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Self Injury: Is It a Syndrome?

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Self injury (SI) typically refers to a variety of behaviors associated with self harm without suicidal intent. While there remains a dearth of research on this subject there is emerging evidence to suggest that SI is increasing amongst clinical and non-clinical populations. Studies estimate that 4% of the general population has self-injured (White Kress, 2003; Klonsky, Oltmanns & Turkheimer, 2003); the prevalence among college students is even higher, ranging from 12% (Favazza, 1996) to 35% (Gratz, 2001) of students having had at least one episode of SI. As might be expected, the incidence is higher among clinical populations. In spite of this prevalence, there remains a particular lacuna of research on the phenomenon. The aim of this paper is to briefly review the extant research on SI and discuss the merits of incorporating SI into the Diagnostic and Statistical Manual (DSM) as a separate diagnosis.

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Favazza's (1996) continues to be the most widely accepted definition of SI: "the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage (e.g., scarring) to occur." His definition also includes the classification system based primarily on the frequency and severity of SI. He divided SI into three main categories: major (injury resulting in significant damage to the body, such as amputation or removing one's eye and usually only seen in individuals who are psychotic or intoxicated), stereotypic (repeated and often rhythmic, mostly seen in autistic and mentally retarded populations), and moderate/superficial (little damage and low lethality. It often involves the use of implements such as razor blades or matches). Moderate/superficial SI is considered the most common and is further divided into the categories of compulsive (occurs multiple times daily, and the person is frequently unaware of what he or she is doing (e.g. Trichotillomania)), episodic (occurs occasionally) and repetitive (this type is associated with impulse control and is described as "an overwhelming preoccupation;" symptoms generally wax and wane over time.) Individuals who fall into this category are often identified as "cutters" or "burners."

Other definitions come from a variety of researchers. Gratz (2001) defined SI as "direct, repetitive self-harm behavior with low lethality [which] occurs within a short time frame, is accompanied by personal awareness of the effects of one's actions, and involves a conscious intent to harm oneself" (p. 254). Pattison and Kahan (1983) described people who self-injure as "persons with apparent consciousness and willful intent [performing] painful, destructive, and injurious acts upon their own bodies without the apparent intent to kill themselves" (p. 867). White Kress (2003) used the definition "a volitional act to harm one's body without any intention to die as a result of the behavior" (p. 490). Warm, Murray and Fox (2003) used the Walsh and Rosen definition "deliberate, non-life-threatening, self-effected bodily

harm or disfigurement of a socially unacceptable manner" (p. 72).

Although the definitions all described SI as an action taken to harm oneself that is not meant to be a suicide attempt, a number of differences remain. Favazza (1996) did not specify a specific frequency and can place even rarely occurring SI in the general label of SI. However, Favazza did specify the consequence of tissue damage and thereby excluded hitting oneself as a form of SI. Walsh and Rosen (in Warm et al., 2003) state that it must be "socially unacceptable" and excludes body modification from the definition (which most conventionally means piercings and tattoos, but in extreme forms can include cutting or burning designs on one's body for aesthetic purposes).

Perhaps one reason for the lack of research on the subject is the lack of consensus on how to classify a set of behaviors that may or may not represent the same phenomenon. To date, SI researchers have referred to the phenomenon as : "parasuicide, focal suicide, self-attack, self-mutilation, autoaggression, symbolic wounding, non-fatal deliberate self-harm," (Pattison & Kahan, 1983, p. 867.) The heterogeneity of terms becomes particularly problematic when studying SI in clinical samples. For example, researchers have suggested that the diagnosis of borderlina personality disorder (BPD) often confounds research on SI. White Kress (2003) found that less than half of people who SI met criteria for having BPD, and when SI was excluded from the criteria only 28% met the criteria for diagnosis. This implies that BPD might be over-diagnosed in people who SI because the single "symptom" causes a bias in mental health professionals. This is problematic when studying clinical populations in which BPD might be over represented. In addition, the inclusion of suicidality and/or prior suicide attempts can skew rates of diagnoses such as Depression or Bipolar Disorder as well as amplify the fatality rate associated with self-injuring. Previous research tended to

confound lifetime incidence of SI and suicidality, which exaggerated the suicide rate (Skegg, Nada-Raja & Moffitt, 2004).

Some common ideas and misconceptions about SI have been that it is only, or primarily, found in females, that it is only found in people with BPD, or that it is a suicide attempt or gesture (Warm, Murray, & Fox, 2003). However, Warm and colleagues stated that "it is now commonly held that deliberate self-harm is a behavior that is consistently misrepresented in the psychological and psychiatric literature" (p. 71). They found that over 90% of a self-injuring population agreed that SI is not a "women's problem" or suicide attempt, and a majority agreed that it is not an attention-seeking behavior. These findings have helped facilitate new research examining SI in clinical non-BPD populations and non-clinical populations. Skegg, Nada-Raja, and Moffitt (2004) looked at a "normal" population as a subset of a larger longitudinal study. Participants were directly asked if they "had thoughts of deliberately hurting, rather than killing, themselves during the past year" (p. 189). Within the population who was found to SI, the following diagnoses were considered to be present: mood disorders, substance abuse, anxiety disorders, eating disorders, schizophreniform, antisocial personality disorder, and suicidal ideation. However, the results are inconclusive as one third of the non-SI population also had at least one diagnosis. The authors theorized that diagnoses were over-reported due to low thresholds in making diagnoses because of use of a computerized algorithm. However, these findings provide additional support that SI is not limited to BPD.

Klonsky, Oltmanns, and Turkheimer (2003) studied the prevalence of SI and characteristics of people who self-injure in a population of air force recruits. Participants completed measures of personality traits, peer ratings of personality traits, depression, and anxiety. The gender differences in percentages who self-injured were not significant. The SI population scored higher on

self-report measures of negative characteristics, Personality Disorders, anxiety, and depression. Meanwhile, peer ratings corresponded to self-report ratings. Although measures indicated higher levels of psychopathology in general, it was unclear as to whether the people who self-injured would be diagnosable under DSM criteria.

A study by Ross and Heath (2002) looked at high school students using questionnaires relating to coping with stress, asking if they'd ever hurt themselves on purpose (excluding reckless driving and drug use), and measures of depression and anxiety. The prevalence appeared to be higher in females, but this result was questionable due to the exclusion of reckless driving and drug use, which seem to be more common among males. Overall, 13.9% of students had self-injured at least once, but 64% had already stopped on their own. It seems then that although more adolescents are self-injuring, it is not necessarily a chronic problem for many of them. Rather, SI worked as a temporary and situational coping strategy. Students who SI reported higher levels of depression and anxiety; however, the study did not specify whether the elevated levels of depression and anxiety were clinically significant or just statistically significantly different from those who did not self-injure.

A problem in studying SI in addition to defining it is that there is no standardized measure. Therefore, Gratz (2001) attempted to design a Deliberate Self-Harm Inventory (DSHI) based on a self-report of behaviors using a sample of undergraduate psychology students. The DSHI was constructed based on the definition "deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage... This measure assesses various aspects of deliberate self-harm, including frequency, severity, duration, and type of self-harming behavior" (p. 255). Thirty-five percent of participants had self-injured at least once; of that, 83% had self-

injured more than once, 15% more than 10 times, and 9% more than 100 times. There were no differences between the sexes. The DSHI correlated with measures of SI and BPD. While the attempted creation of a standardized measure is an advance in the field, there were some problems in the DSHI. First, the population used was not representative of the general population. In addition to being students and not a random population, the sample did not reflect real world demographics. Second, the prevalence reported was much higher than in other studies; this leads into a third problem of there being no measure with which to compare it. Participants were told while being recruited that the study was about SI, and that also may have artificially boosted the prevalence because students who did not self-injure could have just chosen not to participate. The correlation between SI and BPD is questionable because that correlation is not consistently found. The researcher used a brief questionnaire that has been used in some of the literature, but the only other established measure was the Borderline Personality Organization Scale (Oldham et al., 1985). Therefore, one cannot adequately judge whether SI is correlated more with BPD or other diagnoses (such as mood disorders, anxiety disorders, etc.).

In spite of the difficulties in studying SI, some findings have been consistent regarding motivations to self-injure. The common reasons for self-injuring are: managing dissociation, regulating or expressing affect, relieving tension or relaxing, feeling in control, and expressing emotional pain or emotions that one could not otherwise express (Muehlenkamp, 2005; Warm et al., 2003).

There is also evidence of physiological connections to SI from research implicating involvement of the serotonergic and endogenous opioid systems, though results are mixed. It has been suggested that people who self-injure have lower levels of serotonin, and selective serotonin reuptake inhibitors have successfully treated some cases of SI. In addition, some people report an

analgesic effect from self-injuring, which led researchers to experiment with giving self-injurers drugs that reverse the effects of the endogenous opioid, and those drugs have been effective in some cases (Muehlenkamp, 2005).

Due to the prevalance of SI, there has been an effort amongst some researchers to introduce a diagnosis of SI to the DSM (Muehlenkamp, 2005). However, establishing a DSM diagnosis is difficult, because of the lack of an established diagnosis and the inability of researchers to use a consistent definition of SI. Some aspects have been achieved; descriptions usually include a caveat to not consider suicide attempts and/or suicidal ideation as part of SI. Overall, more work is needed. Muehlenkamp (p. 325) also cites Favazza and Rosenthal (1990) and Graff and Mallin (1967) as asserting "that, for the SIB [Self-Injurious Behavior] to be considered repetitive and potentially indicative of its own syndrome, an individual must have engaged in five or more acts of nonsuicidal SI." Studies of prevalence in nonclinical populations have consistently shown that significant numbers of people who self-injure do so at least five times.

In addition to an easier means in which to research SI, a clearly set DSM diagnosis would have more advantages. As Muehlenkamp (2005) states, a specific disorder of SI would "ensure that repetitive self-injurious behaviors are considered apart from Borderline Personality Disorder, which has an additional benefit of reducing the number of self-injuring individuals being stigmatized with a borderline diagnosis" (p. 331). Clearly differentiating SI as a disorder from SI as a symptom of BPD would be useful in creating treatment options for those who SI but do not have BPD. Availability of treatments tailored to the needs of a person who self-injures would be helpful to the patient as well as beneficial for the mental healthcare system in that therapy would be more efficient and effective, and less discouraging to both patient and therapist.

While there is general controversy over whether the use of diagnostic labels is stigmatizing, it is possible that putting a diagnostic label to a SI syndrome or disorder would reduce stigma. There are so many misconceptions about SI, such as it being a "trend" among teenagers or a way of attention, that reification would force acknowledgement of the true gravity of the behavior. Differentiating clearly and officially between SI and suicide attempts would eliminate, or at least decrease, the stigma of being labeled suicidal and being hospitalized. Another possible benefit of having a recognized diagnosis is that it has the potential to provide important information to both individuals suffering from SI as well as treatment providers.

Additionally, SI appears to be a behavior that, while present in a variety of disorders, is not specific to any particular disorder. And contrary to prior beliefs, SI is not always part of BPD. As a whole, that indicates that SI is a separate entity that can qualify as a syndrome. Though some perceive the high rate of comorbidity as meaning that SI is not a separate syndrome, is not necessarily informative as Depression is comorbid with many disorders, but is still recognized as a separate disorder.

Proposed criteria for diagnostic schemes of SI include the following:

> Favazza (1996, p. 256): "Repetitive Self-Mutilation Synd-rome" (RMS) to be listed on Axis I among the Impulse Control Disorders Not Otherwise Specified:
> 1. Preoccupation with harming oneself physically;
> 2. Recurrent failure to resist impulses to harm oneself physically, resulting in the destruction or alteration of body tissue;
> 3. Increasing sense of tension immediately before the act of self-harm;

4. Gratification or a sense of relief when committing the act of self-harm;
5. The act of self-harm is not associated with conscious suicidal intent and is not in response to a delusion, hallucination, transsexual fixed idea [in some cases male bodied transsexuals have committed self-castration], or serious mental retardation.

Favazza's criteria seem appropriate as they consider the feelings leading people to SI and the corresponding feeling afterwards (tension or other negative feelings leading up to the act, and the subsequent relief) as well as rule out conditions that confound diagnosis. However, a modification might be necessary regarding time span and frequency. Although such qualifiers can seem arbitrary in some diagnoses (for example, diagnoses of disorders such as Major Depression or Eating Disorders require the feeling or behavior to have lasted specified amounts of time) a time specifier is necessary in diagnosing RMS in order to differentiate between a person who self-injures regularly and one who injured once or twice over their lifespan.

Muehlenkamp (2005, p. 333) suggested:

1. There is a preoccupation with physically hurting oneself that is devoid of conscious suicidal intent or ideation;
2. One has an inability to resist the impulse to hurt oneself;
3. Preceding the act of self-injury, there is a psychological experience of increasing tensions, anger, anxiety, dysphoria, or general distress, which the person feels he or she cannot escape from or control;
4. There is a sense of relief immediately following the act of self-injury;
5. There is a repetitive pattern of self-injury in which 5 or more acts of self-injury have occurred (the method of

self-injury may vary across injury episodes;
6. The self-injury is not better accounted for as a response to psychosis, transsexualism, mental retardation, developmental disorders, or a general medical condition;
7. The self-injury causes clinically significant distress or impairment in social occupational, or other important areas of functioning.

This set of criteria might be more appropriate for use in clinical settings because of the added criterion of the SI causing distress or impairment.

Pattison and Kahan (1983, p. 867) suggested:
1. Sudden and recurrent intrusive impulses to harm oneself without the perceived ability to resist;
2. A sense of existing in an intolerable situation which one can neither cope with nor control;
3. Increasing anxiety, agitation, and anger;
4. Constriction of cognitive perceptual process resulting in a narrowed perspective on one's situation and personal alternatives for action;
5. A sense of psychic relief after the act of self-harm;
6. A depressive mood, although suicidal ideation is not typically present.

This conception differs from Favazza's and Muehlenkamp's because it frames SI as a purely spontaneous behavior rather than as one that has the feature of preoccupation. In addition, Pattison and Kahan allow for the inclusion of SI committed when a person is intoxicated, psychotic, or mentally retarded and may not be fully conscious of their actions.

Recent work on SI has started to address the need to better understand the phenomonen and prevalence of SI in clinical and

healthy samples. However, given the increasing rates of SI, it appears that SI is becoming an important issue which requires further research. Given the heterogeneity of definitions and classifications associated with the current SI literature it seems imperative that researchers in the field aim to develop a consensus around what behaviors and motivations constitute SI. By clarifying these points, further research will be able to better assess and treat this behavior. As previously mentioned in the article, one step toward developing a unified definition and classification system would be to consider SI as a separate DSM category. Although much research remains to be explored in order for SI to receive a separate diagnosis, making this distinction seems especially important for research and treatment of those suffering from SI. As pointed out in this review, although the parameters of SI remain unclear, further research will help understand and discriminate SI and other psychopathologies.

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