# Addressing Self-Injury in the School Setting

Sandra Shapiro, MEd, MSN, RN

**ABSTRACT:** A growing number of students presenting with nonlethal self-injury has recently captured the attention of school nurses. The purpose of intentional self-harm is aimed at reducing emotional distress. This is not a new phenomenon, but what is alarming is the increasing incidence of self-injurious behavior among adolescents. This behavior is raising many questions for school staff. School nurses, along with guidance department staff, are searching for information and direction needed to address this behavior. School nurses, educated about self-injury, can serve as resources for other school staff members. Prevention strategies for all adolescents can be developed as well as strategies targeted at groups of at-risk adolescents. Because mental health care is critical for the treatment of self-injury, referral and early access to counseling is an important role for school nurses. In addition, a plan that includes educating staff members and parents can be developed. Included in this comprehensive plan is developing a protocol to be used to guide the care of adolescents who self-injure.

**KEY WORDS:** cutting, emotional regulation, self-harm, self-injurious behavior, self-injury, self-mutilation

## CASE EXAMPLES

Jenny, a 15-year-old high school freshman, is brought to the guidance department by her friend who says, ''Show her what you did.'' Jenny's wrists have multiple superficial scratch marks self-inflicted with a paperclip. Bethany, a 16-year-old high school sophomore, approaches the school nurse with a request for a band-aid. When asked why she needs it, Bethany reveals her wrist. She used scissors to injure herself. Later, this same student returns to the nurse. This time, the word *death* is carved into her forearm. Then there is Maria, age 13, who has cut herself. Her wounds are hidden under her clothing, but she is eager to reveal a spider web scratched into her abdomen: the tool, a razor blade.

Some of the students seem to be proud when they show the staff the designs they have created. More often, however, they are secretive, wearing clothing that covers any sign of injury. These examples and many others are coming to the attention of school nurses. Such incidents are becoming more frequent in schools. The challenges include understanding this phenomenon and delivering appropriate care for these students.

## INTRODUCTION

At one Massachusetts high school, the growing number of students presenting with self-inflicted injuries has received the attention of school nurses, guidance counselors, and social workers. It is evident from talking with these students that the purpose is not suicide. The purpose of this intentional self-harm is emotional regulation, in other words, to make the student feel better. Self-injury it is not a new phenomenon and is often associated with concurrent mental health concerns. What is new is the growing trend of self-injurious behavior among adolescents without coexisting mental health issues (Cleaver, 2007; Massachusetts Department of Education [MDOE], 2006; Walsh, 2006).

*Sandra Shapiro, MEd, MSN, RN,* is a former school nurse at Westford Academy, Westford, Massachusetts, and an adjunct professor at Middlesex Community College, Lowell, MA.

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The increased incidence of self-injury in the school setting has left school nurses and guidance counselors searching for more information. They need information and direction that will lead to early detection and treatment for those who self-injure. The purpose of this article is (a) to define self-injury, (b) to explore the current literature about self-injurious behavior, and (c) to present an evidence-based interdisciplinary protocol for treating adolescents who self-injure.

## LITERATURE REVIEW

### Definition and Description of Self-Injury

Self-injury is gaining increased attention in the literature. However, in the literature reviewed, the definition and terminology used varied. Muehlenkamp (2005) suggested that difficulty in understanding self-harm may be due to the lack of a standard definition and consistent terminology for the behavior.

Self-injury, as described by Reece (2005), ''is an intentional act of cutting in the absence of conscious suicidal intent'' (p. 561). This definition is limited because self-injury includes not only cutting but also other methods of inflicting self-harm such as burning, bruising, gouging, hitting, picking, stabbing, scratching, and scalding. Nock and Prinstein (2005) stated that ''self-mutilative behavior (SMB) refers to the direct and deliberate destruction of one's own body tissue without suicidal intent'' (p. 140).

Walsh (2006) defined self-injurious behavior as ''intentional, non-life-threatening, self-effected, low-lethality bodily harm of a socially unacceptable nature, performed to reduce psychological distress'' (p. 4). Some might argue with this definition because self-injury is socially acceptable in some groups. The NANDA International (2007) classification of nursing diagnoses includes the diagnoses ''self-mutilation'' and ''risk for self-mutilation.'' In these diagnoses, self-mutilation is defined as ''deliberate self-injurious behavior causing tissue damage with intent of causing nonfatal injury to attain relief of tension'' (p. 191).

The literature suggests there are various methods of self-injury: abrading, biting, burning, bruising, constricting, cutting, hitting, gouging, inhaling, picking, scalding, scratching, stabbing, and severing. Of these various methods, cutting is the most common form of self-harm (Laye-Grindu & Schonert-Reichl, 2005; Walsh, 2006). In addition, a variety of tools are used to self-injure, for example, cigarettes, fingernails, paperclips, razorblades, scissors, and teeth. There is immediate but often not permanent damage to the tissue. The behavior is usually repetitive. Some but not all adolescents who participate in this type of behavior can begin to identify themselves through the activity. Statements such as ''I am a cutter'' are not uncommon among adolescents who self-injure.

To summarize, there are many definitions and terms to describe the phenomenon of self-injury. The commonly used terms are *self-injury, self-harm, self-injurious behavior*, and *self-mutilation*. Whatever term or definition is used, the behavior is intentional for the purpose of relieving emotional distress.

### Incidence

Self-injury has gained considerable attention in popular culture. Recent movies depict self-injury, such as *Girl Interrupted, 28 Days*, and *Secret Cutting*. The lyrics of songs such as ''Bleed'' by Cold, ''Razor'' by Foo Fighters, and ''Scissors'' by Slipknot cry out about the emotional pain of cutting. Then there are the personal stories told by Diana Princess of Wales, singer/songwriter Fiona Apple, actress Angelina Jolie, and actor Johnny Depp, all of whom have publicly discussed their self-injurious behavior. Web sites and discussion boards about self-injury are too numerous to count (Whitlock, Eckenrode, & Powers, 2006). This suggests an increased incidence of self-injurious behavior, which is supported by research (Muehlenkamp & Gutierrez, 2004; Ross & Hearth, 2002).

In a study of 424 adolescents, Laye-Grindu and Schonert-Reichl (2005) reported that 15% of the participants reported self-injury. The Massachusetts Youth Risk Behavior Survey (MDOE, 2006), a primary data source for *Healthy People 2010*, reported that ''nineteen percent (19%) of students report having hurt themselves on purpose (cuts, burns, bruises) on at least one occasion during the previous twelve months'' (p. 18). These figures have been consistent for the past 3 years. Because questions regarding self-injury have been on the survey for only 3 years, it is difficult to demonstrate any trend. Regardless, the occurrence of self-injury among today's youth is a significant mental health issue that is becoming increasingly evident in the school setting (White Kress, Gibson, & Reynolds, 2004).

### Risk Factors

Research suggests that girls self-injure more often than do boys (Engstrom & Laflamme, 2002; Laye-Grindu & Schonert-Reichl, 2005; MDOE, 2006; Ross & Hearth, 2003; Walsh, 2006). Low socioeconomic status also may be a factor in self-injurious behavior, although conclusive research is sparse. Engstrom and Leflamme (2002) reported that ''among female adolescents aged 15–19 years . . . the incidence of 286/100,000 for (children of) unskilled workers compared with 156/100,000 for (children of) high/intermediate level salaried employees'' (p. 28). The literature review reports no conclusive evidence for a link between culture and self-injurious behavior.

The most obvious risk factor for self-injury is age. Self-mutilation, as a negative coping pattern, usually begins at the onset of adolescence (Favazza, 1996; Nock, Teper, & Hollander, 2007; Ross & Hearth, 2002; Walsh, 2006). Because it is repetitive in nature, it can

continue into adulthood (Favazza; Nock et al., 2007; Ross & Hearth, 2002; Walsh, 2006).

There are many other contributing factors that arise from the overall inability to cope with stress. These factors can include a childhood history of illness or surgery. Children with a history of abuse, especially sexual abuse, are also at risk for developing self-harming behaviors, as are children with emotional disturbances (Favazza, 1996; Walsh, 2006). These children may not have the skills to deal with the powerful emotions attached to abusive events (Favazza; Walsh, 2006). A family history of alcohol abuse, drug abuse, or other self-destructive behaviors puts children at risk for developing negative coping strategies, among them self-injury. Self-injury can also be associated with other mental health disorders, especially anorexia, anxiety, depression, obsessive-compulsive disorder, borderline personality disorder, and other major psychiatric disorders (Ross & Hearth, 2002; Walsh, 2006; White Kress, 2003).

Social modeling may play an important role in self-injury. Eighty-one percent of the adolescents studied reported having a friend who also had an incident of self-injury in the past 12 months (Nock & Prinstein, 2005). Finally, any life event that leads to the inability to develop healthy, adaptive coping strategies can result in self-injurious behavior.

### Purpose

Nock and Prinstein (2005) have developed a theoretical model that proposes four primary functions of self-injury. These functions are (a) to stop bad feelings, (b) to feel something (even if it is pain), (c) to avoid doing something that is unpleasant, and (d) to get attention. Self-injurious behavior, as a coping strategy, is an attempt to manage life. It is an effective method of relieving stress and emotional tension (Best, 2005; Froeschle & Moyer, 2004; Klonsky & Muehlenkamp, 2007; Laye-Grindu & Schonert-Reichl, 2005; McDonald, 2006; Nock & Prinstein; Walsh, 2006). Self-injury, when used as an emotional regulator, offers the individual a way to deal with negative feelings toward the self—a way to cope with life and the stressors that accompany it.

There is a distinction between self-injury as a negative coping skill and self-injury occurring with suicidal ideation. The main distinction is in the intent. Understanding this difference will help guide assessment and treatment. When associated with suicidal thoughts, the intent of self-harm is clearly different: The goal is to end emotional pain by ending life. Conversely, self-injurious behavior is aimed at coping and managing life, not ending it. This behavior is separate from suicidal gestures and can occur without concurrent mental health concerns. There have been arguments for a separate clinical syndrome called "self-mutilation" (Muehlenkamp, 2005). Resolution to this argument will become clearer as empirical studies increase our understanding of this phenomenon.

## ASSESSMENT

The nurse in the school setting is often the first adult to find out about an adolescent's self-injury. For this reason, the school nurse is poised to gather information about the behavior and to offer care to these individuals. The adolescent may ask for help, but more than likely will try to conceal the injury. The school nurse should always be watchful for signs of self-injury. Once self-injury is suspected, the approach for the initial interview can form the basis of a therapeutic relationship. The initial interview should begin by using a "low-key dispassionate demeanor" (Walsh, 2006, p. 76). Approach the adolescent with a calm and nonjudgmental manner (Woldorf, 2005). This method is recommended for several reasons. First, it conveys to the adolescent that you acknowledge his or her thoughts and feelings without judgment (White Kress et al., 2004). Second, the interview can be emotionally charged. A calm demeanor will not add volatility to an already emotional situation (Froeschle & Moyer, 2004; Walsh, 2006). In addition, a low-key approach will not reinforce the behavior. Another recommendation is to approach communication with respectful curiosity, that is, asking pointed questions in a way that does not convey any negative tone or judgment (Walsh, 2006). These strategies form the basis of a trusting relationship between the nurse and the adolescent. This approach conveys to the adolescent that the school nurse is a safe and trusted caregiver.

Using this approach, ask direct questions about the location of the injury, the intent, the time and place of the injury, the tools used, and the emotions attached to the behavior (White Kress, 2003). This inquiry will help differentiate self-injury from a suicidal gesture, a critical differentiation because it will guide the intervention (Best, 2005; Nafisi & Stanley, 2007; Walsh, 2006; White Kress, Drouhand, & Costin, 2006).

Physical assessment of the injury is part of the initial evaluation of self-injurious behavior in the school setting. Clearly, if the wounds require immediate care or first aid, they should be dressed and bandaged as needed prior to any further assessment.

Based on the current body of knowledge and numerous case studies, Walsh (2006) offered practical advice for assessment that can be used in the school setting based on environmental, biological, cognitive, affective, and behavioral factors. These assessments will help to further clarify the motivation for the self-harming behavior.

Environmental factors refer to events that triggered the behavior; therefore, questions that address potential stressors at home or school are important. Was there some activity or event that triggered the injury?

Biological factors contributing to self-injury can include chronic physical and emotional conditions. The current state of mind should be explored: Is there anger, anxiety, rage, or sadness? Is there fatigue, insomnia, alcohol abuse, or drug abuse? These are all biological factors contributing to self-injury that should be explored in the initial assessment. What thoughts are involved with the self-injury? These can include negative core beliefs such as "I am such a loser." Repeated thoughts, images, flashbacks, memories, or dreams can be antecedents to self-injury. Events, even a group of girls talking, can trigger self-harm if the event is interpreted negatively (Walsh, 2006). These cognitive factors set the stage for self-injury.

Because the primary function of self-injury is to relieve tension or emotional distress, the affective domain is an important component of the assessment (Froeschle & Moyer, 2004; Klonsky & Muehlenkamp, 2007; Laye-Grindu & Schonert-Reichl, 2005; Walsh, 2006). What emotions are experienced just prior to the self-injury? Anger, anxiety, fear, panic, guilt, shame, or sadness are some of the emotions frequently reported. How the person feels after the injury is equally important and also should be explored.

Behavioral factors answer the question, "What were you doing just prior to the injury?" (Walsh, 2006). This inquiry can offer insight into behaviors that might be triggers. The time of day and whether the injury took place in seclusion or in the presence of others is also relevant. There has been scholarly and anecdotal evidence that some adolescents will begin self-injury if their friends have been injuring themselves (Nock & Prinstein, 2005; Walsh, 2006).

## INTERVENTION

Accurate assessment, early detection, and early intervention are essential to the successful treatment of self-injury. "Determination of risk must guide intervention activities while ensuring safety and promoting more effective coping strategies" (Crowe & Willoughby, 2001, p. 449). Prevention strategies should be aimed at all adolescents. A comprehensive health education program should include coping skills, interpersonal communication, goal setting, anger management, and advocacy skills (Taras, Duncan, Luckenbill, Wheeler, & Woole, 2004, para. 2-07). This type of program can offer an opportunity for students to model and practice social skills that are important for implementing healthy and safe decisions.

Other nursing interventions are aimed at identifying at-risk adolescents and focusing programs more directly to their needs. Small-group activities can be developed for these adolescents to help them avoid self-injury. The strategies might include teaching coping skills, body confidence, problem solving, feeling identification, verbal expression of emotions, positive relationship development, and impulse control (Crowe & Willoughby, 2001).

Once an adolescent is identified as someone who self-injures, the nursing interventions are aimed at access and referral to counseling services (Crowe & Willoughby, 2001; Gratz, 2007). Treatment should begin as soon as self-injurious behavior is identified (Muehlenkamp, 2006; Nock et al., 2007). There are several reasons for this approach, and it is important for nurses to understand the rationale for early access to care. First, self-injury can become a repeated, maladaptive coping strategy and can begin to have an addictive quality (Simeon & Favazza, 2001; Walsh, 2007). In addition, the risk for an accidental death increases with each event (Best, 2005; Favazza, 1996). The overall goal of the nursing intervention is to access care before these more serious sequelae develop (Muehlenkamp, 2006; Walsh, 2006).

### The Role of the School Nurse

*Healthy People 2010* recognizes that the mental health of children is a national priority.

> Lifelong mental disorders may start in childhood or adolescence. For many other children, normal development is disrupted by biological, environmental, and psychosocial factors, which impair their mental health, interfere with education and social interactions, and keep them from realizing their full potential as adults. (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, n.d., para. 18-7)

Furthermore, *Healthy People 2010* encourages better services for children that include "effective collaboration across critical areas of support: families, social services, health, mental health, juvenile justice, and schools" (para. 18-7). With recommendations from *Healthy People 2010* in mind, developing a plan to address self-injurious behavior among adolescents is a responsibility of the school nurse.

The position statement from the National Association of School Nurses on the mental health of students emphasizes the responsibility of the school nurse in caring for those who self-injure.

> School nurses play a vital role as part of a multi-disciplinary team to support early assessment, planning, intervention, and follow-up of children in need of mental health services. Further, school nurses provide a unique contribution as advocates and providers of mental health services both within the school environment and within the community. (National Association of School Nurses, 2005)

"The role of the school nurse in self-mutilation is critical and encompasses identification, assessment, referral, prevention, and education of family and staff" (McDonald, 2006, p. 196). The school nurse can develop a plan to address self-injurious behavior in the school setting that includes these components. Collaboration with a multidisciplinary team to initiate and carry out the plan of care is also part of the school

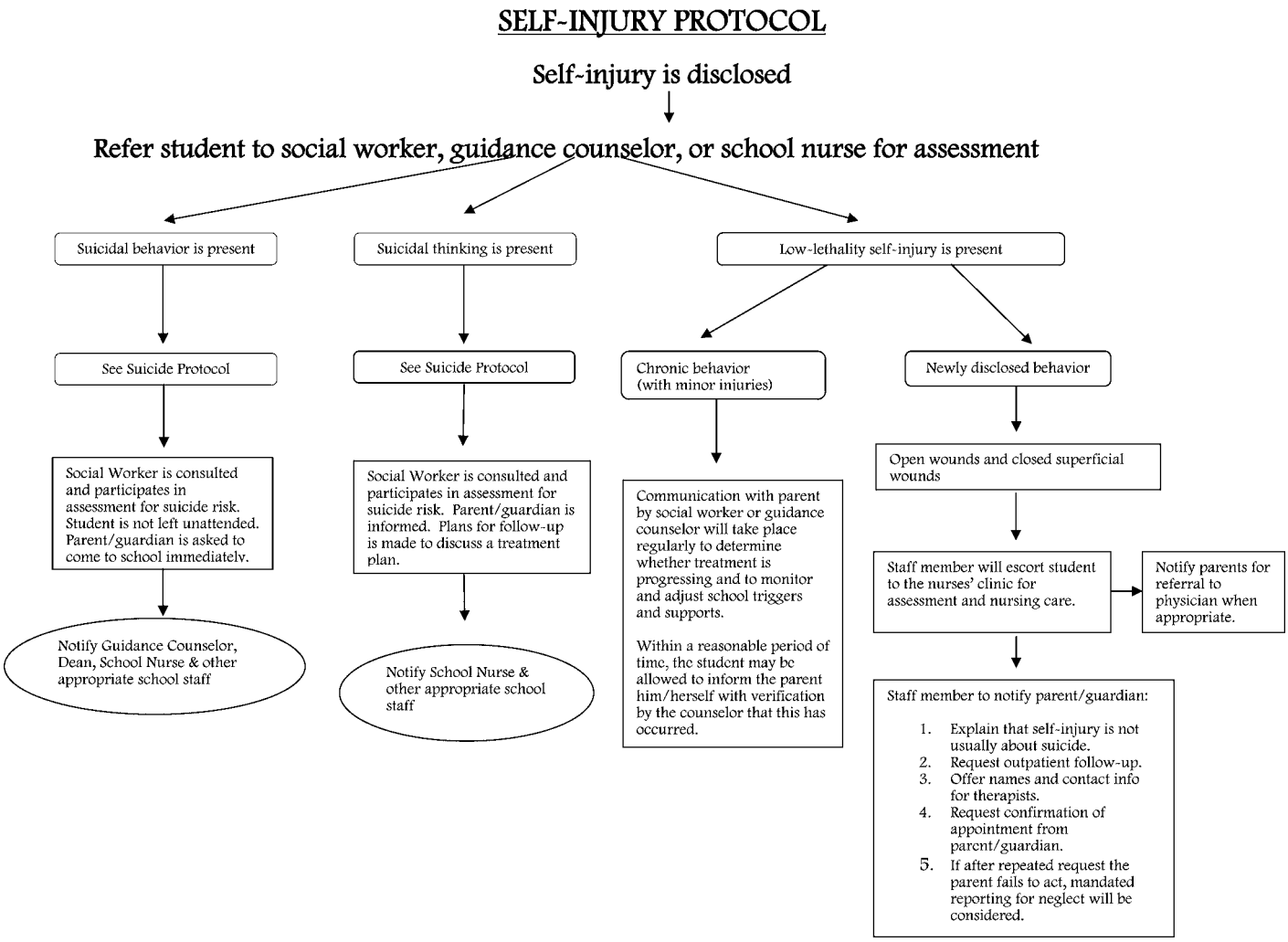


**Figure 1.** Self-Injury Protocol.

nurse's role. Educating guidance staff and teachers about self-injury will facilitate early identification and treatment of students who self-injure.

Care in the school setting is aimed at accurate nursing assessment with emphasis on early referral to mental health care. "The school nurse's knowledge about self-mutilation, along with collaboration with the school psychologist, social worker, or crisis counselor, can lead to an appropriate referral" (McDonald, 2006, p. 197). A comprehensive plan will include prevention strategies that include educational programs for students, school staff members, and parents.

## Protocol Development

A protocol to address self-injury at one Massachusetts school has been operationalized. Based on the literature review, an interdisciplinary plan was developed that began with educating guidance counselors and social workers. Education is the foundation of the nursing intervention plan because of the lack of knowledge and misunderstandings that school staff identified about self-injury (Best, 2005; Froeschle & Moyer, 2004; Roberts-Dobie & Donatelle, 2007). Presenting school staff members with information based on the current research, along with photographs and quotes from adolescents who self-injure, helps to increase understanding of this behavior. A PowerPoint® presentation lends itself nicely to this activity, but whatever the educational approach, providing the current information to staff members is the goal.

In addition to increasing knowledge about self-injury, guidelines for care of those who self-injure need to be developed. In a recent study of the needs of school counselors in relation to students who self-injure, Roberts-Dobie and Donatelle (2007) concluded that not only are counselors wanting more information about self-injury, but they also want policies and procedures to follow when working with self-injurers. With this in mind, an interdisciplinary brainstorming session was conducted with the goal of protocol development. An algorithm was developed to guide the care for students who self-injure (Figure 1). The main purpose of the protocol was to direct the care in the school setting based on the current literature. This two-step plan, staff education and protocol development, will result in consistent care of adolescents who

**Table 1.** Pretest/Posttest About Self-Injurious Behavior

| | |
|---|---|
| 1. In your practice, you recognize the need for more information about self-injurious behavior. | T F |
| 2. Self-injury usually causes permanent damage to the body. | T F |
| 3. Suicide is one form of self-injury. | T F |
| 4. A nurturing attitude toward someone who self-injures is a beneficial approach. | T F |
| 5. Self-injury often begins during early adolescence. | T F |
| 6. Self-injury is an effective method of emotional regulation. | T F |
| 7. Teaching self-soothing skills is the aim of treatment for self-injurious behavior. | T F |
| 8. Asking, in a nonjudgmental way, "What tools do you use?" is an appropriate assessment question. | T F |
| 9. An adolescent is at greater risk of self-injury if his or her friend is using self-injury as a coping skill. | T F |
| 10. Early access to mental health care is indicated for those who self-injure. | T F |

self-injure. It will also provide a guide for dependable interdepartmental communication.

The algorithm, as the literature review suggests, begins with differentiating self-injury from a suicide attempt. The application of assessment strategies includes using a low-key dispassionate demeanor, avoiding judgment, and approaching communication with respectful curiosity. This approach conveys to the adolescent that the school staff member, be it the nurse or the guidance staff member, is a safe and trusted caregiver.

Furthermore, interview questions that assess environmental, biological, cognitive, affective, and behavioral factors will help confirm self-injury. Once assessment validates self-injury, the protocol directs the care. This takes into account nursing care or medical treatment as needed for wounds. It includes communication with family and guidance staff. Family communication will have the following goals: to educate the family about self-injury, to recommend professional counseling, and to offer ongoing support.

### Program Evaluation

Although program evaluation is a continual activity, the initial evaluation was positive. To address the issue of self-injury, a two-part program was implemented. The first part was an educational program for the school staff members. After participating in the hour-long in-service program on the topic of self-injury, knowledge of the staff members is measured with a pretest/posttest design (Table 1).

The second part of the program was protocol development. The true test of learning will be the ability to transfer the new knowledge into action. The multidisciplinary process of protocol development also reinforced learning from the initial in-service program. The protocol will direct care of those who self-injure in this school setting. Ultimately, the goal of the program is an evidence-based practice change.

## IMPLICATIONS FOR SCHOOL NURSING PRACTICE

The intervention plan outlined here is the first step of a comprehensive treatment plan for caring for those who self-injure. Another component of a comprehensive and consistent approach to self-injury within the school setting might include a written guideline for assessment questions. Future plans might include an educational program that is expanded to include the teachers. This can be done in a similar fashion as the guidance counselors' program. Taking advantage of staff in-service time, a self-injury PowerPoint® presentation is one approach.

Education and prevention programs for both adolescents and parents can be developed. Educating the parents about self-injury as well as positive coping strategies can be accomplished through several different channels. A forum such as the Parent Teacher Organization would be ideal for a presentation developed with the parent audience in mind. Newspaper articles, the parent newsletter, and the school Website are additional methods for educating the community about self-injury. Prevention that targets adolescents should include teaching positive coping skills and decision making strategies, as well as promoting healthy relationships and self-concept (Crowe & Willoughby, 2001). Positive skill development can be incorporated in health education class.

## SUMMARY

Self-injury is a problem that is increasingly being recognized in the school setting. Various methods and tools are used to injure, but the purpose is the same: to relieve stress and emotional tension. Risk factors for self-injury include age, gender, history of abuse, illness, mental health issues, social modeling, and socioeconomic status. Because this behavior can have other negative consequences, including accidental death, it is imperative to address this growing problem. A multifaceted approach is needed. Developing a prevention program for adolescents, parents, and school staff members is part of this approach, whereas targeted programs reach out to at-risk adolescents. Protocols to guide both communication and consistent referral to counseling are essential for those who self-injure. School nurses are a valuable resource for identifying self-injury and leading the way toward a multidisciplinary approach to prevention, treatment, and education. In this role, they have a unique opportunity to promote adaptive coping strategies and positive

outcomes for this challenged—and challenging—population of students.

## REFERENCES


Best, R. (2005). An educational response to deliberate self-harm: Training, support, and school-agency links. *Journal of Social Work Practice, 19,* 275–287.

Cleaver, K. (2007). Characteristics and trends of self-harming behavior in young people. *British Journal of Nursing, 16,* 148–152.

Crowe, J., & Willoughby, C. (2001). Self-mutilation prevention. In M. Craft-Rosenberg & J. Denehy (Eds.), *Nursing interventions for infants, children, and families* (pp. 445–459). London: Sage.

Engstrom, K., & Leflamme, L. (2002). Socio-economic differences in intentional injuries: A national study of Swedish male and female adolescents. *Acta Psychiarica Scandinavica, 106*(s 412), 26–29.

Favazza, A. R. (1996). *Bodies under siege.* Baltimore: The John Hopkins University Press.

Froeschle, J., & Moyer, M. (2004). Just cut it out: Legal and ethical challenges in counseling students who self-mutilate. *Professional School Counseling, 7,* 231–236.

Gratz, K. L. (2007). Treating emotion dysregulation in the treatment of self-injury. *Journal of Clinical Psychology: In Session, 63,* 1091–1103.

Klonsky, D. E., & Muehlenkamp, J. J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology: In Session, 63,* 1045–1056.

Laye-Grindu, A., & Schonert-Reichl, K. A. (2005). Nonsuicidal self-harm among community adolescents: Understanding the "whats" and "whys" of self-harm. *Journal of Youth and Adolescence, 34,* 447–458.

McDonald, C. (2006). Self-mutilation in adolescents. *Journal of School Nursing, 22,* 193–200.

Massachusetts Department of Education. (2006). *2006 Massachusetts youth risk behavior survey results.* Retrieved March 17, 2007, from http://www.westford.mec.edu/yrbs/docs/yrbs06.pdf

Muehlenkamp, J. (2005). Self-injurious behavior as a separate clinical syndrome. *American Journal of Orthopsychiatry, 75,* 324–333.

Muehlenkamp, J. (2006). Empirically supported treatments and general therapy guidelines for non-suicidal self-injury. *Journal of Mental Health Counseling, 28,* 166–186.

Muehlenkamp, J., & Gutierrez, P. (2004). An investigation of differences between self-injurious behaviors and suicide attempts in a sample of adolescents. *Suicide and Life-Threatening Behavior, 34*(1), 12–22.

Nafisi, N., & Stanley, B. (2007). Developing and maintaining the therapeutic alliance with self-injury patients. *Journal of Clinical Psychology: In Session, 63,* 1069–1079.

NANDA International. (2007). *Nursing diagnosis: definitions & classifications 2007–2008.* Philadelphia: Author.

National Association of School Nurses. (2005). *Position paper: Mental health of students.* Retrieved March 18, 2007, from http://www.nasn.org/Default.aspx?tabid=231

Nock, M. K., & Prinstein, M. J. (2005). Contextual features and behavioral functions of self-mutilation among adolescents. *Journal of Abnormal Psychology, 114,* 140–146.

Nock, M. K., Teper, R., & Hollander, M. (2007). Psychological treatment of self-injury among adolescents. *Journal of Clinical Psychology: In Session, 63,* 1081–1089.

Reece, J. (2005). The language of cutting: Initial reflections on a study of the experience of self-injury in a group of women and nurses. *Issues in Mental Health Nursing, 26,* 561–574.

Roberts-Dobie, S., & Donatelle, J. (2007). School counselors and student self-injury. *Journal of School Health, 77,* 257–265.

Ross, S., & Hearth, N. (2002). A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence, 1,* 67–77.

Ross, S., & Hearth, N. (2003). Two models of adolescent self-mutilation. *Suicide and Life-Threatening Behavior, 33,* 277–287.

Simeon, D., & Favazza, A. R. (2001). Self-injurious behaviors: Phenomenology and assessment. In D. Simeon & E. Hollander (Eds.), *Self-injurious behaviors: Assessments and treatment* (pp. 1–28). Washington, DC: American Psychiatric Publishing.

Taras, H., Duncan, P., Luckenbill, D., Wheeler, L., & Woole, S. (2004). *Health, mental health and safety guidelines for schools.* Retrieved February 1, 2008, from http://www.nationalguidelines.org

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.) *Healthy people 2010, 18-7.* Retrieved December 8, 2007, from http://www.healthypeople.gov/Document/HTML/Volume2/18Mental.htm#Toc486932699

Walsh, B. (2006). *Treating self-injury: A practical guide.* New York: Guilford Press.

Walsh, B. (2007). Clinical assessment of self-injury: A practical guide. *Journal of Clinical Psychology: In Session, 63,* 1057–1068.

White Kress, V. E. (2003). Self-injurious behavior: Assessment and diagnosis. *Journal of Counseling and Development, 81,* 490–497.

White Kress, V. E., Drouhard, N., & Costin, A. (2006). Students who self-injure: School counselor ethical and legal considerations. *Professional School Counseling, 10,* 203–207.

White Kress, V. E., Gibson, D., & Reynolds, C. (2004). Adolescents who self-injure: Implications and strategies for school counselors. *Professional School Counseling, 7,* 195–201.

Whitlock, J. L., Eckenrode, J., & Powers, J. L. (2006). The virtual cutting edge: The Internet and adolescent self-injury. *Developmental Psychology, 42*(3). Retrieved December 15, 2007, from Medline database.

Woldorf, G. M. (2005). Clinical implication of the paradox of deliberate self-injury. *Journal for Specialists in Pediatric Nursing, 10,* 196–200.