function, severity, and frequency of self-injury. Consider working with the patient on replacement behaviors. In addition, MBT and DBT may provide effective treatment of NSSI and should be kept in mind. Further research is needed to provide more information about management, treatment outcomes and prognostic indicators for children and adolescents who have recurrent NSSI.

**References**


**Dr. Nicole Garber** is a clinical assistant professor of Psychiatry at University of Texas Medical School-Houston. She may be reached at nicoledgarber@comcast.net.

**Dr. Alice Mao** is a member of the AACAP Consumer Issues Committee, and associate professor of Psychiatry at Baylor College of Medicine. She may be reached at maobrams@aol.com.

Lorena Reyna is a fourth year medical student at Baylor College of Medicine. She may be reached at lereyna@bcm.edu.