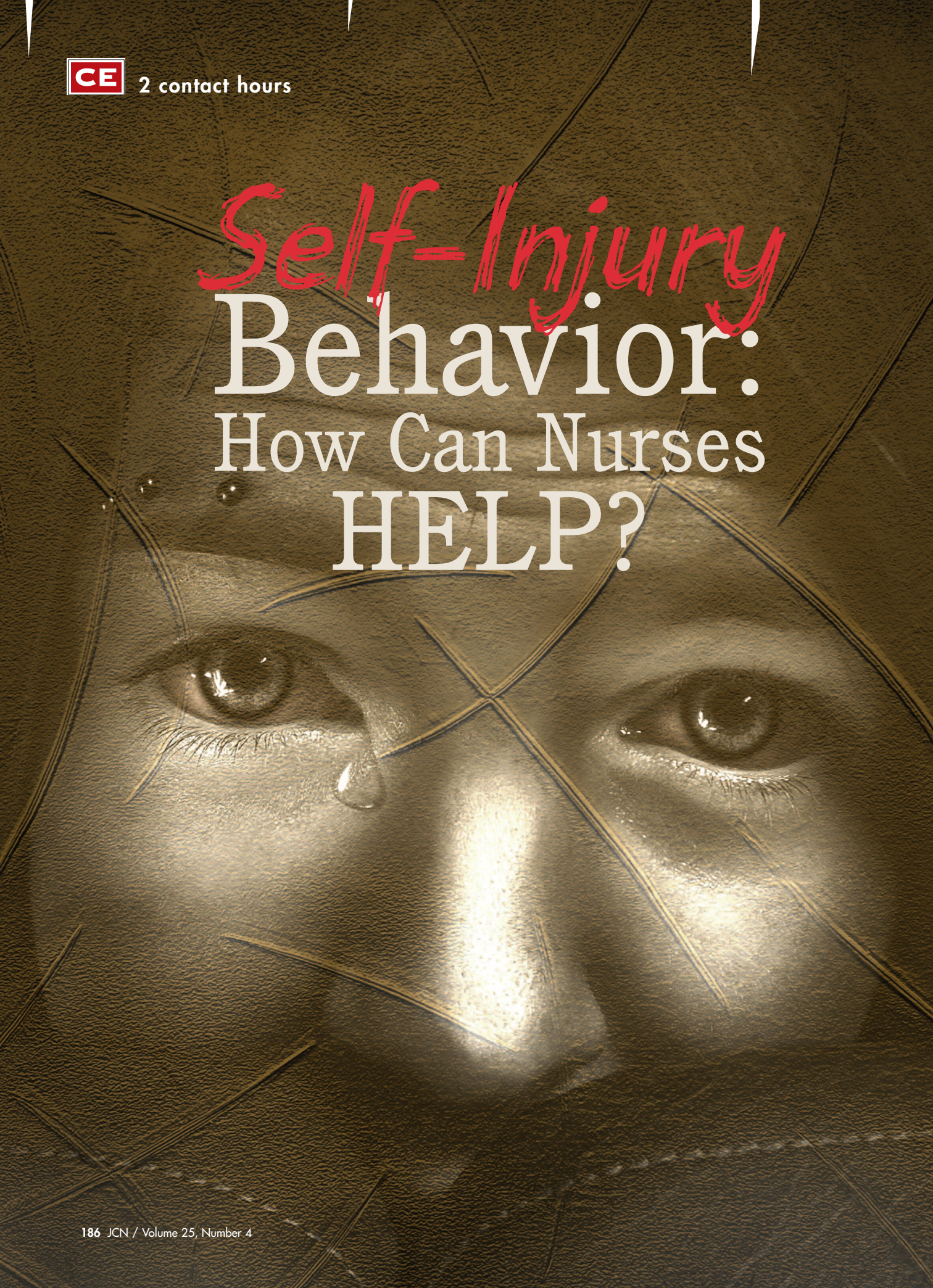
CE 2 contact hours

Self-Injury Behavior: How Can Nurses HELP?



She can see the *GAPE* of *CRIMSON* grow larger as it spills over the edges and runs down her hand. She can see the *SCARLET DROPS* grow larger as they gather at her fingertips and then detach and fall through space. But no sound comes from her lips. To an onlooker this would seem an *EERILY QUIET* moment, a moment engulfed in deathly silence. But the girl lying in the *PUDDLE* of *BLOOD* in the silent war hears the discordant noises . . . raging and roaring as they grate through her mind, *PIERCING REMINDERS* of what she'd rather *FORGET. . . .* (Anonymous, 2001)

Emily* submitted this poem to her high school creative writing teacher. She began cutting her upper arms and thighs with a pocketknife when she was 15 years old and had hundreds of healed scars and several fresh cuts. In an effort to conceal her self-inflicted wounds, Emily wore black baggy pants and long-sleeved black jackets. She dyed her hair black, which matched her fingernail polish and contrasted sharply with her pale skin. Emily relayed that cutting provided temporary relief from emotional pain, anger, anxiety, and feelings of self-worthlessness. She cut when she felt dead inside. When she saw her blood, she was relieved to realize that she was still alive.

Emily stated, "It gave me a sense that I was taking care of my problems, but I knew nothing was getting done. I settled for the quick fix; the problem would come again and eventually it would get to the point where I cut myself again" (Lesniak, 2007b, p. 4).

by Rhonda Lynn Goodman Lesniak

DEFINING SELF-INJURY

Self-injury behavior (SIB) is a complex group of behaviors involving deliberate destruction or alteration of body tissue without conscious suicidal intent (Cerdorian, 2005; Favazza, 1996). The self-injury is non-life threatening (Shaw, 2002), done to alter a perceived intolerable mood state by inflicting physical harm serious enough to cause pain and tissue damage to the body (Levander, 2005, p. 3). Self-injury is used as a coping mechanism to help the individual deal with emotional pain or to break feelings of numbness by arousing sensation (LifeSigns Self Injury Guidance and Network Support, 2005, p. 5). The key components of SIB are listed in Table 1.

Although McDonald (2006) referred to this phenomenon as self-mutilation, most authors use the term "self-injury" (i.e., American Self-Harm Information Clearinghouse, 2005; Van Sell, et al., 2005). Others use the terms "self-harm" (Ayton, Rasool, & Cottrell, 2003; Harris, 2000), "self-wounding" (Sharkey, 2003), or "self-inflicted violence" (SIV) (Alderman, 1997). Because the term "self-mutilation" evokes grotesque images and implies permanent damage or alteration to one's body (Alderman, 1997),

Table 1. Key Components of Self-Injury Behavior

- A harmful act done to oneself (self-abuse)
- A behavior performed on oneself by oneself
- An intentional act
- Typically performed alone (secretive behavior)
- Includes some type of physical violence (self-injury, pain)
- Not performed with the intent of killing oneself
- Typically follows a ritualistic pattern (a particular instrument on the same bodily location in a specific environment at a certain time)

Sources: Alderman, 1998; Clark & Henslin, 2007; Sutton, 2005.

Rhonda Lynn Goodman Lesniak, MA (theology), MS, FNP-BC, is a PhD candidate at the Florida Atlantic University Christine E. Lynn College of Nursing. She is a nationally certified school nurse. Rhonda works as a family nurse practitioner at The Little Clinic in Lake Worth, Florida. She is a deacon and faith community nurse at First Presbyterian Church of Boca Raton, Florida.

*Name has been changed to protect privacy.

a Glance

- **Self-Injury Behavior (SIB)** *is inflicting deliberate physical harm on oneself without suicidal intent; ~1% of the U.S. population and 12% of teens self-injure.*
- **SIB temporarily** *relieves intolerable emotions, offers control, may release endorphins, and provides opportunity for self-nurturing after wounding; but increases feelings of shame and guilt.*
- **Treatment must** *include authentic caring and address physical, mental, and spiritual healing.*

it is particularly annoying to those who self-injure (Hoyle, 2003; Levander, 2005; Sutton, 2005). In contrast, SIB usually is temporary and often unnoticeable or hidden.

What are typical self-injury behaviors? The most common are cutting and burning or branding. Other behaviors include stabbing, needle sticking, punching oneself, interference with wound healing (reopening wounds), excessive scratching (Kehrberg, 1997), hitting or bruising, nail biting, pulling out hair (trichotillomania), breaking bones, and drinking substances not intended for human consumption (Alderman, 1997; Murray, Warm, & Fox, 2005). The tools most often used are razors, knives, lighters, broken glass, matches, sewing needles, pencils (sharpened lead and erasers), and sandpaper. Cerdorian (2005) asserted that SIB often is inflicted repeatedly on the same part of the body. Contradicting the notion that persons who self-injure are seeking attention, most self-injuring adolescents wear clothing that covers their scars and wounds (Cerdorian, 2005; Hoyle, 2003; Shannon, 2005).

Although suicide can be thought of as the most grievous form of self-injury, SIB is performed without suicidal intent. Indeed, SIB may even be a way to prevent suicide because it relieves emotional distress (Cerdorian, 2005; Starr, 2004). Certain alterations in appearance (piercing, tattoos) might be considered self injurious, but these are performed with the goal of enhancing the body and generally are done by another person. Ritual mutilation performed as a rite of passage publicly acknowledged and offering a sense of belonging and pride (genital mutilation, branding, scarring, tattooing) is not SIB.

Self-injury is not classified as a disorder or syndrome in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (American Psychological Association, 2000). However, SIB has been classified into four types. It can be related to *psychosis,* in which hallucinations or delusions prompt a mentally ill person to self-injure, to *organic physiology* from autistic disorders, to *developmental or physiologically induced disabilities* (lip biting, head banging to stimulate or sooth), or to *emotional factors.* The latter is the most common, typical SIB (Alderman, 1997).

CULTURAL ORIGINS OF SIB

Self-injury behavior has been described as a culturally defined phenomenon because different cultures have various definitions and unique expressions of the behavior (Favazza, 1996; Kehrberg, 1997). The perspective of Western cultures is not favorable toward self-injury. However, the perspective of other cultures differs. Some cultures use self-injury as a form of identification for family or tribal units, whereas others use self-induced scars as a sign of adulthood, a symbol of beauty, or a rite of passage (Kehrberg, 1997).

Self-injury behavior first appeared in clinical literature in 1913 (Shaw, 2002). Historically, the significance of blood as a method of payment for or forgiveness of wrongdoing (sin) is recorded extensively throughout biblical and extrabiblical literature. In the fifth century B.C., Herodotus in his Book 6 of *History* described a Spartan leader who cut himself with a knife. Hippocrates in 300 B.C. developed a theory that people could be rebalanced through bloodletting, blistering, vomiting, and so forth to cleanse the body (Clark & Henslin, 2007).

In Scripture, God commanded the Israelites not to cut their bodies ritually as the pagan nations around them did (Leviticus 19:28, 21:5; Deuteronomy 14:1-2). The prophets of Baal attempted, without success, to arouse and appease Baal with extensive cutting and bloodletting (1 Kings 18). In the first century A.D., Mark recorded in his gospel the story of a man who cut himself with stones night and day (Mark 5:1-5).

During the first century A.D., Christian clergy and laity practiced self-flagellation. Early Church martyrs, such as the Desert Fathers, promoted penance through self-flagellation with small leather whips (Favazza, 1996). In the 13th century, the religious orders renewed this practice, which spread and continued into the next century, especially in response to the bubonic plague because followers believed the plague called for penance (Favazza, 1996; Levenkron, 1998). Favazza reports that this continues today, "particularly

A Call for HELP

As a high school nurse, I taught classes on first aid and cardiopulmonary resuscitation (CPR). Over a period of several weeks with one class, I noticed a girl who seemed to be asking for my attention. I would observe her watching me or sitting near my chair. I felt drawn to speak with her, almost as if I were being pulled in her direction. I recognized this as a call for nursing. I intentionally spoke about school events, class work, and so forth to build trust. I was responding to the girl's call for attention, yet I also was calling to her to trust me and making myself accessible in a nonthreatening manner.

One day the girl informed me that she had a friend who was cutting and asked how this friend could be helped. I sensed that the "friend" and my student were the same person. However, I continued to be present with my student, to listen, to be nonjudgmental, and to allow her the time she needed to reveal her story fully.

On the day the students were learning to take blood pressures. My student and her lab partner were having difficulty with the cuff. As I pushed up my student's sleeve to apply the cuff, I saw the scars. I sent her partner to another group and quietly asked my student how long she had been cutting. With tears in her eyes, she stated, "I'm so glad you finally know. I have wanted to tell you for so long."

After this incident, we had many long talks after class and during lunch. Together we spoke with her guidance counselor and her mother and were able to find resources from which she could receive the therapy she needed. This gentle method of conveying genuine caring provided the foundation for a relationship that enabled this student's call for nursing to be answered.

during the Lenten season prior to Easter, in areas such as the Philippines, Mexico, and some parts of the United States" (p. 40).

Self-injury for religious reasons is not unique to Christianity. The Abidji tribe on the Ivory Coast cut their abdomens with knives while entranced to celebrate the New Year festival, believing this will assuage guilt and anxiety and bring about healing for the entire tribe. Many shamans practice self-sacrifice to promote healing of self and others (Favazza, 1996; Strong, 1998). According to Hinduism, suffering and sacrifice are intended to help one identify with the cycles of creation and destruction and maintain control over these cycles. The followers of Shia Islam practice self-flagellation and self-infliction of wounds. Another Islamic sect, the Sufic brotherhood Hamadsha, conducts healing rituals in which they seek union with God by slashing their heads, eating spiny cactus, and drinking boiling water. Suffering is a way of penance for these followers and, according to their beliefs, perhaps even the path to salvation (Favazza, 1996).

Some psychological experts have suggested that SIB might stem from biblical writings (Ellis, 1988; Favazza, 1996; Freud, 1927). In documented instances, isolated followers or peripheral sects have cut off an offensive body part to appease their consciences (Favazza, 1996; Strong, 1998). However, this type of self-injury reflects an interpretation of biblical texts (Mark 9:43-48) that literally follows the letter of the word rather than the intent, which is to allow nothing to thwart a full relationship with God. Scripture teaches that there is healing power in the blood of Jesus Christ (Isaiah 53:4-6; Hebrews 9:22; 1 John 1:7). Sadly, persons who self-injure to procure atonement are unaware of the blood of Christ as the only true atoning sacrifice or do not understand it (Romans 3:22-26).

Sadly, SIB is becoming a cultural phenomenon in the American adolescent population (Conterio & Lader, 1998). The American Self-Harm Information Clearinghouse (2005) estimates that one percent of the population has participated in self-injury behavior, whereas other researchers report that 12 to 13 percent of adolescents self-injure (Favazza, 1996; Ross & Heath, 2002; Strong, 1998). A subculture of the Goth movement known as "Emo" (short for emotional) actively celebrates self-harm, and Emo Web sites offer ideas, songs, and poetry promoting SIB (Sands, 2006).

WHO IS SELF-INJURING?

Most persons who self-injure begin during adolescence, usually around the ages 12 to 14 years (Cerdorian, 2005).

Self-injurers typically are high school educated. They usually have a history of physical or sexual abuse or come from a home with an alcoholic parent (Murray, Warm, & Fox, 2005; Ross & Heath, 2002; Santa Mina et al., 2006). Much of the research on SIB has been conducted with adolescent girls, suggesting that SIB is more common among females, but this is not validated. Some self-injurers (~13 percent) witnessed another person self-injuring (Levander, 2005), then began to self-injure themselves.

Common comorbid conditions are eating disorders (Murray et al., 2005), marital violence, childhood illness, loss of a parent at an early age (Kehrberg, 1997), and familial impulsive self-injury behavior (Shaw, 2002). A common risk indicator for self-injury, depression, often is overlooked, underdiagnosed, and undertreated among adolescents (Evans, 2002). Often, SIB is accompanied by a diagnosis of dissociation, mood disorders, substance abuse, and anxiety disorder. However, Kehrberg asserts that the strongest predictor of self-injury is body alienation, resulting from a history of physical or sexual abuse.

Physiologically, research findings support a relationship between decreased serotonin levels, increased dopamine levels, temporal lobe dysfunction, decreased perfusion of the prefrontal cortex, and self-injury behavior. These in turn are related to depression, irrational thinking, learning differences, mental processing, and social skills—the external behaviors observed in relationship to SIB (Clark & Henslin, 2007). A complete list of characteristics associated with SIB can be found in Table 2.

Table 2. Characteristics Associated With Self-Injury Behavior

Low self-worth, invalidation of self	Adolescence
Hopelessness	Lack of control
Depression (especially untreated)	Impulsivity
Family or social problems	Conflict over one's sexual orientation
Social deprivation, emotional neglect	Unemployment
School problems	High-fat diets
Cigarette consumption	Substance abuse
Overcrowded living conditions	Posttraumatic stress disorder
Hypersensitivity to rejection	Chronic anger
Chronic anxiety	Avoidance behavior
Family history of alcoholism	↑ Dopamine, ↓ serotonin in the brain

Sources: Ayton, Rasool, & Cottrell, 2003; Cerdorian, 2005; Clark & Henslin, 2007; Levander, 2005; Kehrberg, 1997

WHY SELF-INJURE?

Those who self-injure find SIB to be an effective coping mechanism that brings inner pain to the surface (Strong, 1998) and maintains equilibrium. The following lyrics recorded by Plumb (2006) reflect emotions experienced by those who self-injure:

I do not want to be afraid
I do not want to die inside just to breathe in
I'm tired of feeling so numb
Relief exists I find it when
I am cut.

Research confirms that SIB provides "temporary relief from a host of painful symptoms" (Favazza, 1996, p. xix). Women ages 20 to 45 years have reported a feeling of cleansing, as explained by one participant, "I was trying to cut out all the bad inside me" (Harris, 2000, p. 166). Self-injurers report that SIB is a survival tactic, even allowing a good night's sleep (Sutton, 2005).

Specific motivations for SIB have been summarized as the eight Cs: coping and crisis intervention, calming and comforting, control, cleansing, confirmation of existence, creating comfortable numbness, chastisement, and communication (Sutton, 2005, p. 137).

Adolescents who self-injure claim the behavior affords them a sense of desired control. Some describe a feeling of relief when experiencing the pain of SIB because it is then that they know they are truly alive. Others claim it produces a state of numbness or dissociation. Such chastisement is self-punishment for imagined or real mistakes or shortcomings, in which the self-inflicted wound is a conduit for the voice that the adolescent lacks (Sutton, 2005).

Self-injury actually may produce physiologic side effects by releasing endorphins, dynorpins, and enkephalins —endogenous morphines produced by the body in response to stressful stimuli (Clark & Henslin, 2007; Favazza, 1996; McCance & Huether, 2002; Sutton, 2005). Endorphins function to inhibit pain impulse transmission in the brain and to produce feelings of relaxation, well-being, euphoria, and excitement, much the same as the high experienced

by runners. A possible SIB–endorphin connection has led some to suggest that SIB fulfills an organic need (Clark & Henslin, 2007).

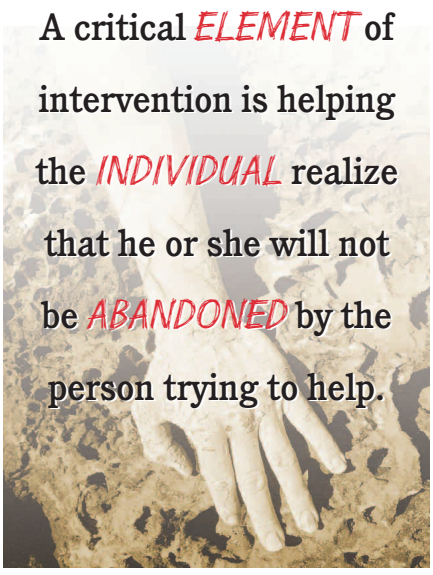
An intriguing motivation for SIB is the concept of self-nurturing or self-care. Strong (1998) posited that because self-injury provides a temporary relief from emotional turmoil, it can be used as a means of nurturing and preserving self. The person who self-injures has the opportunity to cleanse and dress the wounds, providing an avenue for caring for self and aiding in one's own healing process. In addition, while witnessing the healing of the physical and external wounds, participants may transfer the illusion of healing to their internal pain.

THE CYCLE OF SELF-INJURY

The stories of three young women who self-injured throughout their adolescent years illustrate the emerging patterns of this phenomenon (Lesniak, 2006; Lesniak, 2007a; Lesniak 2007b). The women described feelings of frustration, anxiety, anger, and tension. As their emotions escalated, the self-injury act occurred, resulting in relief, calmness, and relaxation. Later, the women described feelings of shame. They felt stigmatized and experienced increasing feelings of abandonment as their friends and family members did not understand their self-injury. These negative feelings led them back to the desire for temporary relief. As one participant stated,

"I just cut myself and thought about the pain, and I cried and then it was over. I felt better until the next time problems came, whether they were the same problems or different ones, and I did the same thing. It was just something that got me through it." (Lesniak, 2007b)

In essence, the inability to cope with intolerable feelings leads to alternate ways of expressing those feelings. Self-injurers may experience relief from SIB. However, the shame resulting from the act of harming oneself leads in a patterned manner back to emotions that are unacceptable. Other researchers describe the cycle of self-injury in adolescents using six points: mental anguish (escalating emotions), emotional engulfment (fright, anxiety), panic stations (loss of control, detachment), action stations (act of self-injury), better/different feeling (relief, control regained), and the grief reaction (shame, guilt) (Sutton, 2005, p. 114).



HOW CAN NURSES HELP?

To identify and intervene with self-injurers, it is critical to develop a relationship of trust and caring. Nurse theorists Paterson and Zderad (1976/1988) suggest that nurses should approach the "nursing experience" with intentionality and authenticity. After the experience, called the "nursing situation," the nurse reflects upon it, describes it, identifies the calls for nursing and the nursing responses, and evaluates the knowledge gained from the experience. Paterson and Zderad emphasize authentic presence whereby one commits to being open and available to the other. It is through this presence that genuine dialogue may occur. For the adolescent who may be experiencing depression, this intentional and authentic approach by the nurse may be the impetus needed to unlock and verbalize his or her feelings.

The call and response between client and nurse is the mainstay of Paterson and Zderad's (1976/1988) theory. This involves an intentional call from the person who has a need and expects and hopes to receive care. The call is heard by the nurse, who responds with the intention of giving care. However, the call and response may travel both ways because the client also may be responding to a call the nurse has issued through providing a safe, nurturing, and caring environment.

Active listening is critical. In a study with adolescent girls, Machoian (2001) wrote:

> *If girls feel someone is not listening, they may conclude that the person does not genuinely care. Relationships in which girls feel free to express themselves honestly have been found to be important in assessments of girls' overall psychological health. Not being listened to increases girls' risk for psychological distress.* (p. 2)

A nurse who intentionally approaches a troubled adolescent using a caring perspective may be able to promote the feelings of self-worth needed by that teen.

Perhaps Jesus Christ best explained how to enter into a caring relationship when he said, "And whoever welcomes a little child like this in my name welcomes me" (Matthew 18:5, NIV) and "See that you do not look down on one of these little ones" (Matthew 18:10a, NIV). Nurses can welcome and truly see a troubled adolescent, then help the teenager find the voice needed to express intolerable feelings and begin to find a way out of SIB. A critical element of intervention is helping the individual realize that he or she will not be abandoned by the person

trying to help. The sidebar, "A Call for Help," offers a case study applying Paterson and Zherad's (1976/1988) theory to a nursing encounter with an adolescent girl using SIB.

Treatment of SIB must address physical, mental, and spiritual healing. Physical treatment includes improving nutrition, treating any underlying illnesses, and managing physiologic depression, psychosis, attention deficit disorder (ADD)/attention deficit/hyperactivity disorder (ADHD), and the like. Mental treatment involves therapy and possibly psychological testing with a trained professional (psychotherapist, psychologist, psychiatrist).

Spiritual healing may be the most significant component because it "can open the door for powerful whole-person recovery" (Clark & Henslin, 2007, p. 182). From a Christian perspective, spiritual healing begins with discovering and embracing a personal relationship with God through Jesus Christ—the way, the truth, and the life (John 14:6). Self-injurers can identify with biblical redemption, the story of the suffering and love of God, who ultimately triumphed over pain through the death and resurrection of Jesus Christ. Embarking on spiritual growth and persevering in it through Bible study, prayer, church attendance, and experiencing community, the self-injurer discovers a God who brings hope and beauty from wounds. Guilt and shame can be replaced by grace through understanding and accepting God's forgiveness (Psalm 103:8) (Clark & Henslin, 2007). Often, deep inner healing is needed, and Christian healing ministry (MacNutt, 2006) or Theophostic prayer ministry (Clark & Henslin, 2007) by a trained prayer minister can be an important adjunct to counseling. Table 3 summarizes concrete, research-based

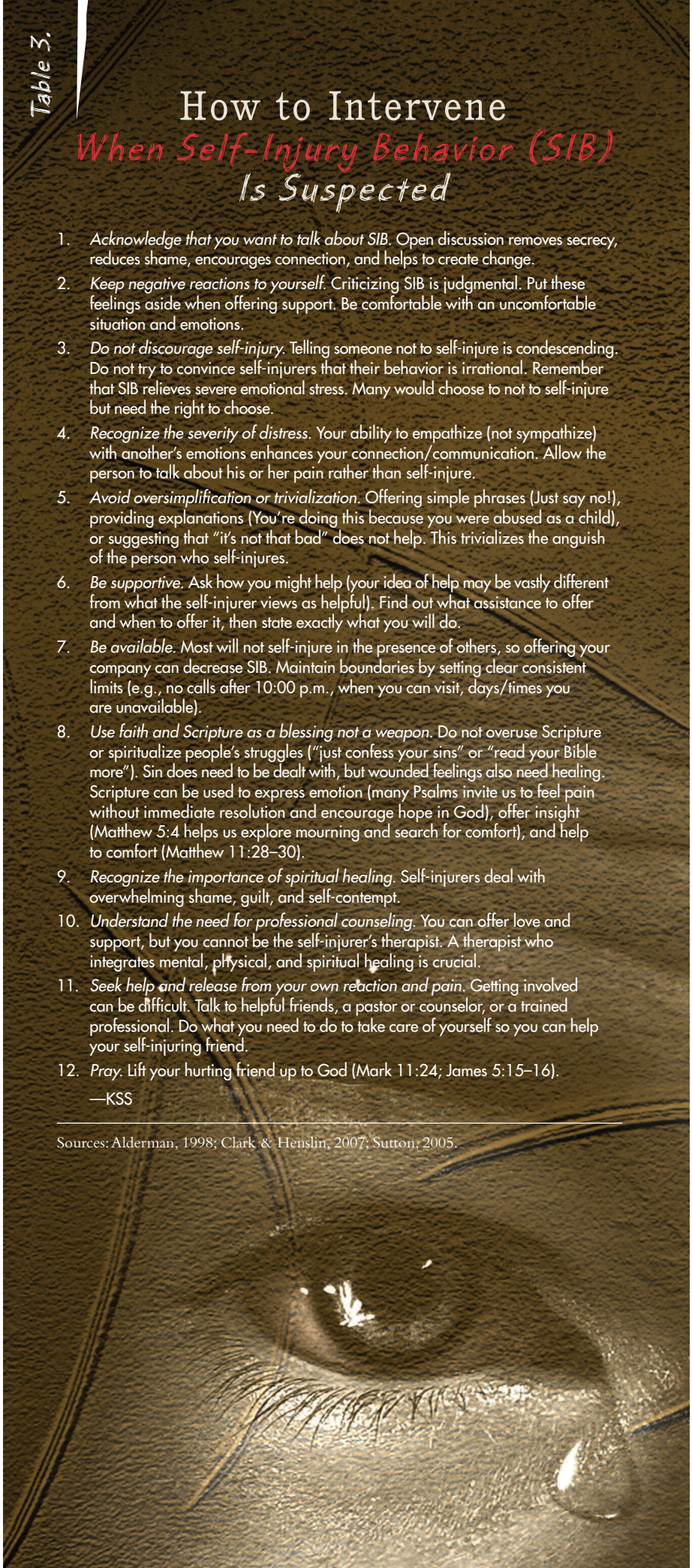
Table 3.

How to Intervene When Self-Injury Behavior (SIB) Is Suspected

1. *Acknowledge that you want to talk about SIB.* Open discussion removes secrecy, reduces shame, encourages connection, and helps to create change.
2. *Keep negative reactions to yourself.* Criticizing SIB is judgmental. Put these feelings aside when offering support. Be comfortable with an uncomfortable situation and emotions.
3. *Do not discourage self-injury.* Telling someone not to self-injure is condescending. Do not try to convince self-injurers that their behavior is irrational. Remember that SIB relieves severe emotional stress. Many would choose to not to self-injure but need the right to choose.
4. *Recognize the severity of distress.* Your ability to empathize (not sympathize) with another's emotions enhances your connection/communication. Allow the person to talk about his or her pain rather than self-injure.
5. *Avoid oversimplification or trivialization.* Offering simple phrases (Just say no!), providing explanations (You're doing this because you were abused as a child), or suggesting that "it's not that bad" does not help. This trivializes the anguish of the person who self-injures.
6. *Be supportive.* Ask how you might help (your idea of help may be vastly different from what the self-injurer views as helpful). Find out what assistance to offer and when to offer it, then state exactly what you will do.
7. *Be available.* Most will not self-injure in the presence of others, so offering your company can decrease SIB. Maintain boundaries by setting clear consistent limits (e.g., no calls after 10:00 p.m., when you can visit, days/times you are unavailable).
8. *Use faith and Scripture as a blessing not a weapon.* Do not overuse Scripture or spiritualize people's struggles ("just confess your sins" or "read your Bible more"). Sin does need to be dealt with, but wounded feelings also need healing. Scripture can be used to express emotion (many Psalms invite us to feel pain without immediate resolution and encourage hope in God), offer insight (Matthew 5:4 helps us explore mourning and search for comfort), and help to comfort (Matthew 11:28–30).
9. *Recognize the importance of spiritual healing.* Self-injurers deal with overwhelming shame, guilt, and self-contempt.
10. *Understand the need for professional counseling.* You can offer love and support, but you cannot be the self-injurer's therapist. A therapist who integrates mental, physical, and spiritual healing is crucial.
11. *Seek help and release from your own reaction and pain.* Getting involved can be difficult. Talk to helpful friends, a pastor or counselor, or a trained professional. Do what you need to do to take care of yourself so you can help your self-injuring friend.
12. *Pray.* Lift your hurting friend up to God (Mark 11:24; James 5:15–16).

—KSS

Sources: Alderman, 1998; Clark & Henslin, 2007; Sutton, 2005.



Although *SUICIDE* can be thought of as the most *GRIEVOUS* form of self-injury, SIB is performed without suicidal *INTENT*.

information on how nurses can intervene when they suspect SIB.

SUMMARY

Although historical, religious, and cultural examples provide some understanding of SIB, the importance of further research, especially in adolescent SIB, cannot be underestimated. Nursing research is needed to explore the correlation between SIB and the spiritual needs of adolescents. Shannon (2005) stated that SIB is a common precursor to suicide. If adolescents at risk for this behavior are identified earlier, perhaps fewer teens will be lost to suicide. Although many use self-injury as short-term relief from their problems, it is repetitive in nature. If nurses are able to assist adolescents in interrupting emerging patterns of SIB, future self-injury may be prevented.

Adolescents at risk for self-injury behavior are searching for a way to give voice to their pain. When approached with a caring attitude that reflects the love of Christ, when listened to with intentionality, and when nurtured by an authentic presence, self-injurers are relieved to externalize their difficult emotions through verbal means rather than to record their pain with visible stories on their skin. For even when the wounds heal, the scars remain a visible reminder of the hurt hiding within. In essence, the history of the self-injurer is recorded on their skin.

Web Resources

- www.self-injury.org—Lysamena Project (Christian-based resources)
- www.selfinjury.org—American Self-Harm Information Clearinghouse
- www.siari.co.uk—SIARI: Self-Injury & Related Issues for the International Community
- www.selfharm.net—Secret Shame: Self-Injury Information and Support

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