DSM-5, SELF-HARM, AND SUICIDE: FUTURE DIRECTIONS & CLINICAL IMPLICATIONS

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Diagnostic and Statistical Manual: A Brief History

- DSM-II (1968). Expanded list to 145 diagnostic categories but very similar to first manual in form.
Process of Revision

- *DSM-5* represents the first major revision in 30 years.
- Revisions of both DSM (5) and ICD (11 [2015]). Continuing effort to make DSM/ICD compatible

- Workgroups. Conferences. Field trials. APA website w/ updates & opportunity for feedback.
- Both APA and WHO committed to making the *DSM-5* and *ICD-11* a “living document.”
  - Print and electronic versions plus a mobile app of diagnostic criteria for iOS and Android.
DSM-5 Structure

- No more Axes I-V. Just list diagnostic codes.
- 3 Sections and Appendix.
  - Section II, Diagnostic Criteria and Codes.
  - Appendix: Highlights of Changes from DSM-IV to DSM-5, Glossary of Technical Terms
Diagnostic Groupings

- Neurodevelopmental Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Elimination Disorders
Diagnostic Groupings, cont.

- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Substance-Related and Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders
- Paraphilic Disorders
- Other Mental Disorders
- Medication-Induced Movement Disorders and Other Adverse Effects of Medication
- Other Conditions that may be a Focus of Clinical Attention
Section III introduces emerging measures and models to assist clinicians in their evaluation of patients, in addition to *Conditions of Further Study*.
Some proposed conditions had clear merit but ultimately were judged to need further research before they might be considered as formal disorders.

Inclusion of conditions in Section III was contingent on:

- the amount of empirical evidence available on a diagnosis
- diagnostic reliability or validity,
- a clear clinical need
- potential benefit in advancing research
Additional research may result in new information and data that can guide decisions in future editions of DSM.

Such was the case of the criteria sets provided for further study in DSM-IV.

Some acquired an evidence base that warranted their inclusion for widespread clinical use.

However, other conditions were dropped from the manual altogether failing to have garnered utility or empirical evidence since the prior manual was published.
Premenstrual Dysphoric Disorder...Finally!

- Criterion A is that in most menstrual cycles during the past year, at least 5 of the following 11 symptoms (including at least 1 of the first 4 listed) were present:

1. Markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts
2. Marked anxiety, tension, feelings of being “keyed up” or “on edge”
3. Marked affective lability (eg, feeling suddenly sad or tearful or experiencing increased sensitivity to rejection)
4. Persistent and marked anger or irritability or increased interpersonal conflicts
5. Decreased interest in usual activities (eg, work, school, friends, and hobbies)
6. Subjective sense of difficulty in concentrating
7. Lethargy, easy fatigability, or marked lack of energy
8. Marked change in appetite, overeating, or specific food cravings
9. Hypersomnia or insomnia
10. A subjective sense of being overwhelmed or out of control
11. Other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of bloating, or weight gain
The symptoms must have been present for most of the time during the last week of the luteal phase, must have begun to remit within a few days of the onset of menstrual flow, and must be absent in the week after menses.

Criterion B is that the symptoms must be severe enough to interfere significantly with social, occupational, sexual, or scholastic functioning
Criterion C is that the symptoms must be discretely related to the menstrual cycle and must not merely represent an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, dysthymic disorder, or a personality disorder (although the symptoms may be superimposed on those of any of these disorders).

Criterion D is that criteria A, B, and C must be confirmed by prospective daily ratings during at least 2 consecutive symptomatic menstrual cycles. The diagnosis may be made provisionally before this confirmation.
New Treatments are available:

Think It's PMS?
Think Again...
It could be PMDD.

If you suffer from instability, sadness, sudden mood changes, tension, bloating, or if you have many of these symptoms month after month and they clearly interfere with your daily activities and relationships you could have PMDD. PMDD, Premenstrual Dysphoric Disorder, is a distinct medical condition that is characterized by intense mood and physical symptoms right before your period.

Sarafem can help. Doctors can treat PMDD with Sarafem, the first prescription medication for PMDD.
What is this new Wonder Drug?
Sarafem® is the exact same drug as Prozac® (Fluoxetine®), but relabeled with a more feminine name, and marketed to doctors and consumers for a different purpose.
Prozac for PMS
This study examined the relative effectiveness of:

- cognitive behavior therapy (CBT) (ten sessions),
- fluoxetine (20 mg daily) and
- combined therapy (CBT plus fluoxetine) in women with premenstrual dysphoric disorder (PMDD).

Treatment lasted for 6 months; additional follow-up was undertaken 1 year post-treatment.
The main outcome measures were premenstrual scores on the Calendar of Premenstrual Experiences (COPE) and percentage of PMDD cases (DSM-IV diagnostic criteria).
Significant improvement occurred in all three treatment-groups after 6 months' treatment, assessed by the COPE.

There were no group differences in the percentage of DSM cases of PMDD post treatment.

The authors conclude that CBT and fluoxetine are equally effective treatments for PMDD.
However, at follow-up CBT was associated with better maintenance of treatment effects compared with fluoxetine.

Recall, this study also had a 1-year follow-up. So, even though the meds & therapy were both effective, better maintenance (or long-term gains) was associated with counseling, not Prozac.
Hunter, M.S. et al. (2002). A randomized comparison of psychological (cognitive behavior therapy), medical (fluoxetine) and combined treatment for women with premenstrual dysphoric disorder. *Journal of Psychosomatic Obstetrics & Gynecology.*
Why Now?

Proposed Inclusion of Suicidality/Self-Harm in DSM-5
Facing the Facts – A Clear Clinical Need

- In 2010, 38,364 people in the United States died by suicide.

- About every 13.7 minutes someone in this country intentionally ends his/her life.
Suicide is considered to be the second leading cause of death among college students.

Suicide is the second leading cause of death for people aged 25-34.

Suicide is the third leading cause of death for people aged 10-24.

Suicide is the fourth leading cause of death for adults between the ages of 18 and 65.

Police officers are twice as likely to die from suicide than in the line of duty.
The suicide rate was 12.4/100,000 in 2010.

It **greatly exceeds** the rate of homicide. (5.3/100,000)

From 1981-2010, 939,544 people died by suicide, whereas 479,471 died from AIDS and HIV-related diseases.
Welcomed Change

Greater recognition of Suicide Risk for several disorders throughout the manual

- Schizophrenia (p.104)
- Schizoaffective Dx (p.109)
- Bipolar (p.131)
- Major Depression (p.167)
- OCD (p.240)
- PTSD (p.278)
Conditions of Further Study: I

Suicidal Behavior Disorder
Suicidal Behavior Disorder

- A suicide attempt within the past 24 months.
- The act is not nonsuicidal self-injury.
- Suicidal ideation does not qualify.
Suicidal Behavior Disorder: Proposed DSM-5 Criteria

A. Within the last 24 months, the individual has made a suicide attempt. **Note:** A suicide attempt is a self-initiated sequence of behaviors by an individual who, at the time of initiation, expected that the set of actions would lead to his or her own death.

B. The act is does **not** meet the criteria for nonsuicidal self-injury- that is does not involve self-injury directed toward the surface of the body undertaken to induce relief from a negative feeling/cognitive state or to achieve a positive mood state.

C. The diagnosis is **not** applied to suicidal ideation or to preparatory acts.

D. The act was not initiated during a state of delirium or confusion.

E. The act was not undertaken solely for a political or religious objective.

- **Specify if:**
  - **Current:** Not more than 12 months since the last attempt
  - **In early remission:** 12-24 months since the last attempt
Suicidal Behavior Disorder

- **Specifiers:**
  - If the suicidal behavior occurred 12-24 months prior to the evaluation, the condition is considered to be in **early remission**
  - Individuals remain at higher risk for further suicide attempts and death in the 24 months after a suicide attempt.
Suicidal Behavior Disorder

- **Other Specifiers:**
  - Violence of method (overdoes vs. gunshot)
  - Medical consequences of behavior
  - Degree of planning vs. impulsiveness of attempt
What could be helpful about this new DSM code?

- It creates a way to organize, and perhaps track, risk for suicide.

- Creating a code “calls out” suicidal risk in an individual’s clinical record, distinguishing it from being seen as “just a symptom.”
Suicidal behavior (death and attempts) is usually a complication of psychiatric conditions, most commonly mood disorders.

Also occurs in schizophrenia, substance use disorders (particularly with alcohol), and personality and anxiety disorders.

However, 10% of those who commit or attempt suicide have no identifiable psychiatric illness.

(OQUENDO, 2008)
Suicidal Behavior Disorder

Approximately 25-30% of persons who attempt suicide will go on to make more attempts.
“For the first time suicidality would have the **status** of a separate syndrome...”

Kapusta, (2012), p.2
Suicidologists Ron Maris and Mort Silverman successfully argued fifteen years ago that
- "...suicide is, by definition, not a disease, but a death that is caused by a self-inflicted intentional action or behavior"

- The new DSM-5 diagnosis process would automatically make suicide a mental disorder
“The inclusion of suicide attempts as a diagnostic criterion of borderline personality disorder, despite limited evidence to support the link, led to an increased stigmatization of suicide attempters.”

Perception of BPD among Mental Health Staff

- The questionnaire contained descriptions of challenging behavior in which the patient was described with a diagnosis of depression, schizophrenia or BPD

- Participants were asked to identify a likely cause of the behavior and then on a Likert-type scale rate attributions of internality, stability, globality and controllability

- In addition they recorded their level of sympathy with the patient and their optimism for change

Markham & Thrower, (2010)
Perception of BPD among Mental health staff

- **Results:** Patients with a label of BPD attracted more negative responses from staff than those with a label of schizophrenia or depression.

- Causes of their negative behavior were rated as more stable and they were thought to be more in control of the causes of the behavior and the behavior itself.

- Staff reported less sympathy and optimism towards patients with a diagnosis of BPD and rated their personal experiences as more negative than their experiences of working with patients with a diagnosis of depression or schizophrenia.
Another Potential Problem...

- From DSM 5 criteria:
  - “The diagnosis is not applied to suicidal ideation or to preparatory acts”
Conditions of Further Study: II

Nonsuicidal Self-Injury
Non-Suicidal Self Injury (NSSI)

- Whereas in DSM-IV non-suicidal self-injury (NSSI) was considered a symptom of borderline personality disorder (BPD), in the revised manual it is recognized as a distinct condition.

- Research suggests that NSSI can occur independent of BPD, such as in patients with depression or even in those with no other diagnosable psychopathology.
Non-Suicidal Self Injury (NSSI)

- Self inflicted injury in the absence of suicidal intent
  - Many practitioners wanted NSSI to be identified as a specifier due to the recent rapid increase in SH in youth and across diagnoses.
  - The need for early recognition, development of preventative measures, and concerns about associated medical risk may lead to stronger research and treatment implications in DSM5.1, .2
  - DSM-5 Task Force concern: SI is inappropriately represented in DSM IV as associated with BPD even though it occurs in a variety of disorders
Three key differences between NSSI and attempted suicide

1. Most people engaging in NSSI have, per definition, no intent to die during the self-injuring act.

2. Methods and injuries of NSSI are often less severe and usually the damage is not life threatening.

3. NSSI and suicide differ in the frequency of the act, as NSSI occurs close to daily in many instances

Whitlock et al., (2013)
DSM-5: NSSI

- Proposed criteria:
  - 5 or more days of intentional self-inflicted damage to the surface of the body without suicidal intent within the past year.
Proposed criteria

The individual engages in the self-injurious behavior with one or more of the following expectations:

- To obtain relief from a negative feeling or cognitive state.
- To resolve an interpersonal difficulty.
- To induce a positive feeling state.

Note: The desired relief or response is experienced during or shortly after the self-injury, and the individual may display patterns of behavior suggesting a dependence on repeatedly engaging in it.
The intentional self-injury is associated with at least one of the following:

- Interpersonal difficulties or negative feelings or thoughts, depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the SI act.
- Preoccupation with the SI is difficult to control.
-Thinking about SI occurs frequently, even when it is not acted upon.
- The SI is not socially sanctioned not restricted to nail biting or picking a scab.
Non-suicidal self-injury - where did it come from and what does it mean?

- The concept is not new - in the 1960s clinicians in the USA described seeing increasing numbers of people who cut themselves in order to feel better rather than seeking to die.
A growing recognition that some individuals, young people in particular, were injuring themselves but did not meet the criteria for borderline personality disorder or psychiatric illness.

A diagnosis of NSSI would mean that one might avoid a potentially inappropriate personality disorder label, while still having a formal diagnosis for which they could receive treatment.
A distinct condition

Several studies have indicated that fewer than 50% of those who engage in NSSI suffer from Borderline Personality Disorder.

A distinct condition-prevalence

- In a recent adolescent community study the prevalence rate of NSSI using the proposed criteria for DSM-5 was 6.7%.

“Establishing a Dx of NSSI would allow delivering treatment to patients with self-injurious behavior which otherwise might not fulfill criteria for any other disorder”.

Plener et al. (2012)
Benefits of Inclusion of NSSI in DSM

- Improved communication between professionals
  - Avoid inappropriate diagnostic label

- Increased research into the nature, course, and outcome of NSSI

- May be needed to provide financing from health insurances for treatment
The motives behind the introduction of NSSI are well-intended, based on research that shows this is a separate construct, and that many folks may have increased access to effective Tx with this inclusion as a separate Dx.
Potential problems

- There is a paradox that overdose can never be included as NSSI, even when patients report episodes as categorically non-suicidal.

- Hospital-based studies suggest that as many as 25-50% of those who overdose may report no suicidal intent.

Potential problems

- “Non-suicidal self-injury is restricted to methods such as cutting, burning, stabbing, hitting or excessive rubbing, which leaves non-suicidal self-poisoning in the classificatory wilderness”.

More Potential Problems

- **Methods of self-harm change over time**

- Those with episodes of NSSI may subsequently poison themselves and vice versa

- In a large cohort study of over 7,300 individuals presenting to general hospitals in England and followed up for an average of 9 months, 1,234 repeated self-harm and a third of these switched methods
Method switching was particularly common in people who cut themselves - over 60% changed methods over time, most frequently to overdose/self-poisoning.

Potential problems

- The prefix ‘non-suicidal’ is misleading because of the strong association between NSSI and suicidal behavior.

- In a recent study, over a third of individuals reported they had engaged in NSSI while actually experiencing suicidal thoughts.

Longitudinal research has identified NSSI as one of the most important risk factors for suicide attempts.

Self-cutting is the most common method of NSSI and a behavior that is often regarded as being of limited seriousness by clinical services.

However, there is evidence that self-cutting that results in hospital treatment is actually associated with greater risk of eventual suicide than overdose in both adults and adolescents.

Even episodes of self-harm with no reported suicidal intent are related to an elevated risk of repeat self-harm and suicide compared with the general population.

Andover et al., (2012); Cooper, (2005)
A study of nearly 8,000 individuals presenting with overdose or self-injury to four emergency departments.

The subsequent suicide mortality was equally elevated regardless of whether individuals indicated that they did or did not wish to die at the time of the attempt.


Investigated patients with repetitive NSSI

- > 80% reported almost daily urges to self-injure
- > 60% reported at least once-a-week acts of self-injury
- 74% of the adolescents reported having attempted suicide at least once in the past 6 months
Thus, one of the most problematic issues is the risk of missing associated suicidality when using the term “non-suicidal”
"Given the pressure on front-line clinical services, the danger of an attempted suicide/NSSI dichotomy is that those with NSSI will be given lower priority and receive poorer treatment than other patients.

Although self-harm is not a perfect descriptor, we might well be better off sticking with the terminology we currently have.”

Kapur, et al. (2013)
Sticking with what we know
FACTORS AFFECTING COUNSELING EFFECTIVENESS

- Expectancy: 15%
- Therapeutic Alliance: 30%
- Extratherapeutic Factors (Client Strengths): 40%
- Model & Techniques: 15%

Diagram shows the percentage distribution of factors affecting counseling effectiveness.
The Alliance

- Over 1000 studies have demonstrated that the alliance between the therapist and the client accounts for more variance than the particular model or technique.

- Next to what the client brings to therapy, the client’s perception of the therapeutic relationship accounts for most of the gains associated with therapy.

Bachelor & Horvath (1999)
“TAP” into client strengths….

- TRAITS
- ACTIVITIES
- PEOPLE
What about Treatment with NSSI??

“An effective therapeutic alliance is one of the key factors that helps patients develop alternative modes of coping with intolerable affects when habitual self-injury has become common”

What about Treatment with NSSI??

- The **therapeutic alliance** has been described by Michel (2011) as a “major, although largely unspecific, therapeutic element that keeps the suicidal person alive in the short term as well as in the long term” (p24).
Suicide Prevention: CAMH

- Handbook of Suicide Prevention & Assessment

“The alliance between the clinician and client is essential to the treatment and management of suicidal clients and should be considered and addressed in any treatment plan”

(Sakinofsky, 2010; CARMHA, 2007).
Building a Therapeutic Alliance With the Suicidal Patient

Edited by

Konrad Michel and David A. Jobes
“Mental health professionals working with patients at risk for suicide must recognize...while they are experts in the assessment and treatment of disorders of mental health, when it comes to the patient’s suicidal story, the patient is the expert.”

Successful interventions with suicidal patients must therefore be empathic and honor the very personal perspective of the patient.

Text covers:
- methods of establishing a working alliance
- patient-oriented therapies for suicidality
“The healing of any personal crisis of the self always begins with telling your story….to listen to someone else’s story without judgment, and resisting the urge to offer advice is the first and perhaps most important gift you can give to honor the client’s story, to honor their pain and struggle, to honor them”
Thinking About Suicide includes a personal account of living with, and recovering from, persistent suicidal feelings.

Each chapter addresses a specific issue using two distinct voices – a narrative voice of the author’s personal experience, followed by a more reflective commentary voice that is informed by the author’s reflections on his survival as well as his PhD research.
In 2006 David Webb completed the world’s first PhD dissertation on suicide by someone who has attempted suicide. In it he argued that suicide is best understood as a crisis of the self rather than the prevailing view that it is the consequence of some pseudo-scientific ‘mental illness’.
“In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his or her own personal growth?” ~Carl Rogers
Carl Rogers with a Twist
"Roger's with a twist" builds on the all accepted micro-counseling skills of empathy, genuineness, congruence, etc. but adds a “twist” to the reflection

- Provide validation & reflection of the client's complaint

- Clearly ground the client’s complaint in the "past tense,"

- Replace the client's language of "stuckness" or despair with a language of **possibility**
Carl Rogers with a Twist

- For example, instead of saying to the client,

  “You are experiencing a lot of depression about your inability to fix this situation”

- You might say,

  “You have gone through some times when you have felt really down because you have not yet found a way to cope with this situation”
Carl Rogers with a Twist

- **Basic reflection**
  - “You are experiencing” = present tense
  - “depression” = diagnosis
  - “inability” = helplessness

- **Possibility Reflection**
  - “You have gone through” = past tense
  - “really down” = normalizing phrase
  - “not yet” = implies possibility of growth
You can characterize negative emotions as taking place in the past by using a variety of phrases.

- “For a long time you have felt…
- “When that happened, you felt…
- “You have felt trapped by this situation, and have not yet found a way to break loose…

Past-tense Phrasing
Possibility Statement

- Dropping in some suggestions of the possibility of a future resolution is an excellent way of planting the seeds of change.

- “So far, you have not seemed to be able to…”
- “You have not yet been able to accomplish this…”
You can even suggest that this feeling or perception may be different now by saying,

“Until now, it has seemed to you that...”