link between subjective SES and mental health, above and beyond conventional measures of SES, suggests that some aspects of social changes which are strongly associated with mental health have not been fully captured by those conventional measures.

Some scholars have argued that income inequality and social polarization can heighten an individual's sense of relative deprivation, resulting in frustration, anger and resentment[2]. Our data suggest that how much one believes he/she has compared to others is more relevant than how much one actually has in understanding mental health problems in contemporary Korea. These findings may offer some lessons for the countries experiencing similar economic and social changes.

Further research is needed to better understand how subjective social status is formed and what mechanisms underlie the strong link between subjective social status and mental health problems.

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DOI:10.1002/wps.20357

Nonsuicidal self-injury in men: a serious problem that has been overlooked for too long

Nonsuicidal self-injury (NSSI) refers to the act of deliberately destroying one's own body tissue without conscious intent to die and for reasons that are not socially sanctioned[1-3]. Common methods include cutting, scratching, and burning oneself. It is estimated that around 6% of adults in the general population have engaged in NSSI at least once during their lifetime[2]. While once thought to occur primarily within the context of borderline personality disorder, contemporary research demonstrates that NSSI is a transdiagnostic condition which is associated with significant functional impairment[3]. As a result, NSSI disorder has been included in DSM-5 as a condition for further study.

By definition, the function of NSSI is different from that of suicidal behavior, where the goal is to end one's life. The most common reason that patients provide for engaging in NSSI is that they believe that it helps them to regulate their emotions. Other commonly alleged reasons include self-punishment, physiological stimulation, and communication with others[1,2]. Although NSSI and suicidal behavior are clearly distinct, increasing evidence suggests that NSSI is a significant risk factor for suicidal behavior. NSSI is more strongly associated with history of suicide attempts than impulsivity, depression, anxiety, and borderline personality disorder. Actually, NSSI is a stronger prospective predictor of suicide attempts than history of suicide attempts[4-6].

Despite the significant implications that NSSI has for patients' health, well-being, and risk for suicide, this important clinical condition has been largely overlooked among men. This lack of attention is due in large part to the historical viewpoint that NSSI is far more common among females than males[7]. However, contemporary population-based studies of NSSI have consistently failed to find evidence for sex differences in rates of NSSI among adults[2,8]. A recent meta-analysis including many clinical studies concluded that "women are slightly more likely than men to engage in NSSI", but the overall rate of NSSI identified among males (26.36%) was still remarkably high[9].

In that meta-analysis, the observed sex difference appears to have been largely driven by the inclusion of clinical samples. The discrepancy in sex differences observed between clinical and population-based studies of NSSI may be due to the fact that women are more likely to seek out psychiatric treatment than men[9]. Sample selection practices might also help to explain this discrepancy, as clinical settings that have a preponderance of male patients (e.g., veterans' hospitals) are likely to be under-utilized in NSSI research. In support of this view, we found that 57% of male veterans seeking treatment for post-traumatic stress disorder reported a history of NSSI[10], suggesting that men who are actively seeking treatment for psychiatric issues may be just as likely as women to engage in NSSI.

Sex differences in the expression of NSSI could also affect prevalence estimates. The above-mentioned meta-analysis explored sex differences in NSSI methods and found that females were more likely than males to engage in cutting, biting, scratching, and hair pulling[9]. Wall/object punching was not included among the twelve NSSI methods considered in the meta-analysis. However, Whitlock et al[1] reported that wall/object punching is the single most common form of NSSI endorsed by college-aged men. Moreover, males who self-injure are significantly more likely to engage in wall/object punching than females who self-injure (44% vs. 19%, $p<0.001$).

Such findings are critically important, because the vast majority of NSSI research has not examined wall/object

punching as a possible NSSI method. Thus, it is entirely possible that the systematic exclusion of one of the most common NSSI methods for males to use has resulted in a significant underestimate of the true prevalence of NSSI among men. More importantly, the failure to include wall/object punching and other forms of NSSI in standard psychiatric risk assessment batteries has likely resulted in many individuals (particularly men) who engage in NSSI not being properly identified and treated, despite the fact that NSSI is one of the strongest predictors of suicide attempts identified to date.

In sum, NSSI is common among men and associated with high levels of clinical distress, significant functional impairment, and increased risk for suicide attempts. It is possible that prior research has underestimated the true prevalence of NSSI in men due to biased selection and assessment methods. It is time for clinicians and researchers to recognize that NSSI is a serious problem that warrants careful investigation in both men and women.

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This work was supported by the Research and Development and Mental Health Services of the Durham VA Medical Center and the VA Mid-Atlantic Mental Illness Research, Education, and Clinical Center. N.A. Kimbrel was supported by a Career Development Award (no. IK2CX000525) from the Clinical Science Research and Development (CSR&D) Service of the VA Office of Research and Development. J.C. Beckham was supported by a Research Career Scientist Award (no. 11S-RCS-009) from CSR&D. The views expressed in this letter are those of the authors and do not necessarily reflect the position or policy of the VA or the US government.

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DOI:10.1002/wps.20358

5-HTTLPR and DISC1 risk genotypes for elevated PTSD symptoms in US military veterans

The serotonin transporter linked polymorphic region (5-HTTLPR) genotype is a candidate vulnerability factor for post-traumatic stress disorder (PTSD). Recently, Telch et al[1] reported in this journal that the 5HTTLPR-S' variant was associated with elevated levels of PTSD symptoms in military personnel deployed to Iraq, supporting similar findings in deployed military personnel by our group[2]. Variants in several other genes have been associated with greater severity of PTSD symptoms in civilian populations. In a further study, we screened a panel of nine candidate genetic variants with potential to influence the development of PTSD in veterans deployed in support of the wars in Afghanistan and Iraq.

Study subjects were male US military veterans registered to receive health care at the Central Texas Veterans Health Care System. The local institutional review board approved and monitored the study. Subjects who did not have a chart diagnosis of schizophrenia or bipolar disorder and who provided informed consent were enrolled in the study independent of their mental health status. Recruitment took place in a variety of venues, including the main lobby of the hospital and mental health waiting rooms.

Participants (N=102) completed the Impact of Events Scale Revised (IES) and donated saliva for genetic research. The IES has been increasingly used as a self-report instrument to assess current PTSD symptom severity. It yields a total symptom severity score and three psychologically and biologically relevant sub-factor scores: avoidance, intrusion and hyperarousal. Saliva samples were collected with Oragene DNA collection kits (DNA Genotek, Ottawa, Canada), and genomic DNA was extracted and purified.

5-HTTLPR genotyping was accomplished with a triplex/double digestion PCR protocol[2]. Alleles were re-classified using rs25531 into the triallelic classification. A Taqman SNP panel for COMT (rs4680), FKBP5 (rs1360780), DTNBP1 (rs9370822), PACAP receptor ADCYAP1R1 (rs2267735), 5-HT1A (rs6295), DISC1 S704C (rs821616), BDNF val66met (rs6265) and NTRK1 (rs6336) was performed using ABI TaqMan SNP Genotyping Assays (Applied Biosystems, Inc., Foster City, CA) on ABI PRISM 7900 HT Sequence Detection System (Applied Biosystems). Distributions did not vary from Hardy-Weinberg equilibrium (all p values >0.05).

Stepwise regression modeling identified two genetic variants that significantly contributed to variance in PTSD symptoms: 5-HTTLPR and DISC1 S704C. Risk genotypes selected by the regression (model cumulative $R^2=0.30$) were 5-HTTLPR-S' carriers (vs. 5-HTTLPR-L'L'; $p<0.031$) and DISC1 TT (vs. A carriers; $p<0.034$). The next closest gene to significance in the model was NTRK1 ($p<0.11$). When the stepwise procedure was repeated after removing 5-HTTLPR and DISC1, no other variant significantly contributed to PTSD symptom load. The