PRACTICE BRIEFS

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# Nonsuicidal Self-Injury: Diagnosis, Assessment, and Treatment

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**ABSTRACT:** Non-suicidal self-injury (NSSI) is the purposeful damage of body tissue for purposes of emotion regulation, escaping a negative state, inducing a positive state, self-punishment, communicating distress, interpersonal influence, or punishing others. Common forms of NSSI include cutting, scratching, wound interference, striking objects, banging/hitting, pinching, and pulling hair. Treatment approaches that enhance emotion regulation and tolerance may be implicated, such as dialectical behavior therapy (DBT), emotion regulation individual therapy, or cognitive therapeutic approaches.

## Introduction

According to the International Society for the Study of Self-Injury (ISSS; n.d.), non-suicidal self-injury (NSSI) is "the deliberate, self-directed damage of body tissue without suicidal intent and for purposes not socially or culturally sanctioned." NSSI can take many forms, but some common forms of NSSI include cutting, scratching, wound interference, striking objects (Andrei et al., 2024), banging/hitting, pinching, and pulling hair (Xiao et al., 2022). Likewise, NSSI can serve many functions, and those functions can change over time. Functions of NSSI may include emotion regulation, escaping a negative state, inducing a positive state, self-punishment, communicating distress, interpersonal influence, and punishing others (Taylor et al., 2018, p. 766). However, the most frequently reported function of NSSI is emotion regulation (Taylor et al., 2018). Rates of NSSI vary by study and depend on both the researchers' definition of the behavior and the population being studied. Researchers estimate NSSI prevalence rates around 5% for adults (Liu, 2023) and approximately 20% for adolescents (Lim et al., 2019; Xiao et al., 2022).

## Description of NSSI

In the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5-TR*; American Psychiatric Association [APA], 2022), NSSI is listed among "other conditions that may be a focus of clinical attention." An NSSI code is used for "individuals who have engaged in intentional self-inflicted damage to their body of a sort likely to induce bleeding, bruising, or pain" (p. 822). The two NSSI codes in the *DSM-5-TR* include the following: (1) Current Nonsuicidal Self-Injury (R45.88) and (2) History of Nonsuicidal Self-Injury (Z91.52).

Research suggests multiple risk factors for NSSI. Among adolescents, researchers have identified a connection between NSSI and emotion regulation difficulties (Faura-Garcia et al., 2024), depressive symptoms, child maltreatment (Calvo et al., 2024), and cyberbullying (Predescu et al., 2024), to name a few. Additionally, using Nock's (2009) work as a framework, Lee et al. (2024) conducted a latent profile analysis using six distinct established risk factors for NSSI (i.e., "negative cognition, emotional vulnerability, poor coping skills; peer victimization, family adaptability, perceived stress") to identify three latent profiles of individuals who self-injure (i.e., severe, moderate, and mild' p. 8). Both Predescu et al.'s (2024)

and Lee et al.'s (2024) work highlight the ubiquitous role of both intrapersonal and interpersonal distress in the development of NSSI.

NSSI has also been found to be frequently comorbid with a number of mental health conditions, which can complicate clinical diagnosis and treatment. Specifically, NSSI may be comorbid with panic disorder (Bentley et al., 2015), posttraumatic stress disorder (PTSD), eating disorders (Sohn et al., 2023), depressive disorders, substance use disorders, and borderline personality disorder (BPD; Nitkowski & Petermann, 2011). Turner et al. (2015) examined the characteristics of individuals who self-injure with and without comorbid BPD. They found that individuals with comorbid BPD and NSSI tend to experience more frequent and severe NSSI, have higher levels of anxiety, and experience suicide ideation with greater severity. Such research may be helpful in guiding diagnostic procedures.

Although NSSI and suicide share some characteristics and can coexist (Andover & Gibb, 2010; Hamza et al., 2012; Willoughby et al., 2015), they are conceptually distinct clinical phenomena that can largely be differentiated based on intent, function, frequency, severity, and outcome. Whereas NSSI is predominantly used as a means of coping with internal distress, possibly serving an anti-suicidal function (Klonsky, 2007), the intent of suicide is to end one's life. Moreover, many individuals who self-injure engage in frequent NSSI, whereas suicide attempts are comparatively less frequent (Klonsky et al., 2011). And similarly, self-injurious thoughts tend to be more frequent and less intense, whereas suicide thoughts tend to be less frequent but have a longer duration (Nock et al., 2009). Similarly, the severity of NSSI wounds tends to be lower than wounds inflicted during suicide attempts (Klonsky et al., 2011). Finally, although anger tends to precede both NSSI and suicide attempts, anger tends to decrease following NSSI and increase for individuals who attempted suicide but survived (Chapman & Dixon-Gordon, 2007). However, intensity can fluctuate, intent can change over time, and overlap can exist across the two behaviors, which necessitates the use of recursive assessment procedures.

## Assessment Strategies

### Self-Injurious Thoughts and Behaviors Interview–Revised

Self-Injurious Thoughts and Behaviors Interview–Revised (SITBI-R; Fox et al., 2020) is a modification to the SITBI (Nock et al., 2007), which measures the "presence, frequency, and characteristics of suicide and self-harming thoughts and behaviors" (Fox et al., 2020, p. 677). The SITBI-R is a 65-item self-report measure. The SITBI-R is divided into four sections, with five questions that address dangerous behaviors, 21 questions that address NSSI, 20 questions that address suicide thoughts, and 19 questions that address suicide plans (Fox et al., 2020). Items are constructed in multiple ways, with a combination of Likert scale, single-select, multi-select, and text entry items.

### The Non-Suicidal Self-Injury Assessment Tool

The Non-Suicidal Self-Injury Assessment Tool (NSSI-AT; Whitlock et al., 2014) is a 27-item self-report measure that addresses NSSI characteristics (e.g., forms, functions, recency, frequency, wound locations, initial motivations, severity, practice patterns, perceived life interference, disclosure, treatment experience, and personal reflections). Items are constructed in multiple ways, with a combination of Likert scale, single-select, multi-select, and text entry items. The NSSI-AT is also available in a brief version (BNSSI-AT; Whitlock et al., 2014).

### Deliberate Self-Harm Inventory

The Deliberate Self-Harm Inventory (DSHI; Gratz, 2001) is a 17-item measure of NSSI; it does not assess self-injury with suicidal intent. The DSHI screens for the presence of self-injury, age of onset, duration, frequency, and severity. It also asks participants to identify their means of self-injury. The DSHI is also available in a youth version (DSHI-Y; Gratz et al., 2012).

## Treatment Approaches

There is no discernable preferred treatment for those who engage in NSSI. Indeed, researchers continue to report small to medium effect sizes of treatments (Arqueros et al., 2023; Kothgassner et al., 2020) and, as such, preferred treatment modalities for NSSI remain unclear. Taylor et al. (2018) noted that, due to the key function of emotion regulation for a majority of individuals, treatment approaches that enhance emotion regulation and tolerance may be implicated. Examples may include DBT (Chen et al., 2025; Fang et al., 2025), emotion regulation individual therapy (Bjureberg et al., 2017), and emotion regulation individual therapy (Gratz et al., 2014), although DBT has the strongest evidence base at this time. Additionally, there is some support for cognitive therapeutic approaches (Hawton et al., 2016) and family systems interventions (Fang et al., 2025) in the treatment of NSSI.

### Dialectical Behavior Therapy

DBT is widely recognized as one of the most empirically supported interventions for reducing suicide attempts and NSSI (DeCou et al., 2019), particularly among adolescents (Fang et al., 2025; McCauley et al., 2018) and individuals with BPD (Brodsky et al., 2025). Recent meta-analyses and systematic reviews suggest some effectiveness of DBT in reducing NSSI frequency (DeCou et al., 2019; Hawton et al., 2016; Tebbett-Mock et al., 2020) with emerging evidence indicating comparable effectiveness across outpatient, intensive outpatient, and telehealth-delivered formats (McCauley et al., 2018; Lakeman et al., 2022; Zalewski et al., 2021). Additionally, there is evidence to support the effectiveness of DBT for Adolescents (DBT-A) in reducing NSSI frequency (McCauley et al., 2018; Mehlum et al., 2019; Fang et al., 2025), depression, (Fang et al., 2025) and suicide attempts among adolescents (McCauley et al., 2018), even in reduced-length DBT-A programs (Dallenbach et al., 2024).

DBT may also be used for suicide safety planning and crisis intervention (Ceccolini et al., 2023), as its core skills directly target the most common functions of NSSI (Clarke et al., 2019). Consistent with earlier relational findings, newer studies confirm that DBT outcomes are significantly strengthened when delivered within a validating, collaborative, and nonjudgmental therapeutic alliance (Bedics et al., 2015), with therapist adherence and skills coaching frequency serving as key moderators of treatment success (Harned et al., 2022). Although DBT demonstrates robust short- and medium-term reductions in self-injury, longitudinal findings indicate that gains may plateau following the first year of structured DBT, underscoring the importance of stepped-care models, aftercare planning, and relapse-prevention integration rather than indefinite protocol extension (Mehlum et al., 2019). Current clinical guidelines now position DBT as a first-line intervention for NSSI and high-risk suicidal behavior when delivered with full program fidelity (National Institute for Health and Care Excellence, 2022).

### Cognitive Therapy/Cognitive-Behavioral Therapy

Contemporary research continues to support the use of cognitive therapy and cognitive behavior therapy (CBT) in the treatment of NSSI, particularly when interventions directly target self-critical thinking, maladaptive core beliefs, and emotion regulation deficits. Recent studies consistently demonstrate that individuals who engage in NSSI endorse elevated levels of self-criticism, shame, hopelessness, and rigid negative self-schemas, all of which are core cognitive targets in CBT (Tong et al., 2025). Cognitive distortions related to worthlessness, emotional intolerability, and perceived interpersonal rejection are now understood as central vulnerability mechanisms that sustain self-injury over time (Wolff et al., 2019).

Updated clinical trials and meta-analyses suggest that CBT-based interventions may produce small to moderate reductions in NSSI frequency (Hawton et al., 2016; Kothgassner et al., 2020). Specifically, some empirical evidence supports the clinical utility of positive reframing and support seeking (Thomassin et al., 2017) as effective components of CBT-informed NSSI treatment. Efficacious treatments also tend to focus on NSSI-specific thoughts and beliefs (Tonta et al., 2024) and include a focus on family skills training (e.g., problem solving and family communication), parent education and training (e.g., contingency

management and monitoring), and individual skills training (e.g., problem solving and emotion regulation; Glenn et al., 2014).

### Functional Assessment/Functional Behavioral Analysis of NSSI

Functional assessment remains a central evidence-based component of CBT-oriented NSSI treatment. Although functional assessment may be considered part of the assessment process, the outcome of functional assessments are intended to guide treatment so that interventions match the unique functional needs of NSSI experienced by clients. Recent behavioral models continue to emphasize the role of intrapersonal triggers, interpersonal contingencies, and emotional relief functions in maintaining NSSI (He et al., 2025). And contemporary models define NSSI as a functionally maintained behavior, reinforced through intrapersonal emotion regulation, negative reinforcement of distress, and intermittent interpersonal feedback (Apicella et al., 2025). Updated functional analytic approaches integrate ecological momentary assessment, digital self-monitoring, and emotion tracking to identify real-time maintaining variables. By explicitly targeting the antecedents and reinforcing consequences of self-injury, CBT interventions help clients interrupt automatic self-injury cycles and implement adaptive coping responses in vivo (Tong et al., 2025). However, researchers caution against relying exclusively on distraction-based substitutes and instead supports teaching flexible, context-responsive replacement behaviors that meet the same regulatory function as NSSI (Andover et al., 2015; Thomassin et al., 2017).

### Trauma-Informed Therapy

Trauma-informed therapy recognizes the pervasive impact of trauma on emotional regulation and coping behaviors, emphasizing safety, trust, empowerment, and collaboration within the therapeutic relationship (Substance Abuse and Mental Health Services Administration [SAMHSA], 2024). Although trauma-focused treatments such as trauma-focused cognitive behavioral therapy (TF-CBT), eye-movement desensitization and reprocessing (EMDR), cognitive processing therapy (CPT), prolonged exposure (PE), and cognitive restructuring (CR) for PTSD are not primary interventions for NSSI, they become clinically indicated when NSSI functions as a trauma response, a dissociation-regulation strategy, or a means of managing intrusive trauma memories. Trauma-informed care requires comprehensive assessment, including screening for adverse childhood experiences and evaluating the role of trauma in current symptom presentation (Wang et al., 2022). Assessments such as the Adverse Childhood Experience Questionnaire for Adults (California Surgeon General's Clinical Advisory Committee, 2022), the Life Events Checklist (LEC; Gray et al., 2004), and the Trauma History Questionnaire (THQ; Hooper et al., 2011) can be helpful for screening for exposure to traumatic events, whereas the PTSD Checklist for *DSM-5* (PCL-5; Weathers et al., 2013b) can be used for screening for PTSD symptoms, and the Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5; Weathers et al., 2013a) can be helpful for diagnosing PTSD. The use of these screening and diagnostic tools is consistent with a trauma-informed approach. Core trauma-informed principles such as safety, trust, choice and control, collaboration, and strengths-based focus help support stabilization and reduce the risk of re-traumatization (SAMHSA, 2024).

## Cultural and Ethical Considerations

Due to its established relationship to suicide (Victor & Klonsky, 2014; Ye et al., 2022) and the possibility of tissue damage inherent to NSSI, its treatment can involve a number of ethical considerations and challenges. Importantly, professional counselors should conduct a robust informed consent process with their clients to identify the expectations and bounds of treatment, in addition to emergency procedures. When faced with ethical concerns, particularly those involving threat to life, professional counselors should utilize an ethical decision-making model (Standard I.1.b.; American Counseling Association, 2014), inclusive of appropriate supervision and/or consultation (Standards B.7.a., B.7.b., C.2.e.). Common ethical considerations in the treatment of NSSI may include conducting appropriate assessment (Section E); monitoring and assessing for foreseeable harm (Standard B.2.a.); utilizing evidence-based therapeutic

approaches (Standard C.7.a.); managing confidentiality (Standards B.1.c., B.1.d., B.2.e., B.5.c.); and using comprehensive and contemporaneous documentation procedures (Standard A.1.b.).

Professional counselors should also be mindful of the level of care indicated by their assessment results so that the type of intervention is appropriate to the severity of the client's presentation. This type of level of care assessment should be conducted at intake and recurrently as indicated by changes in the client's presentation, and is an important component of risk management when working with individuals who self-injure. Finally, professional counselors should exercise caution in the use of harm-reduction techniques (see Lindquist & West, 2021), as implementation procedures for harm-reduction are not clearly delineated. It is not possible to eliminate risk associated with treating individuals who self-injure, but utilizing appropriate risk management, ethical decision-making, and documentation procedures can help to reduce liability.

## Conclusion

Professional counselors should utilize validated instruments, such as the SITBI-R, NSSI-AT, and DSHI to assess the functions and severity of NSSI, thereby guiding treatment. professional counselors may also conduct a functional assessment of NSSI, utilize appropriate suicide and trauma assessments as indicated, and conduct a thorough clinical interview with clients who self-injure. Although the evidence base for NSSI treatments continues to emerge, professional counselors may consider DBT, CBT, functional analytic approaches and trauma-informed therapy, as there is some evidence to support these modalities.

## Resources

- **Addressing ethical issues in treating client self-injury**, Counseling Today
- **Cornell University Self-Injury & Recovery Resources**
- **International Society for the Study of Self-Injury**

### Assessment

- **DSHI direct access**
- **BNSSI-AT direct access**
- **NSSI-AT direct access**
- **SITBI-R direct access**

### Treatment

- **Behavioral Tech Research and Clinical Training**
- **Linehan Institute Behavioral Tech Research**
- **SAMHSA Evidence-Based Practices Resource Center**
- **Self-harm: Assessment, management, and preventing recurrence**, National Institute for Health and Care Excellence
- **The Beck Institute**

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