Nonsuicidal Self-Injury (NSSI) and NSSI Disorder: Perspectives of Psychologists and Psychiatrists

by

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A Thesis
presented to
The University of Guelph

In partial fulfillment of the requirements
for the degree of
Master of Arts
in
Psychology

Guelph, Ontario, Canada

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ABSTRACT

NONSUICIDAL SELF-INJURY (NSSI) AND NSSI DISORDER: PERSPECTIVES OF PSYCHOLOGISTS AND PSYCHIATRISTS

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University of Guelph, 2018

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Nonsuicidal Self-Injury Disorder (NSSI-D) was proposed as a condition for further study in the Diagnostic and Statistical Manual of Mental Disorders (5th edition; DSM-5). No research has examined the attitudes of professionals who could confer a diagnosis of NSSI-D towards individuals who self-injure. A sample of 127 North American psychologists and psychiatrists (diagnosing professionals; DPs) were surveyed about self-injury and NSSI-D related attitudes. DPs reportedly value NSSI as an important healthcare issue, hold positive attitudes towards these clients, and do not see self-injury as a manipulative or attention-seeking. DPs presented some misconceptions about the relation between NSSI, Borderline Personality Disorder and suicidality. As currently presented, DPs express some resistance to the inclusion of NSSI-D in an upcoming DSM, and diagnostic labeling could have both a positive and negative impact on DPs’ attitudes towards clients meeting criteria for NSSI-D. Future research prospects and implications for clients and diagnosing professionals are discussed.
ACKNOWLEDGEMENTS

I would like to extend my sincere gratitude to all the individuals who supported me in the completion of my Master’s thesis project. First, a heartfelt thank you to Dr. Stephen Lewis. I am very grateful to have such a knowledgeable, supportive and inspirational graduate advisor. Thank you to my committee member, Dr. Margaret Lumley, for her time and research expertise that improved the quality of my thesis. And, finally, thank you to my graduate faculty member, Dr. Arlene Young, for her insightful comments and questions, and to my defense chair, Dr. Kaitlyn McLachlan.

To my cohort members, Katherine, Mackenzie, Jenny and Katie, thank you for being an invaluable support system and always challenging me to live life to the fullest. I would also like to thank my best friend Carolyn for her resounding support and positivity. Finally, my deepest gratitude to my mother and father, your thoughtfulness, compassion and perseverance have made me the person I am proud to be today.
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Introduction

Nonsuicidal self-injury (NSSI) is the act of deliberately damaging one’s own body tissue through methods such as cutting, scratching and burning, without the intent to die by suicide (Nock & Favazza, 2009). Approximately 14 - 24% of individuals, ages 12 to 25, report engaging in NSSI at least once in their lifetime (Jacobson & Gould, 2007; Nock & Favazza, 2009). Indeed, a recent meta-analysis and meta-regression found the lifetime pooled prevalence to be 17% for adolescents, 13% for emerging adults, and 5.5% for adults (Swannell, Martin, Page, Hasking, & St. John, 2014). While individuals of all ages may self-injure, peak NSSI engagement occurs during adolescence (ages 14 to 17; Muehlenkamp, Claes, Havertape & Plener, 2012; Swannell et al., 2014). A review by Lewis and Heath (2015) found that most studies report a higher prevalence of self-injury in adolescent females than males, while some studies found no sex differences in this age group.

Individuals who engage in NSSI endorse a variety of reasons for why they self-injure. Most commonly, NSSI is used as a coping mechanism to manage strong negative emotions such as anger, anxiety and sadness (Klonsky, 2007). Further, NSSI can function to generate feeling when experiencing dissociation, express distress to others, refocus attention away from the source of distress, and as a form of self-punishment (see Klonsky, 2007 for review). Accordingly, engagement in NSSI can be associated with myriad psychological difficulties (e.g., emotion regulation difficulties, impulsivity, negative cognitive style), and mental disorders (e.g., depression, borderline personality disorder, anxiety) (Lewis & Heath, 2015). Prior NSSI engagement is also an important predictor of future suicide attempts among adolescents. Indeed, engagement in NSSI confers risk for both suicidal ideation and capability according (Klonsky, May & Glenn, 2013). Within an inpatients sample, 70% of adolescents who self-injure and reported a suicide attempt at least once in their lifetime (Nock, Joiner, Gordon, Lloyd-
Richardson & Prinstein, 2006). NSSI’s pronounced relation with suicidality and high prevalence among adolescence underscores its importance as a public health concern.

**Nonsuicidal Self-Injury Disorder**

Numerous researchers and organizations have advocated for the recognition of NSSI as an independent mental disorder in future editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (see Glenn & Klonsky, 2013; Gratz, Dixon-Gordon, Chapman & Tull, 2015; Muehlenkamp, 2005; Selby, Kranzler, Fehling & Panza, 2015; Shaffer & Jacobson, 2009; Wilkinson & Goodyer, 2011; Zetterqvist, 2015). In 2013, the fifth edition of the DSM proposed the first set diagnostic criteria for Nonsuicidal Self-Injury Disorder (NSSI-D) (see Table 1), which led to efforts to evaluate the utility and acceptability of the criteria and disorder [American Psychological Association (APA), 2013]. DSM-5 field trials were conducted to examine the degree to which two clinicians could independently agree on the presence or absence of NSSI-D in patients interviewed on separate occasions and settings (Regier et al., 2013). Regier and colleagues found that clinicians utilizing NSSI-D criteria demonstrated very low inter-rater reliability. Research allowing for improved sensitivity and specificity of criteria was thus called for before the DSM could adopt the disorder as an official diagnosis. To encourage such research, the DSM-5 has included NSSI-D in Section 3 of the DSM as a condition for further study (APA, 2013; Regier et al., 2013). Reviews by Zetterqvist (2015) and Selby et al. (2015) have presented arguments both for and against the introduction of NSSI-D into the DSM. As discussed below, arguments come from clinical, empirical, and practical lenses.

**Arguments for NSSI-D.** Zetterqvist (2015) reviewed 16 studies exploring the viability of NSSI-D and found it to be a useful diagnosis capable of delineating a subgroup of individuals who self-injured and for whom there was associated functional impairment. In comparison to
community samples, there are considerably more individuals who meet criteria for NSSI-D in clinical samples. Within an inpatient clinical sample, Glenn and Klonsky (2013) found that 50% of all inpatients and 78% of inpatients who self-injured met criteria for NSSI-D. In contrast, only 6.7% of adolescents in a community sample met criteria for NSSI-D (Zetterqvist, 2015). Further, in comparison to those with a history of NSSI who do not meet criteria for NSSI-D, individuals meeting criteria present with elevated levels of functional impairment, clinical severity, and/or internalizing or externalizing behaviours (Andover, 2014; Selby, Bender, Gordon, Nock & Joiner, 2012).

In addition to the above, proponents of NSSI-D contend that not only could diagnostic independence provide the field with a consistent definition for NSSI and inspire research into more specialized and effective treatment, but it could reduce misdiagnosis of Borderline Personality Disorder (BPD) among individuals who self-injure and provide clarity into the NSSI-suicide link (Favazza, 1996; Glenn & Klonsky, 2013; Selby et al., 2015; Shaffer & Jacobson, 2009; Zetterqvist, 2015).

Given the high prevalence of NSSI among individuals with BPD, NSSI is appropriately included as one of nine BPD criteria in the DSM. In one study, among adolescents with BPD (ages 12–18, predominately female and Caucasian), up to 78% also met criteria for NSSI-D (Glenn & Klonsky, 2013). However, in the same study, among adolescents meeting criteria for NSSI-D, only 52% also met criteria for BPD. Thus, while most individuals with BPD engage in NSSI, it is less likely that most individuals who engage in NSSI have BPD. Engagement in NSSI can be associated with myriad psychological difficulties (e.g., emotion regulation difficulties, impulsivity, negative cognitive style), and mental disorders (e.g., bulimia, depression, anxiety and substance abuse) (Lewis & Heath, 2015). Furthermore, individuals who self-injure may not
have any diagnosable disorders, i.e., approximately 12% of clients engaging in NSSI within a psychiatric inpatient sample did not meet criteria for any psychiatric disorders (Nock et al., 2006). Classification of NSSI as a symptom of BPD may not accurately portray its clinical significance outside of a BPD context (Glenn & Klonsky, 2013). When comparing youth who self-injure who have BPD and who do not have BPD, those with BPD report higher levels of emotion dysregulation, and functions of self-injury as self-punishment, anti-suicide, and anti-dissociation (Bracken-Minor & McDevitt-Murphy, 2014). Indeed, individuals who self-injure independent of BPD may have a unique psychological profile. Inappropriately classifying a client who self-injures as having BPD can carry considerable stigma from treatment providers. For example, clients who self-injure and have BPD have been perceived as attention-seeking, manipulative, and treatment resistant (Aviram, Brodsky & Stanley, 2006; Nehls, 1998). These views are not only inaccurate (Klonsky et al., 2011; Lewis, Mahdy, Michal & Arbuthnott, 2014), but may be harmful to client’s wellbeing by exacerbating stigma and impeding the client’s help-seeking efforts (Lewis et al., 2014).

Previous versions of the DSM do not explicitly define NSSI or distinguish it from a suicide attempt. Conflation of NSSI with suicide may contribute to inappropriate hospitalization which can negatively impact a client’s confidence in the medical system, and thus discourage future help-seeking which is low among adolescents who self-injure (Fortune, Sinclair & Hawton, 2008; Selby et al., 2015). Prior NSSI engagement is an especially important predictor of future suicide attempts among adolescents (Klonsky, May & Glenn, 2013; Nock et al., 2006). However, most individuals who self-injure do not take their own lives (Cutliffe, Braithwaite, Stevenson, 2008). Further, the cognitions associated with self-injury and the frequency and severity of NSSI engagement differs from the those associated with individuals who self-injure
with suicidal intent (Muehlenkamp & Gutierrez, 2004; Muehlenkamp, Swanson & Gutierrez, 2003). Hence, while NSSI is a robust predictor of suicidal ideation and attempts, NSSI and suicidality are nonetheless independent phenomenon.

**Arguments against NSSI-D.** Some researchers have expressed concern that the inclusion of NSSI-D in the DSM could inadvertently pathologize those who self-injure (Selby et al., 2015). Individuals with lived NSSI experience echo these sentiments (Lewis, Bryant, Schaefer & Grunberg, 2016). Although NSSI is associated with a multitude of risks and mental health difficulties, NSSI has the highest prevalence among adolescents (Swannell et al., 2014), and is often episodic in nature (e.g., occurring during acute distress). In this way, it may not always connote the same degree of psychopathology often ascribed to other difficulties (e.g., eating disorders, mood disorders). Further, for many adolescents, NSSI does not continue into adulthood (Whitlock & Selekman, 2014). Hence, some researchers have argued that engagement in NSSI may be better described as a normative—yet atypical—adolescent behaviour (Adler & Adler, 2007). To rebut, in some cases, NSSI becomes more frequent and persists well into adulthood; in other cases, it does not even present until adulthood (Bjärehed, Wångby-Lundh & Lundh, 2012; Moran et al., 2012; Wichstrom, 2009). Moreover, among those adolescents whose NSSI remits, many continue to experience significant long-lasting consequences (e.g., shame associated with scarring (Asarnow et al., 2011; Klonsky, 2009). Collectively, there are mixed views as to whether the chronicity of NSSI should inform its inclusion as a DSM disorder. It is important to consider that the chronicity argument has been posed against most DSM disorders and the diagnostic classification system (Klein, 2008).

An additional concern among those with lived experience is that utilizing the diagnosis of NSSI-D in practice could detract from NSSI’s significance as a behavioural symptom of other
disorders such as BPD and Major Depressive Disorder (In-Albon, Ruf & Schmid, 2013; Lewis et al., 2016). While there appears to be distinct psychological and biological mechanisms at play for individuals who meet criteria for NSSI-D (Crowell et al., 2005; Groschwitz & Plener, 2012; Nielsen, Sayal & Townsend, 2016; Plener, Bubalo, Fladung, Ludolph & Lule, 2013; Stanley et al., 2016), this is notwithstanding the co-occurrence of NSSI with other psychological or other mental health difficulties (Lewis & Heath, 2015). There is a need to adopt a comprehensive clinical approach that focuses on both the client’s NSSI as well as other presenting difficulties and disorders.

Finally, there are concerns that Criterion A (i.e., In the last year, the individual has on 5 or more days engaged in NSSI that was severe enough to cause minor or moderate damage, but without suicidal intent), and Criterion E (i.e., NSSI causes significant distress or impairment in important areas of functioning) proposed for NSSI Disorder may not capture the full range of clinically significant self-injury presentations (see Table 1 for NSSI-D criteria). Muehlenkamp, Brausch & Washburn (2017) examined the clinical utility of Criterion A and found that five days of engagement in NSSI may be too conservative a frequency that does not consider the severity of self-injury. For example, two days wherein the client makes 50 minor cuts may still be clinically significant. Criterion E which requires the client to have significant distress or impairment may require further operationalization to ensure clients are not being inappropriately excluded. Among outpatient and community samples of individuals with a repetitive NSSI history, Criterion E received relatively lower endorsement (Andover, 2014). Individuals who self-injure can perceive NSSI as a behaviour that reduces distress, rather than a behaviour that is impairing their everyday life (Andover, 2014; Lengel & Mullins-Sweatt, 2013; Selby et al., 2015; Zetterqvist, Lundh, Dahlström & Svedin, 2013). Overall, NSSI-D criteria have been
examined across several studies and appear largely viable; however, some criteria (such as those noted above) may need modification before NSSI-D’s potential inclusion in a future iteration of the DSM. Accumulating evidence suggests there is a good likelihood that NSSI-D will become an official mental disorder diagnosis in the future (Selby et al., 2015; Zetterqvist, 2015).

Healthcare Professionals' Attitudes Towards NSSI

It is critical that healthcare providers (HCPs) respond to a client's NSSI disclosure in a nonjudgmental and empathic way that validates their experiences in order to facilitate a positive therapeutic encounter (Klonsky & Lewis, 2014; Linehan, Tutek & Dimeff, 1996; Muehlenkamp, 2006). A HCP’s ability to establish an empathic and validating relationship may be hindered if one holds negative attitudes and stigmatized beliefs towards the client (Corrigan, Markowitz, Watson, Rowan, Kubiak, 2003; Law, Rostill-Brookes & Goodman, 2009). The quality of the therapeutic encounter can have a significant impact on a client’s psychological well-being, treatment adherence, trust in healthcare services, and future help-seeking (Fortune, Sinclair & Hawton, 2008; Mitten, Preyde, Lewis, Vanderkooy & Heintzman, 2016; Taylor, Hawton, Fortune & Kapur, 2009). Indeed, it is valuable to understand HCPs’ attitudes towards clients who self-injure.

Unfortunately, such negative reactions to clients have been documented in the literature; in a review of 31 studies exploring the experiences of clients with a history of NSSI, clients commonly reported having had negative interactions with HCPs (Taylor et al., 2009). Negative interactions were marked by HCPs endorsing misconceptions about NSSI and expressing a lack of sympathy for clients who self-injure. In a more recent study, Mitten et al. (2016) interviewed twelve youth about how they perceived their experiences during inpatient psychiatric and emergency room care. Eight youth felt that HCPs minimized or belittled their problems, and six
reported feeling they had to prove the legitimacy of their psychological distress to gain access to specialized services (Mitten et al., 2016).

**Attitudes toward NSSI among HCPs.** There is a dearth of research examining the extent to which HCPs hold positive or negative attitudes and stigmatized beliefs towards clients who engage in NSSI specifically. Saunders, Hawton, Fortune and Farrell (2012) reviewed 74 studies examining the attitudes of allied healthcare and psychiatric staff in mostly general hospital or emergency room settings. Most of the reviewed studies did not probe attitudes about NSSI specifically, but rather conflated NSSI with suicidal behaviour and/or BPD. Keeping the above limitations in mind, Saunders et al. found that HCPs held largely negative attitudes towards individuals who engaged in repetitive NSSI. Specifically, feelings of frustration and anger were predominantly felt towards clients who self-injured and were especially salient when HCP perceived attention-seeking motives behind a client’s self-injury (as opposed to suicidal intentions). In a more recent study, NSSI attitudes of psychologists, social workers, and psychiatric and medical nurses from 12 Belgium hospitals were investigated (Muehlenkamp et al., 2013). All groups endorsed mostly positive attitudes reflecting empathy towards clients who self-injured. However, those professionals working in mental health related fields (i.e., psychologists and psychiatric nurses), endorsed significantly more positive attitudes than those working within general medicine (i.e., medical nurses and social workers). Taken together, mental health professionals may endorse more positive attitudes than more general hospital staff. However, only one study has examined the attitudes of mental health professionals, and the sample was limited to one European country. Further research with a geographically diverse sample is needed to understand the attitudes of mental health professionals towards individuals who self-injure.
Misconceptions about NSSI among HCPs. When supporting clients who self-injure, HCPs may hold a variety of misconceptions about NSSI. Firstly, HCPs may hold misconceptions about the function of a client’s NSSI. For instance, many HCPs believe that NSSI serves a predominately attention-seeking or manipulative function—a view also held by laypersons (Emerson, 2010; Friedman et al., 2006; McAllister, Creedy, Moyle & Farrugia, 2002) and one that is ubiquitous on the Internet (Lewis et al., 2014). Many individuals who self-injure are aware of these attitudes and are deterred from seeking professional help for fear of being labeled as attention-seeking or manipulative (Fortune, Sinclair & Hawton, 2008). While NSSI may have interpersonal functions (e.g., to communicate a need for help), NSSI is largely not enacted to seek attention—especially in the pejorative manner it is often viewed (Klonsky, 2007). Klonsky’s (2007) review of the literature indicates that other functions are far more common (e.g., affect regulation, self-punishment).

Secondly, misconceptions about the relation between NSSI and suicide may lead HCPs to both under and overestimate suicide risk (Saunders et al., 2012; Taliaferro et al., 2013). According to one study, only 50% of emergency department nurses and doctors strongly or moderately agreed that those who self-injure were at risk for suicide (Friedman et al., 2006). Given the mounting evidence that NSSI represents a unique and robust predictor of suicidal thinking and behaviour (Klonsky et al., 2013; Nock et al., 2006), it is concerning that half of HCPs did not endorse this item. At the same time, conflating NSSI with suicidal behaviour can lead HCPs to overestimate suicide risk (Muehlenkamp, 2005; Selby et. al., 2015). If this overestimation leads to inappropriate inpatient hospitalization, the client may develop a distrust of healthcare services and be less likely to seek help in the future (Selby et al., 2015). Taken
together, it is imperative that HCPs have a fulsome and nuanced understanding of the NSSI-suicide link.

Finally, HCPs may hold misconceptions about the comorbidity of BPD in individuals who engage in NSSI. In past editions of the DSM, NSSI was listed solely as a symptom of BPD (APA, 2013). It was not uncommon for individuals who self-injured to be (mis)diagnosed with BPD—sometimes in an effort to access insured services (Glenn & Klonsky, 2013). For individuals who self-injure, an inappropriate BPD classification can carry considerable stigma; HCPs and laypersons may be more likely to perceive NSSI as attention-seeking and manipulative in these contexts (Aviram, Brodsky & Stanley, 2006). Despite its historical linkage to BPD, no research to date has evaluated the extent to which HCPs perceive the comorbid relationship between NSSI and BPD. It is especially unclear how the introduction of NSSI-D in the DSM would impact how readily BPD is diagnosed.

**Impact of Diagnostic Labeling on HCPs Attitudes Towards NSSI.**

With growing research pointing to the likelihood of NSSI Disorder being adopted in a future DSM edition (Selby et al., 2015; Zetterqvist, 2015), it will be important to explore how a mental disorder classification may impact care provision and attitudes towards clients who engage in NSSI. Link, Cullen, Frank and Wozniak’s (1987) seminal work suggests that the provision of a mental disorder diagnosis may worsen one’s attitudes towards the individual being diagnosed, but only if there are pre-existing negative beliefs towards that individual. As discussed above, HCPs may already endorse negative attitudes towards clients who self-injure, and supplementing NSSI with a mental disorder classification may worsen stigma towards these individuals (Link et al., 1987; Saunders et al., 2012). Individuals who have lived experience with NSSI have voiced concerns that a new diagnostic label may worsen attitudes towards individuals
who self-injure (Lewis et al., 2017). However, no research has corroborated these concerns by examining the impact of diagnostic labeling on HCPs’ attitudes towards patients who self-injure (Lewis et al., 2017; Rowe et al., 2014).

Alternatively, applying a mental disorder classification may help legitimize NSSI as a valid mental health concern deserving of care (Law, Rostill-Brookes & Goodman, 2009; Lewis et al., 2017; Saunders et al., 2012). According to the attribution model of mental illness, when a behaviour (such as self-injury) can be ascribed to a cause such as a mental illness, the person may be less likely to be judged as responsible and in control of engaging in that behaviour (Corrigan et al., 2003). Hadfield, Brown, Pembroke & Hayward (2009) found that some emergency doctors felt apprehension when attending to clients who self-injured for fear they were colluding in the client's attention-seeking efforts. Attributing self-injury to mental illness may influence HCPs to consider them less in control of their behaviours, which may engender more sympathetic interactions and an increased desire to help (Hadfield et al., 2009; Mackay & Barrowclough, 2005).

Given the importance of a positive therapeutic alliance when supporting clients who self-injure (Klonsky et al., 2011; Lewis & Klonsky, 2014), research is needed to explore the extent to which the adoption of NSSI-D in the DSM may affect HCPs' attitudes towards individuals who meet criteria for NSSI-D. Further, the available literature only explores the attitudes of emergency HCPs which may not represent the attitudes of HCPs outside of an emergency department.

**Diagnosing Professionals**

There is certainly merit in better understanding the attitudes of all HCPs towards individuals who self-injure. However, when considering the prospect of NSSI-D in the DSM, it
may be useful to initially focus on those HCPs specialized in diagnosing mental health disorders, namely, psychologists and psychiatrists, henceforth referred to as diagnosing professionals (DPs). Indeed, 32% of individuals accessing mental health services through family physicians are referred to DPs for specialized assessments (Canadian Medical Association, 2012). Further, DPs are familiar with the DSM and may be able to provide important insights into the potential benefits and limitations of a new diagnostic classification for NSSI.

In addition, there is limited research exploring how psychologists and psychiatrists comparatively conceptualize NSSI, and the advent of a new diagnostic classification. In comparison to general hospital staff, psychiatric staff have been found to report more positive attitudes towards individuals who self-injure (Muehlenkamp et al., 2013; Saunders et al., 2011). However, these studies did not distinguish the attitudes of psychologists and psychiatrists when examining the attitudes of psychiatric staff. When comparing medical students to clinical psychology students, Law, Rostill-Brookes and Goodman (2009) found that medical students endorsed more anger, more perceptions of manipulative motives, lower levels of helping behaviour, and higher endorsement of segregatory behaviours towards individuals who self-injure than clinical psychology students. However, findings from medical students may not directly map onto psychiatrists, who receive specialized training in residency and in practice. Therefore, research is needed to explore how both psychologists and psychiatrists perceive individuals who self-injure, and how the advent of a new disorder may impact these perceptions.

**Current Study Objectives**

There were two overarching objectives to the present study: 1) to understand how diagnosing professionals (DPs) understand NSSI and perceive clients who self-injure, and 2) to probe DPs’ receptivity towards the advent of NSSI Disorder in the DSM and the possible impact
of diagnostic labelling on their attitudes. Psychologists and psychiatrists were recruited through email from medical and psychological training programs and chain-referrals to complete a brief online survey about a new diagnostic classification in the DSM. Upon attending to the survey, participants were told the study was about self-injury and NSSI Disorder and given the option to indicate informed consent. Participants completed questions pertaining to their experience with clients who self-injure and their attitudes towards these clients. Participants were then introduced to the DSM criteria for NSSI Disorder and asked for their outlook on the potential advent of this disorder, and how conferring a diagnosis of NSSI-D may impact their attitudes towards clients who self-injure. Given the dearth of research examining the attitudes of DPs towards individuals who self-injure and NSSI-D, the present study adopted an exploratory framework to examine the following research questions.

Attitudes towards clients who self-injure and the NSSI-BPD-suicide relation

1. The primary aim of the study was to understand how DPs perceive clients who engage in NSSI. This involved examining DPs’ attitudes towards NSSI, the extent to which they endorsed common NSSI myths (e.g., NSSI as attention-seeking), and their overall approach for working with clients who self-injure (e.g., as more or less sympathetic). When comparing the findings of Muehlenkamp et al. (2013) and Saunders et al. (2012), it appears that the attitudes of mental-health professionals may be more positive than those of general healthcare providers. However, Muehlenkamp et al.’s findings require replication in a larger, more geographically diverse sample that include attitudes of psychiatrists alongside those of psychologists.

2. The second aim of this study was to evaluate the extent to which DPs endorse misconceptions about the relationship between NSSI, suicide and BPD. First, HCPs in
emergency departments have been found to both under and overestimate suicide risk among individuals presenting with self-injury (Friedman et al., 2006; Taliaferro et al., 2013). However, no research has examined how psychologists and psychiatrists perceive suicide risk among individuals who self-injure. Second, NSSI is included only as a criterion of BPD in the DSM, but not all individuals who self-injure have BPD (Glenn & Klonsky, 2013). No research has explored how DPs perceive the relationship between NSSI and BPD. The current study explored the extent to which DPs endorse the statement, “most clients who self-injure have borderline personality disorder”.

**Acceptability of NSSI Disorder and the impact of diagnostic labelling**

3. A third aim was to explore the receptivity of DPs towards the potential advent of NSSI Disorder in the diagnostic nomenclature. Considering that DSM-5 field trials yielded poor inter-rater reliability, (Regier et al., 2013), it was important to explore how DPs perceive the utility and acceptability of NSSI-D and its criteria. The present study probed whether DPs believe NSSI-D should be classified as its own disorder in the DSM or whether it would be better classified as a behaviour associated with other mental disorders. Further, some of the DSM criteria merit revisions prior to NSSI’s potential inclusion in the DSM (Selby et al., 2015)—specifically, Criterion A (i.e., engagement in NSSI five or more days in last year) has garnered the most controversy (Muehlenkamp, personal communication, June 23, 2017; Selby et al., 2015). Therefore, DPs were also asked whether, in their professional opinion, they felt that Criterion A would adequately capture clinically significant presentations of NSSI.

4. No research has examined how the prospect of NSSI-D may impact the aforementioned variables, (i.e., NSSI attitudes, approaches to clinical care, and the suicide-BPD-NSSI
relationship). The current study attempted to ascertain whether a DPs’ perception towards a client who self-injures are projected to remain unchanged, or become more positive or negative if the client were to meet criteria for NSSI Disorder. To probe the attribution model of mental illness, DPs were also asked to project whether their perception of the client’s ability to control their self-injury would be affected by ascribing their behaviour to a mental disorder classification. In line with conflicting research demonstrating that a mental disorder diagnosis may exacerbate negative attitudes (Link et al., 1987), and/or evoke more sympathetic and helping responses towards individuals who self-injure, no formal hypotheses were made (Corrigan et al., 2003; Hadfield et al., 2009; Mackay & Barrowclough, 2005; Saunders et al., 2012).

Supplemental aims

5. A related aim was to explore how a DP’s training and perception of competence with NSSI may impact their responses to the aforementioned variables. There is support to hypothesize that DPs who have had training in NSSI and feel competent supporting clients who self-injure will endorse more positive attitudes towards these clients (Muehlenkamp et al. 2013; Taylor et al., 2009). No research has examined whether training in NSSI or a DPs’ perceived competence impacts their perspectives on the NSSI-suicide-BPD relationship or their attitudes towards NSSI Disorder in the DSM.

6. A final goal was to examine how the attitudes of psychologists and psychiatrists compared on the aforementioned variables. Muehlenkamp et al. (2013) found that mental health professionals demonstrated more positive attitudes towards clients who self-injure than medical professionals. However, psychiatrists are both mental health and medical professionals and it is unclear how their perceptions towards clients who self-injure may
compare to psychologists. Understanding how psychologists and psychiatrists may compare on their attitudes towards NSSI may help inform the content of psychoeducation programs for these groups.

Methods

Participants

A sample of 127 diagnosing professionals (DPs) were recruited through email from psychiatric or psychological training programs, hospitals, private practices and chain-referrals. DPs were required to have completed the education and supervision required for independent practice within their region’s regulatory bodies, (i.e., psychiatry residents or provisional psychologists were not included). Ninety-eight psychologists (n=4 MA psychologists) and 29 psychiatrists were recruited. The mean age of respondents was 42.4 years (SD = 10.9) and most participants were female (77%). The sample was largely Canadian (70%) with representation from 10 provinces, and the remaining participants represented 19 American states (see Table 2 for participant demographics). Only those DPs who reportedly spent their professional time providing or supervising direct client care were eligible to participate. Most respondents (83.5%) reported sometimes, often, or always “provid[ing] or supervis[ing] direct care to patients who have engaged in NSSI”.

Materials

Given the dearth of research related to the study’s purview, the survey was developed specifically for the present study. The questionnaire consisted of three sections: 1) demographics, eligibility and clinical experience with NSSI, 2) attitudes toward clients who self-injure and the NSSI-BPD-suicide relation, and 3) acceptability of NSSI-D and the impact of diagnostic labelling. See Appendix A for questionnaire items.
1. **Demographics, eligibility and clinical experience with NSSI.** Demographic items probed age, gender, state, province or territory of residence, current employers, and profession. Questions probing the participants' profession ensured survey eligibility and were used to explore group differences between psychologists and psychiatrists. DP’s training, competence and familiarity with clients who engage in NSSI was also probed. Specifically, DPs were asked whether they “have ever received specialized training on how to support clients who engage in NSSI”. Participants were asked to reflect on whether they felt they had the “appropriate knowledge” or “clinical skills” to help patients who self-injure.

2. **Attitudes towards clients who self-injure and the NSSI-BPD-suicide relation.** Items probing attitudes toward NSSI were derived from Muehlenkamp et al.’s (2013) positive empathy (PSE) and negative attitudes scales (NAS). For example, items such as “I am concerned about patients who self-injure” probed positive attitudes, while items such as “Those patients who self-injure are just trying to get attention” probed negative attitudes. Given the short length intended for the survey, the three items with the highest factor loadings on the PSE and NAS were retained for use in the present study (α=.72 -.79; Muehlenkamp et al, 2013). Additionally, two items were designed to probe the possible consequences of these attitudes by exploring DPs’ attitudes toward helping individuals who self-injure, (e.g., “Dealing with clients who self-injure is a waste of healthcare professionals’ time.”). Finally, DPs’ beliefs about the link between NSSI and BPD, and NSSI and suicide were examined, (e.g., “Clients who self-injure should be considered at risk for suicide” and “Most patients who self-injure have Borderline Personality Disorder”). Items within this section were rated along a 5-point scale ranging from *strongly disagree* (1), *neither agree nor disagree* (3), to *strongly agree* (5).
3. Acceptability of NSSI Disorder and the impact of diagnostic labelling. Participants were introduced to criteria for NSSI Disorder as it is presented in the DSM-5. To follow, they were asked about their receptivity to NSSI’s inclusion the in the DSM. In particular, DPs were asked to how strongly they agreed or disagreed with the following statements, “I believe NSSI Disorder should be classified as its own disorder in the DSM” and “NSSI Disorder is better classified as a behaviour associated with other mental disorders than an independent disorder.”. They were also asked to indicate whether “Criterion A would adequately capture clinically significant presentations of NSSI”.

To probe the impact of diagnostic labelling, the items from section two (i.e., attitudes towards clients who self-injure and NSSI-BPD-Suicide) were restated, but DPs were asked to consider whether they would endorse these items much less (1), somewhat less (2), similarly (3), somewhat more (4), or much more (5) if the client presenting with self-injury met criteria for NSSI Disorder. For example, a participant may fill in the blank like this, “if a client who self-injures also met criteria for NSSI Disorder, I would feel they are [much less] likely to self-injure to get attention.”. An item probing whether clients would be perceived as in more or less control over their self-injury was also included to query Corrigan et al.’s (2003) attribution model of mental illness.

Procedure

A four-tier recruitment approach was employed to maximize response rates. First, administrative representatives at clinical psychology and psychiatry training programs across Canada and the United States were asked to forward study invitation to respective employees in their department (see Appendix B for a sample recruitment email). Second, respondents were contacted directly through publicly available emails to ensure geographic diversity within North
America (i.e., representation from Northern provinces). Third, a chain-referral sampling approach was used where existing participants were asked to forward invitations to psychologists and psychiatrists in their professional networks. Finally, respondents were also recruited with permission through professional electronic mailing lists, (i.e., Association for Behavioral and Cognitive Therapies). Invitations to participate were released sequentially to avoid inundating individuals with requests to participate in the study.

Participants were prompted to complete a brief online survey about a new diagnostic classification in the DSM (i.e., 30 questions taking 10-15 minutes). The study received ethical clearance through the University of Guelph’s Research Ethics Board. To promote survey engagement, participants were aware that responses were anonymous and confidential, and that they could enter to win 1 of 4 Amazon gift cards at survey completion. To ensure anonymity, email addresses were not linked to survey responses and prizes will not be drawn until the close of data collection.

Upon attending to the survey, respondents were informed that the study was about self-injury and NSSI Disorder and could indicate informed consent (see Appendix C for consent document). A definition of Nonsuicidal Self-Injury was provided to ensure participants’ responses to survey items referenced self-injury without suicidal intent. Questions probed the DPs’ demographics, experiences with patients who self-injure, and their attitudes towards these patients. Participants were then introduced to the advent of NSSI Disorder in the DSM-5 and prompted to review its criteria. They were then asked to indicate how the availability of NSSI-D as a diagnostic classification may impact their perceptions about clients who self-injure. Finally, participants were debriefed on the study’s purpose and redirected to a secure webpage to provide
their email address to enter the prize draw (see Appendix D). All aspects of the study were delivered to the participants via online secure research software Qualtrics.

**Results**

**Data Analysis Plan and Preparation**

Composite scores for the three positive attitude items were not calculated as internal consistency between items was very low ($\alpha=.11$). Similarly, composites of the three negative attitude items could not be procured as the adequate internal consistency between items ($\alpha=.64$) was largely due to the high correlation between two items probing manipulativeness and attention seeking, $r=.69$, $p<.001$. The two competence items that probed whether DPs had the appropriate knowledge and clinical skills to help patients who self-injure were highly correlated ($r=.85$, $p<.001$), and thus ratings on these two items were aggregated to form the competence (CO) scale.

The Shapiro-Wilk test of normality revealed that all variables were non-normally distributed as significance values were between $p=.0005$ and $p=.018$. As indicated by the Levene’s tests of homogeneity of variance, 31 of 34 variables violated the assumption of equal variance with significance values between $p=.041$ and $p<.0005$. Due to these violations, non-parametric measures were used to examine group difference in profession, training, and competence. Mann-Whitney U tests were used to compare differences between two independent groups (i.e., training and profession) when the dependent variable was either ordinal or continuous. The Kruskal-Wallis test by mean ranks was used to examine differences between two or more groups of an independent variable (i.e., employer, experience) on a continuous or ordinal dependent variable. Spearman’s rank order correlations were used to examine nonparametric correlations between variables. Otherwise, frequency distributions and percentage
breakdowns were most appropriate for communicating the attitudes of DPs towards clients who self-injure, the NSSI-BPD-suicide relation, NSSI Disorder, and the extent to which a diagnosis could influence these attitudes. Ratings from both psychologists and psychiatrists were aggregated.

**Attitudes Towards Clients Who Self-Injure and the NSSI-BPD-Suicide Relation**

A graphic representation of the results is presented in Figure 1 and means and standard deviations of DPs’ responses to study variables are presented in Table 2. Overall, DPs strongly agreed or agreed that they listen fully to the problems and experiences of patients who self-injure (94.5%), and that they demonstrate warmth and understanding to patients who self-injure (97.6%). Most also agreed or strongly agreed (98.4%) that supporting patients who self-injure is an important healthcare issue and disagreed or strongly disagreed (98.4%) with the sentiment that it was a waste of their time to support patients who self-injure. In a similar vein, most DPs strongly disagreed (39.7%) or disagreed (44.4%) that those who self-injure are often doing it to manipulate others or are just trying to get attention (44.9% strongly disagreed and 45.7% disagreed).

With respect to DP’s views regarding the relation between NSSI and suicide and NSSI and BPD, most strongly disagreed (13.4%) or disagreed (49.6%) that most individuals who self-injure also have Borderline Personality Disorder. Only 11.8% agreed or strongly agreed that NSSI commonly co-occurs with BPD. When asked whether patients who self-injure should be considered at risk for suicide, most DPs agreed (51.2%) or strongly agreed (11.0%). However, 27.6% of DPs neither agreed nor disagreed with this view. Further, 8.7% of DPs disagreed and 1.6% strongly disagreed that those who self-injure should be considered at risk for suicide.
Acceptability of NSSI Disorder and the Impact of Diagnostic Labelling

When asked about the prospect of NSSI being apart of the DSM nomenclature (see Figure 1), 41.5% of DPs were undecided or indifferent to the inclusion of NSSI Disorder in a future edition of the DSM. Of those who have a polarized opinion, 35.7% did not believe NSSI Disorder should be in the DSM (8.1% strongly disagree; 27.6% disagree), while a minority of DPs agreed (17.1%) or strongly agreed (5.7%) that NSSI should be classified as its own disorder. When asked whether NSSI was better described as a behaviour co-occurring with other forms of mental illness, most DPs agreed (37%) or strongly agreed (15.7%) with this view. A small fraction disagreed or strongly disagreed (14.7%) with this view. Finally, DPs were asked whether they felt that the proposed DSM frequency criteria (i.e., engagement in NSSI five or more days in last year) captured clinically significant presentations of NSSI. Here, most DPs agreed or strongly agreed that Criterion A was appropriate (43.1%). Yet, others had more divergent views, with 38.2% disagreeing or strongly disagreeing, and 18.7% who were indifferent with the clinical utility of Criterion A.

In addition to probing DPs’ receptivity towards NSSI Disorder, DPs were asked about their perceptions towards individuals who self-injure if they were to meet criteria for NSSI Disorder (see Figure 2 for a graphic representation of results). Here, most DPs indicated a diagnosis of NSSI Disorder would not change their levels of warmth and understanding toward clients (95.1%). When asked about NSSI attitudes, most DPs reported that a diagnosis of NSSI Disorder would not change their attitude toward clients as manipulative (86.2%) or attention seeking (89.3%). However, nearly twelve percent of DPs reported they would feel more concerned about their clients if they met NSSI Disorder criteria. Further, another 27.7%
indicated they would perceive individuals as being less in control or much less in control of their self-injury.

When asked about the likelihood of clients meeting BPD criteria if they were to meet criteria for NSSI-D, most DPs reported that a diagnosis would not influence their attitudes, however 43.9% reported that they believe it would be somewhat or much more likely for clients with NSSI Disorder to also have BPD. Finally, most DPs reported that a diagnosis of NSSI Disorder would not affect the extent to which they thought a client was at risk for suicide (61.0%), however, 33.4% reported they would perceive a patient with NSSI Disorder to be somewhat more or much more likely to be at risk for suicide.

**Impact of Experience, Training and Perceived Competence**

A Kruskal-Wallis test by mean ranks found that DPs in hospital settings had more frequent encounters with clients who self-injure than those from healthcare centers, private practices, and university centers, $\chi^2(4, N=88) = 18.54, p = .001$. The frequency with which DPs reported working with clients who self-injure did not have an impact on any of the study’s variables ($r=.001$ to $r=.15$, $p=.08$ to $p=1.0$). There was a modest positive correlation between a DP’s age and the extent to which they agreed that most patients who self-injure have BPD ($r=.19$, $p=.03$, 95% CI [.013, .36]). Further, there was also a small negative correlation indicating that older DPs were less likely to think that the provision of diagnosis would influence how likely they were to be self-injuring to manipulate others ($r=.20$, $p=.029$, 95% CI [.13, .39]). There was no meaningful impact of gender on survey responses.

Of those diagnosing professionals who sometimes, often or always interact with clients who self-injure, 62.3% have received specialized training for NSSI. As indicated by a Chi-square analysis, psychologists were significantly more likely to have specialized training with NSSI
than psychiatrists, $\chi^2(1, N=127) = 7.55, p = .006$. A Mann-Whitney U test revealed that DPs with NSSI training felt more competent when supporting clients who self-injure $U=989.0, p<.0005$.

A Mann-Whitney U test indicated that training did not significantly affect DPs’ attitudes towards patients who self-injure, perceptions of the NSSI-BPD-suicide relationship, or opinions on NSSI Disorder. However, there was a significant impact of training on the extent to which DPs agreed that supporting patients who self-injure was an important healthcare issue ($U=2430.0, p=.002$), and not a waste of a professional’s time, $U=1380.5, p=.001$.

Finally, the extent to which DPs provided or supervised direct client care to clients who self-injured was significantly correlated with their perceived level of competence with these clients, $r=.46, p<.005$, 95% CI [.30, .61]. The more competent DPs felt they were, the more they reported that they demonstrated warmth and understanding towards patients who self-injure ($r=.21, p=.02$, 95% CI [.062, .41]), and the less they endorsed that patients who self-injure were doing so to manipulate others ($r=.23, p=.009$, 95% CI [.053, .33]). Further, DPs who reported feeling more competent were more likely to disagree with the sentiment that caring for these patients was a waste of a professional’s time ($r=.25, p=.004$, 95% CI [.12, .46]).

A DPs’ perceived competence with self-injury was related to the extent to which they believed most individuals who self-injure also have BPD ($r=.20, p=.023$, 95% CI [.026, .38]), but did not relate to their stance on whether those who self-injure should be at risk for suicide ($r=.07, p=.42$, 95% CI [.063, .22]). As indicated by a Kruskal-Wallis analysis, perceived competence with NSSI did not significantly impact DPs’ opinions on whether NSSI should be its own disorder, [knowledge competence, $\chi^2(3, N=123) = 4.020, p=.26$; clinical skill competence: $\chi^2(3, N=123) = 2.32, p=.51$].
Comparison of Psychologists and Psychiatrists

A final aim of this study was to examine how the attitudes of psychologists and psychiatrists compared on the above variables. However, there was a disproportionate number of psychologists (n=98) to psychiatrists (n=29) in the present study. The variances between the two groups were equal, but the samples were non-normally distributed which would warrant the use of non-parametric measures. A power analysis for different sample sizes was conducted using R software. Assuming a small effect size of 0.2, there would only be a 15.7% probability of finding a true difference between psychologists and psychiatrists if one existed. Therefore, the present study did not examine how the attitudes of psychologists and psychiatrists compared. A sample of approximately 150 -200 psychologists and psychiatrists would be needed to achieve a power of approximately 0.8. Upon the completion of data collection, Mann-Whitney U and Kruskal-Wallis tests by mean ranks would be meaningful in comparing how the attitudes of psychologists and psychiatrists compare on study variables.

Discussion

There were two main objectives to the present study: 1) to understand how diagnosing professionals (DPs) understand nonsuicidal self-injury (NSSI) and perceive clients who self-injure, and 2) to probe their receptivity towards the advent of NSSI Disorder (NSSI-D) in the DSM and explore the impact diagnostic labelling could have on their attitudes towards individuals who meet criteria for the disorder.

Attitudes Towards Clients Who Self-Injure and the NSSI-BPD-Suicide Relation

Individuals who self-injure report several barriers to help-seeking, one of which includes concerns that professionals will not value the significance of their difficulties or will label them as attention-seeking or manipulative (Fortune, Sinclair & Hawton, 2008; Mitten et al., 2016).
Research examining such attitudes is focused on healthcare professionals (HCPs) in mostly general hospital or emergency room settings and conflate nonsuicidal self-injury with suicidal behaviour and/or Borderline Personality Disorder (BPD). The present study aimed to examine how psychologists and psychiatrists perceive individuals who self-injure. It was important that these diagnosing professionals be asked to reflect on self-injury without suicidal intent (versus other forms of general self-harm). Of the 127 psychologists and psychiatrists surveyed, nearly all diagnosing professionals believed that supporting patients who self-injure was an important healthcare issue. They report attempting to demonstrate warmth and understanding towards these patients and listen fully to their experiences. Contrary to what has been reported with respect to attitudes of general HCPs (Saunders et al., 2012), most psychologists and psychiatrists do not believe that individuals who self-injure do so for attention or to manipulate others. This may indicate that more intensive training in mental health, which DPs arguably have, may impact how professionals view NSSI and individuals with lived NSSI experience. Future work ought to explore this possibility before more concrete conclusions can be drawn as other factors (e.g., increased NSSI awareness overall) may also account for these findings.

In line with the above, the current findings mirror those by Muehlenkamp et al. (2013) who found that attitudes of Belgian psychologists and psychiatric nurses (who would also have extensive mental health training) were mostly positive. The present study adds geographic diversity from over 29 North American regions to Muehlenkamp et al’s’ findings. Taken together, it seems that mental health professionals mostly hold positive and accurate perceptions of NSSI and those who self-injury.

The present study also examined the impact of competence, training and experience on DP’s responses. DPs who felt more competent supporting clients who self-injure largely reported
more positive attitudes and disagreed with negative statements about NSSI. Specialized training in NSSI did not impact the extent to which DPs endorsed positive or negative attitudes towards NSSI. However, those with training were considerably more likely to value self-injury as an important healthcare issue worthy of their clinical attention. Familiarity and experience with clients who self-injure may be an important factor in facilitating positive attitudes towards these clients, while the provision of self-injury training may communicate to DPs that NSSI is a mental health concern worthy of professional attention. Research that considers experience and training as moderating variables would be needed to corroborate such conclusions.

When supporting individuals who self-injure, existing clinical guidelines highlight the importance of assessing for suicidality (Klonsky & Lewis, 2014; Lewis & Heath, 2015; Washburn et al., 2012). While most individuals who attempt suicide have self-injured (Klonsky, May & Glenn, 2013), most individuals who self-injure do not attempt suicide (Cutliffe, Braithwaite, Stevenson, 2008). This puzzling distinction has likely lead HCPs in emergency departments to both under and overestimate suicide risk among individuals who self-injure (Friedman et al., 2006; Taliaferro et al., 2013). When asked whether "patients who self-injure should be considered at risk for suicide," most DPs agreed that this was important; however, 10% disagreed and 30% were unsure. Considering that among inpatient samples, 70% of individuals who self-injure attempt suicide at least once in their lives (Nock et al., 2006), arguably all DPs should agree with the statement that those who self-injure should be considered at risk for suicide. However, there may be several reasons why DPs did not unanimously agree with this statement. Most notably, DPs may have interpreted the question to mean that individuals who self-injure are at imminent suicide risk or that their self-injury was a suicide attempt—this would not be true (Nock et al., 2006). Alternatively, DPs may have responded
cautiously to ensure their knowledge of the suicide-self-injury distinction was communicated. Future research may need to ask DPs whether a suicide risk assessment should be conducted when working with patients who self-injure. Nevertheless, this finding underscores the potential need for training for DPs to ensure that all individuals who present with NSSI are assessed for suicide to keep with best practice guidelines (Klonsky & Lewis, 2014; Lewis & Heath, 2015; Washburn et al., 2012).

Given the historical conflation between NSSI and BPD, there have been concerns that DPs may be biased towards diagnosing BPD when working with clients who present with self-injury and related symptomology (Glenn & Klonsky, 2013). The present study was the first to explore the extent to which DPs perceive the comorbid relationship between NSSI and BPD and found that 63% psychologists and psychiatrists understood that most individuals who self-injure do not have BPD. However, 12% of DPs agreed that NSSI and BPD most often co-occur and 25% of DPs were ambivalent or unsure. Within clinical samples, roughly 50% of individuals who self-injure do not meet criteria for BPD. Indeed, it may be important that DPs are educated about NSSI's clinical significance outside of a BPD context (Glenn and Klonsky, 2013; Herpertz, 1995; Nock et al., 2006; Zlotnick, Mattia & Zimmerman, 1999).

**Acceptability of NSSI Disorder and the Impact of Diagnostic Labelling**

In keeping with recent calls from the American Psychiatric Association (APA) for feedback on changes to the DSM-5, including NSSI Disorder (APA, 2013), the present study was the first to ask psychologists and psychiatrists whether or not they agreed with NSSI Disorder potentially joining a future iteration of the DSM. While most DPs were uncertain whether NSSI Disorder should be included in the DSM, those with a polarized opinion largely disagreed (36%) that the diagnosis should exist. Training, experience and competence with NSSI
(as measured in the study) did not appear to have an impact on their stance. There may be several reasons why there was some disapproval of NSSI Disorder from DPs in the present study. First, NSSI has clinical significance as a behavioural symptom of several psychological difficulties, or personality, mood, and eating disorders (Lewis & Heath, 2015; Nitkowski & Petermann, 2011; Nock et al., 2006). Indeed, as queried in the present study, most DPs agreed that NSSI would be better classified as a behaviour associated with other mental disorders than an independent disorder. However, research finds that there may be a subgroup of individuals whose self-injury is more frequent, persistent, and impairing who have distinct psychological and biological mechanisms that may best be categorized as NSSI Disorder (Crowell et al., 2005; Groschwitz & Plener, 2012; Nielsen, Sayal & Townsend, 2016; Plener et al., 2013; Stanley et al., 2016; Zetterqvist, 2015). It is of interest to explore whether DPs’ attitudes towards NSSI Disorder can be influenced by psychoeducation highlighting the clinical significance of diagnostic independence. Second, some researchers argue that NSSI is best viewed as a normative—yet atypical—adolescent behaviour that helps youth cope during acute periods of stress (Adler & Adler, 2007; Selby et al., 2015). Indeed, DPs may have disagreed with the creation of NSSI Disorder to avoid inappropriately pathologizing NSSI. Third, DPs may have mixed opinions towards the utility of the proposed criteria and some professionals may want to see the criteria modified before they can judge the utility of NSSI Disorder. Regier and colleagues found that clinicians had very low agreement when using the NSSI Disorder criteria when assessing patients who self-injure. Criterion A which probes the frequency and duration with which a patient must engage in NSSI currently lacks validity and clinical utility (Ammerman, Jacobucci, Kleiman, Muehlenkamp & McCloskey, 2017; Muehlenkamp, Brausch & Washburn, 2017). As queried in the present study, DPs were similar in their agreement (43%) and disagreement (38%)
that Criterion A (i.e., engagement in NSSI five or more days in last year), could capture clinically significant presentations of NSSI as it is currently defined. Taken together, contrasting opinions with the disorder's utility and criteria may explain why field trials found poor inter-rater agreement. It is still unclear whether NSSI should be incorporated as a full-fledged disorder. As it stands, the acceptance of NSSI Disorder into a future edition of the DSM may be met with resistance from diagnosing professionals. If included, efforts may be needed to ensure DPs understand the clinical significance of the diagnosis and ensure diagnosing professionals can use its criteria reliably.

The present study also examined how DPs’ attitudes towards clients who self-injure may be affected if such clients met criteria for the disorder. In this regard, the vast majority of DPs report that a mental disorder classification would not impact their attitudes towards patients who self-injure. When changes in attitudes were observed, 28% of DPs reported that they would perceive the client to be less in control of their self-injury. This finding is in accordance with the attribution model of mental illness, where a behaviour ascribed to a cause such as mental illness may lead individuals to be judged as less responsible for, or in control of, their behaviour (Corrigan et al., 2003). Finding the patient less responsible for their behaviour may evoke more sympathetic attitudes (Hadfield et al., 2009; Mackay & Barrowclough, 2005). Indeed, 12% of DPs reported they would feel more concerned about the patient if they met criteria for NSSI Disorder. Similarly, the provision of a diagnosis led 8-10% of DPs to find these patients less likely to be self-injuring to manipulate others or seek attention. In this light, the provision of a mental disorder classification may render DP’s attitudes towards these clients to be more supportive.
In contrast, the provision of a diagnosis led 44% of DPs to believe that a client with NSSI Disorder would be more likely to also have BPD. Similarly, 33% felt that a patient with NSSI Disorder would be at a higher suicide risk relative to a patient who did not meet criteria for the disorder. We must consider that those who self-injure and meet criteria for NSSI Disorder may actually have more severe presentations which may present as higher clinical severity, more suicide attempts, and higher likelihood of comorbid disorders (Selby et al., 2012). Nonetheless, the present study corroborates the belief among individuals with lived NSSI experience that a new diagnostic label may have both a positive and negative impact on how they may be perceived (Lewis et al., 2017). While DPs would likely perceive these individuals as less manipulative or attention seeking, they may also see them as more likely to be suicidal or have other mental health disorders. It is critical that if NSSI Disorder is adopted into the DSM, that DPs are aware of how this diagnosis may impact their attitudes and how they perceive patients who would meet criteria (Lewis et al., 2016).

Implications

Notwithstanding the vast stigma associated with NSSI (Lewis et al., 2014), of which those with lived experience are aware (Lewis et al., 2016), the current findings suggest that many psychologists and psychiatrists do not report holding stigmatized attitudes. Indeed, these professionals endorse positive, supportive attitudes and most do not believe that individuals who self-injure are doing so to manipulate others or seek attention. Consideration must be made that these reported attitudes may not translate to practice. However, if true, these positive attitudes can support DPs in establishing an empathic and validating relationship with clients (Corrigan et al., 2003; Law, Rostill-Brookes & Goodman, 2009), which in turn can foster greater well-being, treatment adherence, and future help-seeking among clients (Fortune, Sinclair & Hawton, 2008;
Mitten et al., 2016). To this end, ensuring that prospective clients engaging in NSSI are aware of DPs’ supportive attitudes may help overcome the perceived expectation that they may be misunderstood and stigmatized. For example, there are free, online resources for school counsellors which can be modified to include the present study’s findings. That way, counsellors can guide students to seek professional mental health support from those who are most likely to compassionately attend to their needs (see www.sioutreach.org).

With NSSI Disorder's inclusion as a condition for further study and the growing evidence for its utility as a diagnosis (Selby et al., 2015; Zetterqvist, 2015), there is a good likelihood that NSSI Disorder will become an official mental disorder. As it currently stands, the inclusion of NSSI Disorder in an upcoming DSM would likely be met with some resistance from psychologists and psychiatrists as assessed in the present study. As reported by the growing body of work exploring the validity and reliability of NSSI-D criteria, it is likely that the existing criteria will change. It is possible that these revisions would yield different views about the utility of NSSI-D. Nonetheless, DPs are likely to require some education and training about the unique psychological and biological mechanisms for those who self-injure and meet criteria that would support the need to have them recognized under an independent disorder classification.

In addition to this, it seems that DPs would benefit from more training about the unique relations between NSSI and BPD, and NSSI and suicide. Self-injury is a robust risk factor of suicidality (Klonsky, May & Glenn, 2013; Nock et al., 2006), and all DPs should be assessing suicide risk when supporting clients who self-injure as indicated in best practice guidelines (Lewis & Heath, 2015). Also consistent with these guidelines, DPs should assess for all mental health disorders, as BPD is not the only disorder that may coincide with self-injury.
Finally, researchers are encouraged to delineate between the attitudes of general physicians (i.e., family and emergency doctors) and mental health specialists towards individuals who self-injure (Muehlenkamp et al., 2013; Saunders et al., 2011). Taylor and colleagues (2009) reported that NSSI-service users widely report negative perceptions and reactions towards clinical services. However, service users in the Taylor et al. study were speaking of their experiences towards a wide variety of healthcare providers. If attitudes toward each group were probed individually, the results may have been different. The results of the present study, alongside Muehlenkamp et al. (2013) and Saunders et al. (2012), suggest that the attitudes of mental health professionals towards self-injury may be comparably more positive than those of general healthcare providers. For individuals who are hesitant to receive treatment, it may be best to have a mental health specialist be the first point of contact to increase the likelihood that the client has a positive healthcare experience.

**Strengths, Limitations and Future Directions**

The present study is one of few studies probing the attitudes of mental healthcare professionals towards NSSI dependent of suicidal intent and comorbid BPD. It is also the only study to probe psychologists’ and psychiatrists’ opinions towards NSSI Disorder and explore the impact of diagnostic labelling. The study was also unique in garnering responses from professionals representing 29 North American regions, with unique training, competence and experience with clients who self-injure. However, there were aspects of the study that limited our ability to understand why DPs responded the way they did and to draw more concrete conclusions about the practical implications of our findings for clients who self-injure.

Firstly, a self-report design was necessary to collect anonymous responses from a large, geographically diverse group of DPs. However, the attitudes that DPs endorsed on the self-report
questionnaires may not translate to how they act when interacting with patients who self-injure. It is not surprising that nearly 98% of DPs agreed that they demonstrate warmth and understanding towards patients who self-injure. Most psychologists and psychiatrists vie to empathically understand all their clients, but this may not always happen in practice. Rather than asking DPs whether they attempt to establish a positive therapeutic alliance, it may be more valid to indirectly probe the outcomes of such a positive alliance. For example, DPs may be less vulnerable to social desirability bias if they were asked whether they find it challenging to work with or build a connection with clients who self-injure (Fisher, 1993). Future research may also consider examining how the clients of psychologists and psychiatrists perceive their doctor's attitudes towards them and their self-injury. Comparing client perceptions to professionals’ self-reports may be helpful in corroborating the findings of the present study.

Secondly, the brevity of the survey allowed us to obtain responses from a population that typically has a low response rate (Muehlenkamp et al., 2013; Peer, 2006; Taliaferro et al., 2013). However, this brevity limited our ability to understand the nuances in DPs’ attitudes towards clients who self-injure, and the role of experience and training with NSSI on these attitudes. For example, by including only a few of the items from Muehlenkamp et al.’s (2013) positive empathy and negative attitude scales, the present study found inadequate internal consistency and overarching scales could not be computed. Without positive and negative attitudes scales, we were unable to examine the moderating roles of various factors (e.g., experience with NSSI) in the context of views toward NSSI and those who self-injure. Additionally, the need to maintain a short survey limited us from asking DPs to supplement their responses with short-answer explanations. Had this been feasible, it would have been interesting to follow-up with respondents to understand why 36% of DPs do not want NSSI Disorder to be an independent
classification in the DSM. Future work involving qualitative items or follow-up interviews may be helpful.

Finally, the present study was unable to draw direct comparisons between mental health professionals and general health professionals. It would be fruitful to understand how other healthcare professionals perceive the advent of NSSI Disorder and those who meet criteria for NSSI Disorder. Indeed, emergency room nurses and physicians will have an important role in triaging patients who present with self-injury, and family doctors and social workers are often the first point of contact that many individuals who self-injure have when receiving support. As supported by the present study and others, it is expected that mental health professionals may have more positive and supportive attitudes towards clients who self-injure (Muehlenkamp et al., 2013; Saunders et al. 2012). Using the same measures will be helpful in allowing for direct comparisons between professionals to survey responses. There is also value in understanding how DPs from different healthcare sectors may vary in their NSSI-related attitudes. For example, psychologists and psychiatrists working within an inpatient psychiatric hospital may have had more adverse experiences with clients who self-injure than those working in private practice, and thus may endorse differing attitudes towards those who self-injure (Saunders et al., 2012). Knowing how professionals in different sectors perceive NSSI can help tailor training programs to each field’s specific needs.
REFERENCES


cortical pattern to emotional and NSS-related material. *Psychiatry Research: Neuroimaging*, 203(2), 146-152.


Table 1


A. In the last year, the individual has on 5 or more days engaged in NSSI that was severe enough to cause minor or moderate damage, but without suicidal intent

B. The individual engages inNSSI 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. NSSI is associated with at least one of the following:
   1) interpersonal difficulties or negative feelings or thoughts immediately precede engagement in NSSI
   2) a period of preoccupation with NSSI precedes the NSSI
   3) NSSI urges or thoughts occur frequently even if not acted upon

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

E. NSSI causes significant distress or impairment in important areas of functioning

F. NSSI does not occur exclusively in a state of psychosis, delirium, or intoxication and cannot be accounted for by another medical or psychological disorder
### Table 2

**Participant Demographics.** Numerical values represent the number of diagnosing professionals in each group.

<table>
<thead>
<tr>
<th></th>
<th>Diagnosing Professionals (N=127)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age [Mean (SD)]</td>
<td>42.4(10.9)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>29</td>
</tr>
<tr>
<td>Female</td>
<td>97</td>
</tr>
<tr>
<td>Another</td>
<td>0</td>
</tr>
<tr>
<td>Profession</td>
<td></td>
</tr>
<tr>
<td>Psychologist (PhD)</td>
<td>94</td>
</tr>
<tr>
<td>Psychologist (MA)</td>
<td>4</td>
</tr>
<tr>
<td>Psychiatrist (MD)</td>
<td>29</td>
</tr>
<tr>
<td>Employer</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>31</td>
</tr>
<tr>
<td>University/College</td>
<td>34</td>
</tr>
<tr>
<td>Healthcare Centre</td>
<td>6</td>
</tr>
<tr>
<td>Private Practice</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td>Missing</td>
<td>39</td>
</tr>
<tr>
<td>Country</td>
<td></td>
</tr>
<tr>
<td>Canada (10 provinces)</td>
<td>89</td>
</tr>
<tr>
<td>USA (19 states)</td>
<td>38</td>
</tr>
</tbody>
</table>
Table 3

Means, standard deviations for study variables. Variables are rated on a 5-point scale (i.e., Strongly Disagree to Strongly Agree; and Much Less to Much More). See Table 3 for the variables’ corresponding survey items.

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience with NSSI</td>
<td>3.28</td>
<td>0.81</td>
</tr>
<tr>
<td>Competence: Knowledge</td>
<td>3.73</td>
<td>0.79</td>
</tr>
<tr>
<td>Competence: Clinical Skills</td>
<td>3.83</td>
<td>0.72</td>
</tr>
<tr>
<td>Concern</td>
<td>4.33</td>
<td>0.64</td>
</tr>
<tr>
<td>Warmth &amp; Understanding</td>
<td>4.54</td>
<td>0.55</td>
</tr>
<tr>
<td>Sympathy</td>
<td>2.12</td>
<td>0.78</td>
</tr>
<tr>
<td>Manipulative</td>
<td>1.77</td>
<td>0.73</td>
</tr>
<tr>
<td>Listen Fully</td>
<td>1.56</td>
<td>0.71</td>
</tr>
<tr>
<td>Attention-seeking</td>
<td>1.65</td>
<td>0.67</td>
</tr>
<tr>
<td>Value: Waste of Time</td>
<td>1.21</td>
<td>0.45</td>
</tr>
<tr>
<td>Value: Important Issue</td>
<td>4.45</td>
<td>0.56</td>
</tr>
<tr>
<td>BPD</td>
<td>2.37</td>
<td>0.90</td>
</tr>
<tr>
<td>Suicide Risk</td>
<td>3.61</td>
<td>0.85</td>
</tr>
<tr>
<td>NSSID: Own Disorder</td>
<td>2.85</td>
<td>0.99</td>
</tr>
<tr>
<td>NSSID: Other Disorder</td>
<td>3.51</td>
<td>1.04</td>
</tr>
<tr>
<td>NSSID: Criteria A</td>
<td>3.01</td>
<td>1.04</td>
</tr>
<tr>
<td>Change: Warmth &amp; Understanding</td>
<td>3.04</td>
<td>0.35</td>
</tr>
<tr>
<td>Change: Concern</td>
<td>3.13</td>
<td>0.46</td>
</tr>
<tr>
<td>Change: Manipulate</td>
<td>2.90</td>
<td>0.50</td>
</tr>
<tr>
<td>Change: Attention</td>
<td>2.93</td>
<td>0.45</td>
</tr>
<tr>
<td>Change: Control</td>
<td>2.71</td>
<td>0.62</td>
</tr>
<tr>
<td>Change: BPD</td>
<td>3.47</td>
<td>0.78</td>
</tr>
<tr>
<td>Change: Suicide Risk</td>
<td>3.31</td>
<td>0.67</td>
</tr>
</tbody>
</table>

Sample size for data analysis is N=127, unless otherwise specified.

* N=123, ** N=126, *** N=126
### Table 4

**Survey items corresponding with variables from Table 3.**

<table>
<thead>
<tr>
<th>Experience with NSSI</th>
<th>I have received specialized training on how to support patients who engage in NSSI.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence: Knowledge</td>
<td>I believe I have the appropriate knowledge about NSSI to help patients who self-injure.</td>
</tr>
<tr>
<td>Competence: Clinical Skills</td>
<td>I believe I have the appropriate clinical skills to help patients who self-injure.</td>
</tr>
<tr>
<td>Listen Fully</td>
<td>I listen fully to the problems and experiences of patients who self-injure.</td>
</tr>
<tr>
<td>Concern</td>
<td>I am concerned about patients who self-injure.</td>
</tr>
<tr>
<td>Warmth &amp; Understanding</td>
<td>I demonstrate warmth &amp; understanding to patients who self-injure.</td>
</tr>
<tr>
<td>Sympathy</td>
<td>Individuals who self-injure are usually trying to get sympathy from others.</td>
</tr>
<tr>
<td>Manipulative</td>
<td>Those who self-injure are often doing it to manipulate other people.</td>
</tr>
<tr>
<td>Attention-seeking</td>
<td>Those patients who self-injure are just trying to get attention.</td>
</tr>
<tr>
<td>Value: Waste of Time</td>
<td>Dealing with patients who self-injure is a waste of healthcare professionals time.</td>
</tr>
<tr>
<td>Value: Important Issue</td>
<td>Supporting patients who self-injure is an important healthcare issue.</td>
</tr>
<tr>
<td>BPD</td>
<td>Most patients who self-injure have Borderline Personality Disorder.</td>
</tr>
<tr>
<td>Suicide Risk</td>
<td>Patients who self-injure should be considered at risk for suicide.</td>
</tr>
<tr>
<td>NSSID: Own Disorder</td>
<td>In general, I believe NSSI Disorder should be classified as its own disorder in the DSM.</td>
</tr>
<tr>
<td>NSSID: Other Disorder</td>
<td>NSSI Disorder is better classified as a behaviour associated with other mental disorders than an independent disorder.</td>
</tr>
<tr>
<td>NSSID: Criterion A</td>
<td>I feel Criterion A would adequately capture clinically significant presentations of NSSI.</td>
</tr>
<tr>
<td>Change: Warmth &amp; Understanding</td>
<td>If a patient who self-injures also met criteria for NSSI, I would feel ________ warmth and understanding towards this patient.</td>
</tr>
<tr>
<td>Change: Concern</td>
<td>If a patient who self-injures also met criteria for NSSI Disorder, I would feel ________ concern for this patient.</td>
</tr>
<tr>
<td>Change: Manipulate</td>
<td>If a patient who self-injures also met criteria for NSSI Disorder, I would feel they are ________ likely to be self-injuring to manipulate others.</td>
</tr>
<tr>
<td>Change: Attention</td>
<td>If a patient who self-injures also met criteria for NSSI Disorder, I would feel they are ________ likely to be self-injuring to get attention.</td>
</tr>
<tr>
<td>Change: Control</td>
<td>Compared to a patient who does not meet criteria for NSSI Disorder, a patient with NSSI Disorder is in ________ control of their self-injury.</td>
</tr>
<tr>
<td>Change: BPD</td>
<td>Compared to a patient who does not meet criteria for NSSI Disorder, a patient with NSSI Disorder is likely to also meet criteria for Borderline Personality Disorder.</td>
</tr>
<tr>
<td>Change: Suicide Risk</td>
<td>Compared to a patient who does not meet criteria for NSSI Disorder, a patient with NSSI Disorder is at ________ suicide risk.</td>
</tr>
</tbody>
</table>
Figure 1. The percentage of diagnosing professionals’ (DPs’) who strongly disagree, disagree, neither agree nor disagree, agree, or strongly agree with survey items. E.g., Forty-two percent of DPs agree that they demonstrate warmth and understanding towards patients who self-injure.
**Figure 2.** Graphic depiction of how a diagnostic classification may or may not influence diagnosing professionals’ attitudes towards a patient who met criteria for the disorder. E.g., if a patient who self-injures also met criteria for NSSI Disorder, 87% of DPs would feel no change in their level of concern for this patient.
Appendix A

QUESTIONNAIRE

Demographics, Eligibility and Clinical Experience with NSSI

1. Age
2. Gender
3. Province or territory of residence
4. Current employer(s) → Select all that apply:
   ❑ Hospital
   ❑ University/college
   ❑ Healthcare Centre
   ❑ Private Practice

5. Are you a licensed psychologist or psychiatrist?
   ❑ Yes → Please select which of the following best describes you.
     ❑ Psychologist (Doctoral)
     ❑ Clinical Psychology (C. Psych); Doctor of Psychology (Psy. D); Counselling Psychology (Ph. D); Educational Psychology (EdD)
     ❑ Psychologist (Masters)
     ❑ Clinical Psychology; Counselling Psychology (Ph. D); Educational Psychology
     ❑ Psychiatrist (M.D.)
     ❑ Other: _____________
   ❑ No → Thank you for your time. Unfortunately, you are not eligible to take part in the current study.

6. Do you spend any of your professional time providing or supervising direct client care?
   ❑ Yes
   ❑ No → Thank you for your time. Unfortunately, you are not eligible to take part in the current study.
The following questions ask about your experiences providing support to clients/patients who engage in Nonsuicidal Self-Injury (NSSI). As you may know, **NSSI is defined as the act of deliberately damaging one’s own body tissue through methods such as cutting and burning, without the intent to die by suicide.**

7. I ______ provide or supervise direct client care to patients who have engaged in NSSI.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

8. I have received specialized training on how to support patients who engage in NSSI.
   - [ ] True
   - [ ] False

9. I believe I have the appropriate knowledge about NSSI to help patients who self-injure.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

10. I believe I have the appropriate counselling and clinical training to help patients who self-injure.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>5</td>
</tr>
</tbody>
</table>

**Attitudes towards clients who self-injure and the NSSI-BPD-Suicide Relation**

The following questions will ask about your views towards patients who engage in Nonsuicidal Self-Injury.

11. I demonstrate warmth & understanding to patients who self-injure.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
12. Individuals who self-injure are usually trying to get sympathy from others.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

13. I feel concern for patients who self-injure.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

14. Those who self-injure are often doing it to manipulate other people.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

15. I listen fully to the problems and experiences of patients who self-injure.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

16. Those patients who self-injure are just trying to get attention.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

17. Dealing with patients who self-injure is a waste of healthcare professionals’ time.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
18. Supporting patients who self-injure is an important healthcare issue.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

19. Most patients who self-injure have Borderline Personality Disorder.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

20. Patients who self-injure should be considered at risk for suicide.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
</tbody>
</table>
Acceptability of NSSI Disorder and the Impact of Diagnostic Labelling

The DSM-5 (2013) has included Nonsuicidal Self-Injury Disorder (NSSI-D) within Section 3 as a condition for further study (APA, 2013). The evidence is accumulating for the utility of NSSI-D as a sensitive, but specific diagnosis capable of delineating a subgroup of individuals who self-injure and meet clinically significant levels of impairment (Zetterqvist, 2015).

Please review the DSM’s proposed NSSI-D Criteria:

A. In the last year, the individual has on 5 or more days engaged in NSSI that was severe enough to cause minor or moderate damage, but without suicidal intent

B. The individual engages in NSSI 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. NSSI is associated with at least one of the following:
   1) interpersonal difficulties or negative feelings or thoughts immediately precede engagement in NSSI
   2) a period of preoccupation with NSSI precedes the NSSI
   3) NSSI urges or thoughts occur frequently even if not acted upon

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

E. NSSI causes significant distress or impairment in important areas of functioning

F. NSSI does not occur exclusively in a state of psychosis, delirium, or intoxication and cannot be accounted for by another medical or psychological disorder

21. In general, I believe NSSI-D should be classified as its own disorder in the DSM.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

22. NSSI-D is better classified as a behaviour associated with other mental disorders than an independent disorder.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
23. I feel Criterion A would adequately capture clinically significant presentations of NSSI.

In the last year, the individual has on 5 or more days engaged in NSSI that was severe enough to cause minor or moderate damage, but without suicidal intent

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The following questions will ask you to reflect on if/how your attitudes towards clients who self-injure may be affected if the patient met criteria for Nonsuicidal Self-Injury Disorder (NSSI Disorder).

24. If a patient who self-injures also **met criteria for NSSI Disorder**, I would feel __________ warmth & understanding towards this patient.

<table>
<thead>
<tr>
<th>Much less</th>
<th>Somewhat Less</th>
<th>No change in my level of</th>
<th>Somewhat More</th>
<th>Much more</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

25. If a patient who self-injures also **met criteria for NSSI Disorder**, I would feel __________ concern for this patient.

<table>
<thead>
<tr>
<th>Much less</th>
<th>Somewhat Less</th>
<th>No change in my level of</th>
<th>Somewhat More</th>
<th>Much more</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

26. If a patient who self-injures also **met criteria for NSSI Disorder**, I would feel they are __________ likely to self-injure to manipulate others.

<table>
<thead>
<tr>
<th>Much less</th>
<th>Somewhat Less</th>
<th>Equally/Similarly</th>
<th>Somewhat More</th>
<th>Much more</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
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</table>

27. If a patient who self-injures also **met criteria for NSSI Disorder**, I would feel they are __________ likely to self-injure to get attention.

<table>
<thead>
<tr>
<th>Much less</th>
<th>Somewhat Less</th>
<th>Equally/Similarly</th>
<th>Somewhat More</th>
<th>Much more</th>
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<td>1</td>
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</table>
28. Compared to a patient who does not meet criteria for NSSI-D, a **patient with NSSI Disorder** is in __________ control of their self-injury.

<table>
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<th>Much less</th>
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</table>

29. Compared to a patient who does not meet criteria for NSSI-D, a **patient with NSSI Disorder** is __________ likely to also meet criteria for Borderline Personality Disorder.

<table>
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</table>

30. Compared to a patient who does not meet criteria for NSSI-D, a **patient with NSSI Disorder** is at __________ suicide risk.

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<th>Equal/Similar</th>
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</table>
Appendix B

SAMPLE RECRUITMENT EMAIL

Dear psychologist or psychiatrist,

My name is Dr. Stephen Lewis, Associate Professor in Clinical Psychology at the University of Guelph. My graduate student, Veesta Mavandadi, and I are interested in perspectives of psychologists and psychiatrists regarding a new diagnostic classification that has been proposed in the DSM-5 as a Condition for Further Study.

The linked survey contains 30 Likert-type questions and should take no more than 10 – 15 minutes to complete. All responses will be anonymous and confidential. Participants will also be able to enter to win one of four $50 Amazon gift cards.

We hope to receive your input on the attached survey. Further, if you are willing to forward the below email to any other psychologists or psychiatrists affiliated with your institution, it would be greatly appreciated.

Please follow the link below to read more about the study, review the consent form and begin the survey.

https://uoguelph.eu.qualtrics.com/jfe/form/SV_4303dIJUDurp4Oy

Thank you for your time and consideration,

Stephen P. Lewis, PhD | Associate Professor
Department of Psychology | University of Guelph
50 Stone Rd E | Guelph, ON | N1G 2W1
519-824-4120 Ext. 53299 | stephen.lewis@uoguelph.ca
Appendix C

INFORMATION AND CONSENT LETTER

UNIVERSITY OF GUELPH

CONSENT TO PARTICIPATE IN RESEARCH

Nonsuicidal Self-Injury Disorder: Perspectives of Psychologists and Psychiatrists

You are being invited to participate in a research study conducted by Dr. Stephen Lewis and Veesta Mavandadi, from the University of Guelph, Department of Psychology. The results of this research will contribute to our understanding of the experiences of individuals who self-injure in the healthcare system.

PURPOSE OF THE STUDY

Nonsuicidal self-injury (NSSI) is the act of deliberately damaging one’s own body tissue without the intent to die by suicide. NSSI Disorder (NSSI-D) was recently proposed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a condition for further study. The present study intends to understand the experiences of diagnosing professionals, (i.e., psychologists and psychiatrists) when working with patients who engage in nonsuicidal self-injury. Further, in effort to address recent calls from the American Psychological Association (APA) regarding updates to the DSM-5, we hope to elicit feedback from psychologists and psychiatrists about prospect of nonsuicidal self-injury becoming a new DSM Disorder.

PROCEDURES

- The survey should take no more than 10 – 15 minutes to complete and responses will remain anonymous.
- If you agree to participate in this study, you will be asked to answer six demographic questions, and 24 Likert or true/false questions about your professional experience with patients who self-injure, and your view on the prospect of NSSI Disorder and the impact this disorder may have on individuals who self-injure.

POTENTIAL BENEFITS AND RISKS

- Your responses will guide future efforts to improve the quality of care for patients who engage in NSSI, and contribute to the dialogue evaluating NSSI Disorder as a potential disorder in the DSM. Otherwise, there are no direct benefits to participation in this study.
- As working with patients who self-injure can be difficult for some professionals, it is possible that some participants will feel slight psychological discomfort when reflecting on their attitudes towards patients who self-injure.
- While it is very unlikely, breach of the online Qualtrics server may lead to a release of survey responses. Indeed, depending on your survey responses, this may bring about some embarrassment.
INCENTIVES
• Interested participants may enter an email address (which will not be linked to survey data) for the opportunity to win one of four $50 Amazon gift cards (1 in 100 chances of winning).

CONFIDENTIALITY
• Every effort will be made to ensure that all identifying information is treated with the strictest of confidence.
• To further ensure the confidentiality of data collection, all questionnaires will be administered on a secure server dedicated to these types of surveys. However, confidentiality cannot be guaranteed while data are in transit over the Internet.
• The survey will need to be completed in one sitting (responses cannot be saved so that you can return to the survey at a later time). Further, you will not be able to reverse in the survey to see your past responses. Therefore, your answers will not be visible to others should they use the device you used to complete the study.
• Your responses will remain anonymous. At no point will your email, name, or other identifying information be linked to your responses to the survey questions.

PARTICIPATION AND WITHDRAWAL
• It is your choice whether you wish to participate in this study or not. If you do decide to participate, you are able to withdraw at any time by closing your browser. In addition, you may choose not to answer any, or some of the questions and still remain in the study.
• Your decision of whether or not to participate in this research will not affect any current, or future, relationship or association with the University of Guelph or the International Society for the Study of Self-Injury.
• Once you have submitted your responses, you will not be able to withdraw your data as it will be anonymous.

RIGHTS OF RESEARCH PARTICIPANTS
• This project has been reviewed by the Research Ethics Board for compliance with federal guidelines for research involving human participants
• If you have questions regarding your rights and welfare as a research participant in this study (REB [17-10-035]), please contact: Director, Research Ethics; University of Guelph; Ontario, Canada; reb@uoguelph.ca; (519) 824-4120 (ext. 56606)

If you have any questions or concerns about the research please feel free to contact: Dr. Stephen Lewis at slewis03@uoguelph.ca, 1-519-824-4120 x53299.

Click here to save or print a copy of this consent document for your records.
Appendix D
DEBRIEF LETTER

Thank you for participating in this study.

Your responses will guide efforts to improve the experiences of individuals who self-injure, in the healthcare system. Additionally, in keeping with the recent calls from the American Psychological Association (APA) regarding updates to the DSM-5, we hope to learn more what professionals think about the prospect of Nonsuicidal Self-Injury Disorder being included in the diagnostic nomenclature.

Please click here if you wish to follow any of the following next steps.

1. If you would like to be entered to win one of four $50 Amazon gift cards.
2. If you wish to be advised of the results of this study.
3. If you would be willing to take part in related studies in the future.

You will be redirected to a new webpage where you can provide your email address and select which next step(s) you are interested in. Emails will not be linked to survey data.

Thank you for your time.