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Editorial

Non-suicidal Self-injury and Suicide Risk Assessment, quo vadis DSM-V?

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The question where to go is essential for researchers in several ways. Usually, there are international research trends upon which we can orientate ourselves. Such trends are initialized by research groups with the necessary power to form a scientific discourse in the main research media, such as scientific journals. However, even though much effort is put into a specific direction, such an investment does not necessarily lead to a success in terms of a scientific discovery, invention or progress and may encounter resistance from the scientific community.

One of such new trends in suicide research is the effort made in delineating Non-suicidal Self-injury (NSSI) from suicidal behavior and pushing towards an inclusion of this new syndrome into DSM-V (Shaffer and Jacobson, 2009). Non-suicidal Self-injury has gained much popularity in the new media, and is often depicted as nearly-normal behavior and videos with such contents are downloaded millions of times from Youtube (Lewis et al., 2011). Therefore inclusion of NSSI in DSM-V would be a clear statement that such behavior is to be taken seriously (Plener et al., 2012).

Our history of science is full of research paradigms which turned out to be "scientific blind alleys". Paradoxically, these blind alleys might be viewed as progress. The austro-british philosopher of science, Karl Popper, revolutionized the way of thinking about progress in scientific research, by questioning the ability of positivism to enlarge our knowledge, suggesting the opposite, that knowledge increases not with increasing evidence by proving hypotheses, but with our ability to challenge hypotheses and to reject them as false. He went further by suggesting that the falsifiability of hypotheses is a crucial criterion of good science (Popper, 1959).

Therefore, as researchers, we should be motivated to search for blind alleys or even to try to drive into the dark. From one point of view, it would be highly appreciated to challenge the hypothesis of NSSI as a syndrome distinct from suicidality and to make progress by proving its non-existence. However, questioning traditional paradigms (NSSI is not distinct from suicidality) is a subversive threat, as described by another philosopher of science, the U.S.-born Thomas Kuhn. He termed important turning points in scientific agendas as paradigm shifts. Scientific truths as established knowledge are legitimized by a critical mass of researchers – the scientific community. But established knowledge not necessarily must be true. Even though the greatest inventions in science came suddenly, usurpating and changing the way we think, researchers who aim to challenge established truths encounter resistance from the community (Kuhn, 1962).

Interesting examples of fruitful blind alleys in research are found in the field of genetic research of mental disorders and suicide. The first studies examined whether a single dominant gene vs polygenic inheritance might be involved (Stephens et al., 1975; Smeraldi et al., 1977; Papadimitriou et al., 1991). Together with the fall of the single-gene paradigm and the development of new technical abilities, research focused on candidate genes and genotypes of interest – a work which is still

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incomplete. In parallel, suicide research moved into a paradigm of epigenetics; interactions between genes and environment (Labonte & Turecki, 2010). In this way, psychological and sociological hypotheses entered (after a pure biological detour) the research paradigm again.

The scientific question whether there is an independent phenomenon termed "Non-suicidal Self-injury" and the ethical question whether it would be secure and wise to include such a symptom as a new diagnostic category in the DSM-V are two distinct issues. De Leo (2011) rightly points to the pitfalls, coming with such a new and rather preliminary scientific construct. Accordingly, the two most problematic aspects are: (1) the risk to miss associated suicidality when using the term 'non-suicidal' and (2) labeling a person with such a diagnosis will increase stigma. Both arguments are based on ethical considerations and assumptions but the problems might be avoidable.

The probability of underestimation of suicidality could be accounted for in the diagnostic criteria by a clear definition of how carefully or how periodically suicidal intent has to be ruled out by clinicians. We are aware that even when acute suicidality may be absent or non-fatal during a major depressive episode, the basic risk for suicide remains increased during life-time (Angst et al., 2005). Why should we not understand NSSI in the same way? Since unawareness of suicidality occurs in everyday practice, an introduction of an entity where *suicidal intent has to be excluded* would be rather a progress by rising awareness on this issue. It is also an important argument that establishing a diagnosis 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). The diagnosis of NSSI would be appropriate for those adolescents who engage in self-injurious behavior, and for whom it might be too early to stigmatize them with the chronic diagnosis of for e.g. Borderline Personality or Bipolar Disorder.

Although the positive predictive value of existing suicide risk assessment scales is weak, it has also been proposed to include rating scales for suicidality in DSM-V (APA, 2010) for both, adults and adolescents. For the first time suicidality would have the status of a separate syndrome within psychiatric diagnoses. Suicidality has been previously only present as an optional criterion of Major Depression or Borderline Personality Disorder. In future it would be possible to rate it independently from disorders, which accounts for the fact that suicidality may occur in all psychiatric disorders (Harris and Barraclugh, 1997). We might also think of a mandatory use of such a rating scale and the appropriate assessment when NSSI is to be diagnosed.

The criticism of suicide rating scales often leads to the assumption that suicidality may be only appropriately predicted in unstructured clinical assessments. This suggests a rather pessimistic view of the possibility to predict suicide risk based on scientific means. Although from a rational perspective it should be manageable to develop a rating scale out of a collective clinical experience. Fears that using rating scales might hamper a more suitable clinical assessment based on a sensitive psychotherapeutic relationship might also be misplaced, since we know that suicide prevention suffers from a lack of routine assessment *per se* rather than from an inappropriate approach to the patient. Of course, suicide remains a rare event, hard to predict. This is even truer in children and adolescents where completed suicides are numerically rare but NSSI is highly prevalent (Plener et al., 2009; Nitkowski & Petermann, 2011; Asarnow et al., 2011).

Similarly as with the problem of possibly missed suicidality when diagnosing NSSI, there is the pitfall that a coding of 'no prior or current concern about suicidal behavior' on the proposed rating scale (APA, 2010) cannot rule out possible suicidality in future. But introducing a suicidality rating into the cannon of disorders ensures that in future, the term 'suicidality' will be a visible part of the discourse in scientific and clinical work with DSM-V. Or as proposed earlier, this would give suicidality the prominence that it deserves in written reports and treatment planning for vulnerable patients (Oquendo et al., 2008).

For decades, the understanding of self-injury has been an integral part of Suicidology, leading to a nomenclature Babylon rather than a straight Tower of Babel (O'Carroll et al., 1996; Skegg, 2005). In our established paradigm, self-injury has always been linked to a certain degree of suicidality culminating in the question about intent. But until more scientific evidence is gathered, it remains open whether suicide intention may be assessed validly or whether it is an impasse.

Another example for a probable blind alley might be the research sparked after the 2004 FDA warning on antidepressants use in youth. Although studies reported increased risk for suicidal ideation and suicide attempts in children and adolescents, and this was supported by several meta-analyses (Gunnell & Ashby, 2004; Gunnell et al., 2005; Barbui et al., 2009; Stone et al., 2009), a recently published methodologically improved meta-analysis, by taking individual depression scores into account, reports for youths, that depression severity was strongly related to suicide risk and depression responded to treatment, but no effect of treatment on suicide risk was found (Gibbons et al., 2012). Is this a paradigm shift in the research on the link between emerging suicidality

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during antidepressant treatment in youth? As the authors conclude, even if antidepressants reduce depressive symptoms overall in youths, it is possible that a subset may retain some level of risk for suicidal ideation or attempts. Could it be that it is the group of those who have high rates of NSSI, as indicated by Asarnow et al. (2011) in the TORDIA study?

Many questions concerning NSSI and suicide risk assessment remain unanswered and their inclusion in DSM-V will surely boost future research on these issues. The critical rationalism of Popper is a helpful tool, encouraging us to be critical towards established truths and open to new possibilities. In this sense, Suicidology Online (SOL) is a journal which is open to novel theories and hypotheses. With its critical and growing audience of in the meanwhile over 1000 different visitors monthly and the excellent editorial board, SOL has reached a highly creative potential in the suicide research community. Therefore, interesting discussions and controversies on Non-suicidal Self-injury, suicide risk assessment and other areas of suicide research will definitely follow in future volumes of this journal.

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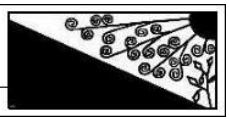

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