Teachers' Awareness of Self-Cutting Behavior Among the Adolescent Population

by Lauren Carlson, Stacy M. DeGeer, Chassity Deur and Kristen Fenton

Abstract

Self-cutting is a type of self-injurious behavior that "has become a more visible mental health issue for adolescents in the past decade" ("Wounds…", 2004, p. 1). Prior to the present one, no studies assessing teachers' awareness of this growing problem have been conducted. This study examined high school teachers' awareness and knowledge of the issue of self-cutting behavior in adolescent students and assessed their ability to intervene with a self-cutting student. Participants included 150 teachers from three suburban Chicago high schools. Participants completed a self-administered questionnaire measuring current knowledge of self-cutting. The majority of the participants did not feel knowledgeable or confident in their ability to respond to self-cutting students. Also, 85% of participants felt that they would benefit from more training. Future research needs to be conducted on this growing phenomenon and also on teachers' abilities to respond to students that self-cut.

Problem Statement

Self-cutting, one form of self-injury, is a growing phenomenon on most high school and junior high school campuses (Galley, 2003). The literature suggests that this mental health issue is complex and highly under-researched. Over the last ten years, mental health workers and school administrators have expressed increased concern over the issue of adolescent self-cutters ("Wounds," 2004). The prevalence of this behavior is unknown but is estimated to be between 0.75% and 14.8% of adolescents (Ross & Heath, 2002; Suyemoto & Kountz, 2000).

Some researchers believe that the increase in cutting behavior began about ten years ago ("Wounds," 2004). One factor that may have promoted this change is its growing presence in the media. In recent years, self-cutting behaviors have become more prevalent in various mediums such as music, popular television programs, and recent movies such as "Thirteen" and "Secretary." The increased media attention coupled with the lack of research may be contributing to a climate of confusion around this issue.

At the same time, this growing phenomenon has led to increased concern among mental health practitioners and school administrators. While self-cutting and other forms of self-injurious behaviors have been studied over the past seventy years among various populations (prisoners, adolescent inpatients, mentally retarded people, personality disordered patients, and psychotic patients), little conclusive research has been conducted among normative adolescent populations. It is stated throughout literature that self-cutting is a growing mental health issue among adolescents, but it remains highly under-researched (Zila & Kiselica, 2001). The lack of knowledge of cutting behavior within the field of mental health is a cause for alarm. As many schools are beginning to recognize the increased number of self-cutting students, it is important for clinicians to assess teachers' and staff members' understanding of the behavior, help teachers and staff become more educated about self-cutting behavior, and create and implement strategies for identifying and serving adolescent self-cutters.

Social workers have the opportunity to educate and consult with those who interact with adolescents on a daily basis. Teachers and friends of self-cutters may often be the first to notice symptoms of self-injurious behavior and the first to approach a self-cutting adolescent. It is important for schools to "foster environments in which students feel comfortable" (Galley, 2003, p. 15) to discuss these important issues. If teachers, who are at the front line, are made more aware of this growing problem, a move towards preventing this "epidemic" will be made.

Literature Review

Self-cutting is one of many forms of self-mutilation (or self-injurious behavior). These are the two most common terms—among many—used throughout the literature. In order to understand self-cutting behaviors, it is important to evaluate this particular behavior in the context of the broader category of self-mutilation. Armando Favazza (1996), an expert in this field, has classified self-mutilation into three categories: major, stereotypic, and superficial/moderate. Major forms of self-mutilation are rare and most often associated with psychosis. Major self-mutilation includes severe destruction or removal of parts of the body (self-amputation, castration, etc.). Stereotypic self-mutilation commonly occurs among individuals

who are institutionalized, such as people with mental retardation or schizophrenia. Stereotypic self-mutilating behavior is repetitive and can include head banging, eyeball pressing, and self-biting.

The third category of self-mutilating behaviors is termed superficial/moderate and is the form associated with the adolescent "epidemic" of self-cutting occurring today. Superficial/moderate forms of behaviors include impulsive (cutting, burning, carving, and preventing wounds from healing) and compulsive (trichotillomania, nail biting, and skin picking) self injury. Cutting and burning are the most common forms of superficial, impulsive self-injurious behavior. Favazza (1996) further classifies the superficial, impulsive behaviors of cutting and burning into episodic and repetitive. Episodic self-injury occurs on occasion and is often associated with specific disorders such as borderline personality disorder, antisocial personality disorder, posttraumatic stress disorder, dissociative disorders, eating disorders, substance abuse, and depression ("Wounds," 2004). Self-cutting or self-burning behavior is classified as repetitive when the behavior becomes an uncontrollable preoccupation, and it is this form of self-injury—Repetitive Self-Mutilation—that is of most concern to educators and administrators in the school setting (Lieberman, 2004).

Due to the varied terminology used in the literature (self-mutilation, carving, self-cutting, deliberate self-harm, self-destructive behavior, and self-injurious behavior), there are varied definitions for these self-inflicted injurious behaviors. Wendy Lader and Karen Conterio (1998), directors of Self Abuse Finally Ends (S.A.F.E. Alternatives), define self-injury as "the deliberate mutilation of the body or a body part, not with the intent to commit suicide but as a way of managing emotions that seem too painful for words to express" (1998, p. 16). For adolescent self-cutters, the cutting experiences vary. What appears to be common, however, is for the self-cutter to use a razor blade (or any other sharp object) and cut the wrists, forearms, thighs, and/or abdomen in a controlled motion (Lader & Conterio, 1998; Zila & Kiselica, 2001).

Though clinicians and researchers agree that self-injurious behavior is escalating among adolescent populations, it is difficult to determine the exact prevalence due to the limited research and various forms of terminology used to define the behavior. Some researchers estimate that nearly three million Americans self-injure (Conterio & Lader, 1998). Other studies have determined the prevalence of self-mutilation among inpatient adolescent populations to be between 40% and 60% (Suyemoto, 1998). Among normative adolescent populations, however, there has been little research conducted from which a specific rate of prevalence can be deduced. Some cite that 4% of adolescents self-harm (Galley, 2003). A recent study evaluated two high schools and results indicated that 13% of students in an urban school and nearly 15% of students in a suburban school had self-mutilated on at least one occasion (Ross & Heath, 2002). From these varied results, it is evident that more conclusive research must be conducted to determine accurate rates of self-injury and self-cutting.

Another factor explaining the difficulty in researching this subject is the potential risk in surveying students about this subject. Asking adolescent students about this behavior can be psychologically harmful because it may have a "potentially suggestive effect" (Lieberman, 2004, p. 4). Some experts in this field refer to this as a "contagion factor," which is a potential explanation for the growing rate of self-cutting behavior. The contagion factor is increasingly problematic because of the ease with which information is spread via the internet. One author believes that this phenomenon is particularly troublesome for school settings is because "self-injury has a tendency to spread from one troubled adolescent to another. It's a contagious behavior" (Galley, 2003, p. 14). It has been noted in some studies that self-harm cases have led to epidemics of self-harm in group settings such as hospitals, prisons, gangs, residential treatment, or dormitories (Farber, 1997). Similarly, it seems that in the school setting there is an "epidemic" of self-cutting taking place among high school and junior high students.

A further complication is the effect of media on adolescents. This topic was introduced to the media in 1985 with the discussion of self-mutilation on a national television station (Zila & Kiselica, 2001). Since then, two movies produced in 2003, "Secretary" and "Thirteen," have characters that engage in self-injurious behavior. Hollywood has also reported on popular actors, such as Angelina Jolie and Johnny Depp, who have had personal experiences with self-cutting ("Wounds," 2004). Music groups such as the Indigo Girls also present self-injurious content through their music lyrics and through art on their album cover (Conterio & Lader, 1998). Most recently, on MTV's *The Real World*, one of the main characters discussed her experiences as a "cutter" (2004).

The media can both positively and negatively affect the adolescent self-cutting "epidemic" by

explaining the reality and dangers of cutting. For example, on one episode of *The Real World* (Murray, 2004), a psychologist appeared after commercial breaks to explain what cutting was, how to get help, and resources for further information. He also gave information to find internet sites to help self-cutting teenagers. Some sites do, in fact, support self-cutters in coping and finding help, but others may "purposely glorify and support this behavior" ("Wounds," 2004, p. 3). While there is great potential for the media to help, there is also great danger for the media to perpetuate the problem through "normalizing" the behavior and potentially furthering its contagion. As one group of authors say, "For parents, health care professionals and educators, it is important to be aware not only of this self-injury behavior, but also the influences—both good and bad—of the Internet and mass media" ("Wounds," 2004, p.5).

A factor that may increase teachers' difficulty in identifying self-cutting students is the isolating nature of the behavior (Suyemoto, 1998). Adolescent "cutters" perform these behaviors in secret—in their bedrooms, bathrooms, empty locker rooms, or other isolated areas (Lieberman, 2004). Additionally, "cutters" often do not seek out mental health services for their cutting behavior, as they find this behavior a necessary means to cope with the challenges of life. Conterio and Lader (1998) believe that it is this group—one that has never been served by medical or mental health professionals—that remains "largely hidden within society…[and] makes up the bulk of the silent 'epidemic' of self-injury" (p. 19).

One way to help prevent this "epidemic" from growing any larger is to help those working in educational systems, who are in regular contact with adolescents, be equipped to identify and help self-cutting adolescents. The first step in equipping staff is to educate them on how to identify features of self-cutters. According to the literature, 70% of cutters are female (Lieberman, 2004), typically single, of middle to upper-middle socioeconomic status, and intelligent (Zila & Kiselica, 2001). School psychologist and author Tracy Alderman reported that a typical self-injurer is "bright, sensitive, helpful to other people, the caretaker of their friends and family, good listeners, above average students, and invisible" (as quoted in Galley, 2003, p. 14). Self-cutters most often report that they began cutting during early adolescence, at about age 12-13 ("Wounds," 2004). Conterio and Lader (1998) have also found that, among females, the onset of self-injurious behavior is often associated with the beginning of puberty because bodily changes can bring up difficult emotional and psychological issues. Clinicians have found that the "onset of menstruation…often corresponds with the beginning of self injury" (Conterio & Lader, 1998, p. 17). Because the onset of puberty is occurring at an earlier age in this society, there is increased risk for early adolescents. It is for this reason that education staff members at both the high school and junior high school levels must be aware of this behavior.

Another common characteristic of adolescent self-cutters is the inability to self-soothe or verbalize painful emotional content, which may stem from adverse childhood experiences. A study conducted by Zila & Kiselica (2001) found that 70% of self-cutting adolescents had grown up in a home where there was abuse (physical, verbal, or sexual) or neglect. Other factors positively correlated with self-cutting are divorce of parents, incarceration of a parent, and family instances of alcoholism or chronic mental illness (Favazza, 1996). Clinicians who work with thee self-injuring populations suggest that difficult circumstances in childhood render the adolescent self-cutter unable to fully handle the developmental tasks of adolescence. When the self-cutter has "acquired no truly adaptive, internal abilities to soothe herself or control distress, the self-injurer comes to rely on action—not thoughts, fantasies, or words—to gain relief from any uncomfortable feelings or thoughts" (Conterio & Lader, 1998, p. 20).

The self-cutting behavior can serve many functions. The response most adolescent self-cutters report is that cutting brings a sense of relief from an overwhelming emotional problem or sense of loss. One adolescent reported, "I cut myself as a way to deal with the pain and frustration in my life" ("Wounds," 2004, p. 1). Some describe cutting as a form of punishment, a means of controlling his/her life, or a way of getting a reaction out of others (National Mental Health Association, 2004).

Though some adolescent cutters have a history of suicidal ideation or attempts (Suyemoto, 1998), there is a distinction between self-cutting and suicidal behavior. As Richard Lieberman, a school psychologist, explains, "A common misperception…is that students who self-mutilate are cutting themselves in an active attempt to commit suicide. Actually, the opposite appears to be true" (2004, p. 2). One adolescent cutter explains, "the objective wasn't to make myself bleed to death, just to let go of the ugly feelings holding me hostage—feelings that would leave at the sight of blood" (Pederson, as cited in Zila & Kiselica, 2001, p. 47). These statements, and the fact

that "cutters" typically wound themselves in non life-threatening areas (thighs, forearms, etc), have helped clinicians to determine that self-cutting is not done as an attempt to end one's life but as a coping mechanism to continue living. It should be noted, however, that some self-cutting is potentially lethal, and efforts to educate educators about this behavior should address how to distinguish superficial from potentially lethal cutting.

This behavior may not be immediately life threatening, but self-cutting can be especially dangerous because it can be associated with other social/emotional risks. Researchers have found that self-cutting and self-mutilation can be associated with eating disorders (Conterio & Lader, 1998; Cross, 1993; Zila & Kiselica, 2001), substance abuse (Favazza, 1996; Zila & Kiselica, 2001), kleptomania (Favazza, 1996), and depression (Galley, 2003; Lieberman, 2004). These associated risk factors provide additional reasons for teachers and education staff to become knowledgeable in order to identify and refer these students to mental health professionals.

Recently published articles have discussed what school administrators, teachers, and other educational staff members should do in response to the growing number of self-cutters. One article states, "Parents, school counselors, and teachers should be aware of these warning signs and should be prepared to handle the situation appropriately" ("Wounds," 2004, p. 4). In addition to symptoms suggestive of depression (tearfulness, low self-esteem, etc), other indicators of self-cutting behavior include: difficulty controlling impulses, anxiety, failure to recognize positive factors in his/her life, continually wearing long sleeves, wrist bands, or long pants even when the weather is hot or humid, and refusing to be involved in physical activities that would involve revealing skin (such as swimming, physical education classes, etc.) ("Wounds," 2004).

Lieberman (2004) asserts that schools should train all staff members to be able to identify self-cutting students, include self-cutting training for a crisis team, train staff to properly respond to a self-cutting incident, cautiously educate students, make parents aware of the growing problem, and work together with the self-cutter's parents and mental health worker. Because "teachers are often the first line of contact for many of these students" (Galley, 2003, p. 15), mental health practitioners must partner with teachers and other educational staff to help teachers know how to properly respond to an adolescent self-cutter. As this "epidemic" continues to grow, it is imperative that mental health workers team with the educational system to help identify, respond to, and serve adolescents participating in these secret, maladaptive, self-cutting behaviors.

Research Question

Today's classrooms are populated with many adolescents who, to the untrained eye, may appear to be emotionally healthy. Some of these seemingly well-adjusted students, however, engage in maladaptive self-cutting behaviors. In light of this, high school teachers must become more aware of this growing problem. This study seeks to address (a) the level of awareness and knowledge that teachers have about self-cutting behaviors of adolescent students and (b) how confident and prepared teachers feel they are to intervene with a self-cutting student.

Methodology

The research design utilizes quantitative data analysis and survey methodology. Self-administered questionnaires were distributed to teachers in three Chicago suburban high schools. The questionnaires asked teachers a series of closed and open-ended questions. The closed-ended questions were coded through quantitative analysis and statistically significant results were reported.

Two of the three high schools allowed for all teachers to be surveyed, while the third high school requested that a sample of teachers from each department be surveyed. At the third school, 60 randomly selected teachers were surveyed.

In two high schools, questionnaires were distributed to all teachers' mailboxes. In the third school, questionnaires were distributed to 60 randomly selected teachers' mailboxes. Included with the questionnaire were instructions to return it in a sealed envelope to a specified location when completed. The researchers gathered the completed questionnaires from the secured location.

To ensure confidentiality and the protection of the participants, the questionnaires were sealed and sent to a secure location. Anonymity was unable to be assured, however, because the questionnaire asked for potentially identifying information, such as the grade the teacher instructs, the gender of the respondent, and the number of years in the profession.

It is possible that the questionnaire evoked disturbing images and thoughts due to the graphic nature of self-cutting behavior. To ensure sensitivity, a cover letter explained that the study was voluntary and also described the purpose of the study. A resource sheet was attached to the questionnaire

which contained hotline phone numbers and informative websites on self-cutting to address any questions that respondents had. The school protocol was also written on the resource sheet, so the teacher would know how to properly respond to a self-cutting student. It was the intention that the supplemental information provided would assist participants who experienced any negative emotion from participating in the study.

Measures

The measure used for this study was a self-administered questionnaire[1], as previously mentioned. The questions on the questionnaire were developed based on the information gathered during the literature review. This questionnaire included closed ended questions and Likert scales. In attempt to encourage participation, the questionnaire took less than ten minutes to complete.

In an attempt to establish reliability and validity, the questionnaire was modified after a pre-test was given. To help ensure face and construct validity, the authors administered a pre-test to an outside sample to ensure clarity of questions. Based on the responses to the pre-test, the questionnaire was modified.

The survey collected descriptive information on participants, such as gender of the teacher, years of experience and grade(s) taught. Additionally, participants' knowledge and confidence levels were measured by: whether the participant has known any self-cutters, how confident the participant would feel in handling a situation with a self-cutter, from where the participant has received information on cutting, and whether/how the participant would prefer to be trained.

Other variables assessed teachers' knowledge of self-cutting, which included their beliefs about significance of the problem, the age of onset of the behavior, the academic achievement level of students who self-cut, and how strongly they agreed that: self-cutting is a suicide attempt, self-cutting is a coping mechanism, self-cutting is due to the influence of drugs, self-cutting is done to gain attention.

Data Analysis

Analysis of the data was performed using the SPSS program, version 12.0. To test variations in categorical data, chi-square analyses were performed. Additionally, independent sample t-tests were run.

Of the 300 questionnaires distributed, 150 were completed and returned. All participants reported teaching at the high school level (grades 9-12). The majority of the participants (60.7%) were female, while 38.7% were male. The mean number of years taught was 11, with a range of 0.5 to 35 years.

The data collected revealed some consistencies between teachers' knowledge of self-cutting behavior among adolescents and actual characteristics of self-cutters. The gender and age of onset were both accurately identified by teachers. Seventy-six percent of teachers responded that self-cutters are more likely to be female and that the mean age of onset is 12.5 years, with a range of age 8 to 17. Additionally, Table 1 shows that 87.4% of teachers believed that students self-cut as a form of coping. Also, more than half of the respondents said that students do not self-cut in an attempt to commit suicide. Nearly half of participants stated that students do not self-cut due to the influence of drugs.

The data also revealed discrepancies between teachers' knowledge about self-cutting behavior and characteristics of self-cutters. Fifty-seven percent believed self-cutting to be a minor problem. Furthermore, 63% of participants said that self-cutting adolescents did so in order to seek attention and only 21% were able to identify self-cutters as being high academic achievers.

Even though teachers were able to accurately identify some characteristics of the self-cutting population, 64% of respondents stated that they did not feel knowledgeable about self-cutting behavior. Moreover, 57% said that they did not feel confident responding to a self-cutting student.

The majority of participants (68.7%) had previous experience with a student who self-cut. On average, participants knew two students who self-cut, with a range of 1 to 17 students. Data analysis using crosstabulation found that participants who had past experience with a student who self-cut felt more confident responding to a self-cutter. This was statistically significant at .006. Similarly, data analysis using Chi square indicated that participants who had past experience with a student who self-cut felt more knowledgeable about self-cutting behavior. This was also statistically significant at .004. Additionally, an independent sample t-test indicated that the participants who felt confident in their ability to respond to students who self-cut knew an average of 3 such students. This was statistically significant at .000.

Discussion

Participants' responses provided valuable information regarding high school teachers' awareness of self-cutting behavior. In particular, the majority of

[1] For a copy of the instrument used in the study, please contact the authors via the School of Social Work.

Table 1

Reasons for cutting: %	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Suicide attempt	.7	16.7	23.3	52.0	7.3
Coping skills	28.7	58.7	6.0	2.7	4.0
Drug influence	4.0	14.7	32.0	40.0	9.3
Seeking attention	22.7	40.0	14.0	20.7	2.0
High academic achievers	4.0	17.3	50.7	22.0	6.0

teachers responded that they did not feel knowledgeable about self-cutting behavior (64%). This lack of knowledge may be part of the reason that 85% of the teachers felt that they would benefit from further training. School administrators need to be aware of this reported lack of knowledge, as well as the fact that teachers feel it would be beneficial to learn more about self-cutting behavior. Teachers indicated an interest in learning from teacher in-services and written materials. Several teachers also indicated that they received information about self-injury from school social workers. This research may indicate to administrators that school social workers have specific knowledge about social/emotional issues, such as self-harm, that cannot be sufficiently managed by teachers.

Another concern was the finding that 56.7% of teachers felt that self-cutting is only a minor problem among the adolescent population. One recent study found that 13-15% of adolescents in two high schools had self-cut on at least one occasion (Ross & Health, 2002). This means that in a school of 2000 students, 260 to 300 students would have self-injured at least once. This hardly seems to be a minor problem. Additionally, research also indicates that a self-cutter tends to be a high-achiever academically, and only 21% of participants strongly agreed or agreed that self-cutters are high academic achievers.

The majority of the teachers responded accurately to some questions that were intended to measure their knowledge on self-cutting. When asked if they felt self-cutting was a suicide attempt, the majority (59.3%) of teachers responded that they did not. Also, the majority of teachers (87.4%) felt that self-cutting was used as a coping mechanism. Their responses to these questions, as well as identifying females as more likely to cut and the average age of onset being 12.5 years, are consistent with current research on the issue of self-cutting.

In regard to the confidence level that teachers had about their ability to intervene, only 43.3% felt confident responding to a student who self-cuts. Our study also found that both confidence and knowledge increased as teachers had contact with self-cutting students. In contrast, teaching experience was alone was not associated with levels of confidence or knowledge. This finding seems to indicate that it takes personal experiences with adolescent self-cutters for teachers to gain knowledge about the issue and to increase their confidence level to intervene. This is rather disturbing because it is only after students are self-cutting that teachers become knowledgeable and more confident. Our schools should be responsible for training teachers before they come into contact with students who self-cut so they can best assist them.

This study has a number of implications. The results clearly indicated that teachers wanted more training about self-cutting behavior. Therefore, designing materials aimed at increasing the levels of knowledge and confidence in regard to responding to self-cutting behavior is important. The majority of the teachers in the study reported not feeling confident in responding to a student who self-cuts. Reviewing the protocol with teachers may be one step toward increasing teachers' level of confidence in intervening with a self-cutting student.

Limitations

One significant limitation of this study is its inability to generalize to other teacher populations. The sample consisted of 150 participants, and all teachers were from three Chicago suburban high schools. The

majority of the participants were Caucasian and middle-to-upper-class. Therefore, it is difficult to generalize that all teachers would have similar attitudes and beliefs about self-cutting behavior.

Another limitation to the study was that the researchers composed the questionnaire, which could be a threat to reliability and validity. The questionnaire has not been used outside of this study and therefore reliability was not established. The responses received from the questionnaire format provided a limited amount of information; subsequently, the information that could have been discovered through interviews may be noteworthy. In an interview setting, the teacher could have the opportunity to verbalize personal experiences with self-cutting students and to provide more detailed information and should be considered for future research. A further limitation of this study is that some teachers may have hesitated to provide truthful responses to the questionnaire and may have felt uncomfortable expressing their true level of awareness and knowledge of self-cutting behavior.

Suggestions for Further Research

Future research should continue to focus on the phenomenon of self-cutting behavior among the adolescent population. This growing phenomenon deserves the attention of mental health professionals and teachers so that individuals who work on a daily basis with the adolescent population can better understand this behavior and be prepared to intervene.

Additional research with respect to teachers' knowledge and awareness about self-cutting behavior and their ability to intervene is still needed. While this study is important because it is the first of its kind, research needs to be carried out with a larger and more generalized sample. Qualitative studies may be particularly useful in gaining a deeper understanding of teachers' experiences with and perceptions of self-cutting students. Research could also be conducted with teachers at the middle school level. Because current research suggests that the average age of onset of self-cutting behavior is age 12, research aimed at identifying whether middle school teachers have more exposure to self-injury may be useful. Assessing their knowledge and confidence level in intervening could provide valuable information for school social workers and administrators.

This study provides important information for school social workers and professionals within the school system. The authors hope it will serve as a catalyst in school settings to encourage increased awareness of, prevention of, and intervention for this problem. Specifically, the authors hope the results of this study will persuade school administrators to take self-cutting behaviors among adolescents seriously and educate their teachers on how to help students who struggle with this mental health problem. Raising awareness through this research may facilitate discussion among teachers and mental health professionals within schools, and may fill gaps in knowledge about this growing problem. Knowledge on this topic is important because teachers and friends are often the first people to whom a student divulges this hidden secret (Galley, 2003).

Self-cutting is a growing phenomenon on most high school campuses and while there are many students engaging in this behavior, there is little information, data, and research on this issue. Since there are a limited number of mental health practitioners and/or school social workers in the school setting, these professionals depend upon teacher awareness and ability to make referrals. It is imperative that teachers have the knowledge to identify a student who is self-cutting and to feel confident in responding to the self-cutting student in order for adolescent students to be adequately served. If teachers continue to be unaware of the signs of self-cutting, students may remain at risk for continual use of this behavior as a coping skill. The results of this study indicating that teachers do not feel they have knowledge or confidence further highlight the importance of school social workers. School social workers have the knowledge and confidence to support and assist students who use self-cutting as a coping mechanism, and can also provide teachers with the necessary tools and information so that self-cutting adolescents can be identified and properly served.

References

Conterio, K. & Lader, W. (1998). *Bodily harm: The breakthrough healing program for self-injurers.* New York: Hyperion.

Cross, L. W. (1993). Body and self in feminine development: Implications for eating disorders and delicate self-mutilation [Electronic Version]. *Bulletin of the Menninger Clinic, 57*(1), 41–68.

National Mental Health Association. (2004). *Cutting.* Retrieved April 6, 2004, from http://www.mpoweryouth.org/411Cutting.htm

Farber, S. K. (1997). Self-medication, traumatic reenactment, and somatic expression in bulimic and self-mutilating behavior. *Clinical Social Work Journal, 25*(1), 87–104.

Favazza, A.R. (1996). *Bodies under siege: Self-mutilation and body modification in culture and psychiatry* (2nd ed.). Baltimore: The Johns Hopkins University Press.

Galley, M. (2003). Student self-harm: silent school crisis. *Education Week, 23*(14), 1, 14–15.

Lieberman, R. (2004). Understanding and responding to students who self-mutilate [Electronic version]. *Principal Leadership, 4*(7), 10–13.

Murray, J. (Producer). (2004, April 6). *The real world.* MTV Productions

Ross, S., & Heath, N. (2002). A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence, 31*(1), 67–77.

Suyemoto, K. L. (1998). The functions of self-mutilation. *Clinical Psychology Review, 18*(5), 531–554.

Suyemoto, K. & Kountz (2000). Self-mutilation. *The Prevention Researcher, 7*(4) 1–4.

Wounds, scars and the visibility of self-injury: Is this troubling behavior a growing problem in adolescents [Electronic version]? (2004, March). *The Brown University Child and Adolescent Behavior Letter, 20*(3), 1, 3–5.

Zila, L. M., Kiselica, M. S. (2001). Understanding and counseling self-mutilation in female adolescents and young adults. *Journal of Counseling and Development, 79*(1), 46–52.

Lauren Carlson received her MSW from the School of Social Work in May 2005. She has worked at Swedish Covenant Hospital in Chicago, IL on an inpatient psychiatric unit for three years. Her first-year internship was also at Swedish Covenant Hospital on an Extended Care unit and on the Telemetry unit. Her second-year internship was at a suburban Chicago high school, where she worked with regular and special education students. She will begin working as a full-time school social worker at Thompson Middle School in St. Charles, Illinois, this fall.

Stacy M. DeGeer graduated in May 2005 with an MSW from the School of Social Work. Her first-year internship was at Breaking Free, an agency where she worked with adolescents and conducted outpatient drug counseling. Her second internship was at a suburban Chicago high school, where she worked with regular and special education students from grades pre-K to 12. She will begin working as a full-time school social worker at Reed Elementary School in Lockport, Illinois, this fall.

Chassity Deur received her MSW from the School of Social Work in May 2005. She completed her first-year internship at Victor Neumann Association and her second-year placement at Jewish Family and Community Service. She is currently working at Victor Neumann Association.

Kristen Sweas Fenton also received her MSW from the School of Social Work in May 2005. Her first year internship was at the Council for Jewish Elderly in Chicago where she provided various case management and counseling services to her clients. Her second-year internship was at a suburban high school, where she worked with regular and special education students individually and in group settings. This fall, Kristen and her husband will be volunteering in an AIDS clinic in East London, South Africa.