DISTINGUISHING SUICIDE ATTEMPTS FROM NONSUICIDAL SELF-HARMING BEHAVIORS

To the Editor:

We would like to applaud Dr. Nock[1] for his timely, thoughtful, and articulate piece addressing the issue of presumed causality in youth suicide. We are also encouraged to see the articles appearing in the same issue of the *Journal* addressing the issues of bullying and alcohol misuse, as they are good examples of the type of quality research that can take the field beyond the emotional drivers for "understanding" youth suicide to better help us consider the complex causal composites of those behaviors so that we may rationally and objectively develop and test appropriate interventions to address this important public health need.[2]

Kudos notwithstanding, we are concerned that Dr. Nock neglected to address a vital aspect of youth suicide research in his otherwise excellent overview. That is the differentiation of suicide attempts (self-harm with the intent to die) from nonsuicidal self-harm behaviors. In the research literature, suicide attempt is often used as an umbrella term referring to self-harm behaviors occurring with or without suicidal intent. In the *International Classification of Diseases*, there is no distinction between nonsuicidal self-inflicted injuries and suicide attempts, with both cases coded as "intentional self-harm."

This aggregation of suicidal and nonsuicidal self-harm behaviors may actually obfuscate important causal relationships and thus may confuse interventional responses. It may also explain why there are such differences in sex rates or why studies such as the one by Klomek et al.[3] find male and female differences in outcomes (e.g., are all suicide attempts in young female subjects really suicide attempts, are a substantial proportion of them actually nonsuicidal self-harm attempts?). Importantly, some recent research suggests that once such differentiation occurs, unique populations may emerge.[4,5]

We would like to see data on self-harm in young people collected, coded, and presented on the basis of the suicidal intent associated with the action. For example, using the terms *suicidal self-harm* when discussing suicide attempts and *nonsuicidal self-harm* when discussing other self-injurious behaviors occurring in the absence of suicidal intent would clarify the discourse around self-harm. Although this could open the door to some degree of interpretation, including potential historical differences in these categories over the life span of an individual, we think that these concerns would be well outweighed by the greater clarity provided by this vital distinction. Determining the differences between populations who engage in suicidal and nonsuicidal self-harm will help us make better sense of this complex domain and may result in the implementation of better adapted prevention strategies and delivery of more appropriate interventions to these groups.

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Dr. Nock replies:

I am grateful to Dr. Kutcher and colleagues for their insightful comments about an important issue: the consideration and assessment of nonsuicidal self-injury (NSSI). They are correct in noting that my editorial[1] did not address NSSI. My failure to do so was not at all because of a perceived lack of importance regarding this topic but because the three articles for which I was asked to provide an introduction and commentary were focused on suicidal self-injury. Nevertheless, I am grateful for the opportunity to address this issue and to respond to the authors' comments about my comments.

I agree completely with, and would amplify, several of the authors' main points but respectfully propose a revision to

their last point. First, I agree that it is important to distinguish between suicidal self-injury and NSSI, and a failure to do so can conceal important causal relations. Recent research has shown that suicidal self-injury and NSSI differ in their prevalence, correlates, and course—highlighting the importance of making such a distinction.[2] Second, this distinction is not always made by researchers, clinicians, and policymakers (e.g., the authors note that the *International Classification of Diseases* does not yet distinguish between suicidal self-injury and NSSI). However, there is reason to be optimistic because this is a distinction that is being made increasingly often. For instance, an increasing amount of research focuses specifically on NSSI[2]; there are new professional organizations dedicated specifically to this behavior problem (e.g., the International Society for the Study of Self-Injury), and a growing number of researchers and clinicians are suggesting that repetitive NSSI should be considered a unique disorder in *DSM-V*.

Third, research will indeed advance most efficiently and effectively if this distinction is consistently made. Fortunately, there are now a number of assessment tools available that can aid researchers and clinicians in making this distinction.[3] However, it is important to remain mindful of the challenges inherent in attempting to make this distinction based on verbal reports of suicidal intent. As in most areas of clinical assessment, poor agreement among adolescents, parents, and clinicians seems to be the rule rather than the exception,[4] raising questions about how best to synthesize information provided by multiple informants. Furthermore, it is important to specifically assess the intent of the behavior. One recent study showed that nearly half (42%) of those reporting a "suicide attempt" indicate, in response to more specific follow-up questions, that they did not intend to die from their behavior but instead used the behavior as a "cry for help."[5] Fourth, I agree with the authors that my commentary was "timely, thoughtful, and articulate." My modesty precludes me from expounding further on this particular point.

The authors' last point is that research should aim at "determining the differences between populations who engage in suicidal and nonsuicidal self-harm." Such a focus is problematic because, although suicide attempts and NSSI are distinct behaviors, the people who engage in these behaviors are not entirely separate populations (e.g., 70% of those who engage in NSSI report a past suicide attempt).[6] Therefore, trying to understand what factors distinguish populations (or samples) of people who make suicide attempts from those engaged in NSSI may not tell us much about why people engage in either behavior. Analogously, smoking and drinking are distinct behaviors, but understanding what factors distinguish smokers from drinkers (e.g., the former have higher rates of lung cancer) tells us little about why people perform either behavior or how best to treat them (especially because, as in this example, we may mistake a consequence for a causal factor). A more fruitful approach is to conduct research aimed at better understanding what leads some people to directly and deliberately harm themselves in general and to search for the causal mechanisms that lead to these distinct, but related, forms of self-harm.

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Dr. Klomek et al. reply:

A very important issue has been raised, which has strong implications on how we define suicidal versus nonsuicidal self-injurious behavior. We agree that this issue is also important when interpreting the finding of our study "Childhood Bullying Behaviors as a Risk for Suicide Attempts and Completed Suicides: A Population-Based Birth Cohort Study."[1]

The strength of our study was the opportunity to study a relatively rare phenomenon (completed suicide and suicide attempt requiring hospital admission) in a large prospective, nationwide sample. Although we had no specific information about the intent of the behavior, we included only suicide attempts that required hospital admission. Usually only severe, life-threatening suicidal attempts are admitted to the hospital after emergency evaluation (those treated only in the emergency department are not included in the hospital discharge registry). Furthermore, all these were cases often requiring several days of hospital stay. In the Finnish Hospital Discharge Register, the diagnostic codes for suicide attempts between 1994 and 1995 were *International Classification of Diseases, Ninth Revision,* codes E950–E959, V156, or V658, and those between 1996 and 2005 were *International*