



SELF HARM IN PEOPLE WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES: AN OVERVIEW

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Introduction – An Overview

- Introduction – including terminology
- Epidemiology – prevalence, risk factors
- Models of self-injurious behaviour
- Management of self-injurious behaviour
- Patient and staff experiences of self-harm

Introduction

- Self-injurious behaviour (SIB) often refers to actions directed toward the self that lead to physical harm, typically in the form of tissue damage.
- Potential forms of SIB can be observed in typically developing children – but typically do not result in physical harm and children tend to “outgrow” them as they develop language and emotional regulation skills.
- Self-injurious behaviours, sometimes referred to as self-harm, can be present in the general population of youth and adults.
- Psychiatric conditions such as borderline personality disorder are associated with deliberate self-harming behaviour in the absence of suicidal intent - these conditions may be related to impulsivity, emotional dysregulation, and inadequate coping skills, and can be seen in part as a way for an individual to bring about relief from or gain control over intense negative emotions.

Introduction

- Hidden Pain report noted that we all engage in self-harm to some degree or other – we eat too much, take insufficient exercise, experience high levels of stress, smoke tobacco or drink alcohol excessively knowing that such behaviours can cause considerable harm to our bodies. Indeed, these behaviours are often socially sanctioned in western cultures.
- Turp (2003) coined the term cashas (culturally acceptable self-harming activities) which include a range of behaviours with general social acceptability including body-contact sports, sleep deprivation, tattooing, body-piercing and over-work in addition to those mentioned above.
- Within the self-harm spectrum, however, there are a range of behaviours that are not socially sanctioned in western culture (although they sometimes are in other cultures) and that inflict direct injury to the body. These are actions that can be described as:
 - ‘a wide range of things that people do to themselves in a deliberate and usually hidden way, which are damaging’ (Camelot Foundation/Mental Health Foundation, 2004)**
- These include: cutting, scratching, burning, scalding, hitting one’s body with another body part, hitting one’s body with or against an object, self-biting, self-pinching, hair-pulling, self-poisoning, ingesting objects, inserting objects into body orifices, and eye poking.

Case A - Community

- 54 year old male, diagnoses of Moderate Learning Disability and Non-Organic Psychosis (NOS); resides in supported accommodation.
- Past Medical History of Epilepsy, but no recent seizures and not under ongoing follow-up.
- Presents with episodic periods of agitation, associated with aggression towards others and self-injurious behaviour.
- Most frequently hits self in abdomen and legs; but can also engage in some head-banging.
- Pharmacological treatment has included use of mood stabiliser and antipsychotic on a regular basis; with PRN Diazepam and Promethazine to manage periods of agitation, to little success.
- Has clearly defined PBS plan.
- Physical investigations undertaken, particularly with regards to abdominal pathology, but nil of note found.

Case B – Inpatient Secure

- 32 year old male; diagnoses of Mild Learning Disability, Schizo-Affective Disorder and Personality Disorder (Antisocial and Emotionally Unstable); residing in MSU.
- Admitted following conviction for arson.
- Long-standing history of self-harm – including head-banging, tying ligatures, swallowing harmful items, inserting items.
- Self-harm has occurred as a way of regulating emotions when distressed; but also associated with assaultative behaviour toward staff, e.g. when secluded.
- Pharmacological approaches have included treatment with regular antipsychotics (oral and depot), mood stabiliser, antidepressant; as well as PRN antipsychotic and benzodiazepines (oral and IM), as well as PRN hypnotic.
- Psychological interventions have included group-based interventions around emotional regulation, social skills and moral reasoning, along with offense-specific work; and individual work including CBT, EMDR and schema therapy.
- Notable progress previously; but relapse prior to discharge, culminating in lengthy period of seclusion.



EPIDEMIIOLOGY

Prevalence

- SIB has a high prevalence rate among individuals with severe intellectual disabilities (ID)
- Population-based study report 22.5% of individuals had challenging behaviours; with 5% engaging in SIB.
- An earlier total population study yielded a 4% prevalence rate for SIB among children and adults with ID and a 33% prevalence rate among those who were identified by caregivers as having more severe challenging behaviour.
- Multiple forms of SIB were common in this group, with some individuals displaying five or more topographies of SIB.
- Deb and colleagues studied the prevalence of SIB in children and adults with ID who were randomly selected from a social service registry - interested in SIB that was frequent (occurring >3x per week) and/or severe, reporting that 24% of the sample met these criteria.

Prevalence in ASD+ID

- Prevalence rates of SIB among individuals with ASD and ID are higher than for individuals with ID alone.
- Baghdadli and colleagues reported a 53.2% prevalence rate of SIB among 222 children with ASD ages of 2–7 who were enrolled in their longitudinal prospective study. Severe SIB was reported among 14.6% children in the study, mild and moderate SIB occurred among 21.5% and 17.1% of children in the study,
- Richards and colleagues surveyed caregivers of 149 children and adults with ASD ages of 4–39 - results indicated that 50% of individuals with ASD had engaged in SIB in the previous month. The three most common topographies of SIB were self-hitting, self-biting, and self-scratching.
- Rattaz and colleagues studied SIB in 152 adolescents with ASD who were part of a large cohort undergoing longitudinal follow-up. Overall, 35.8% of adolescents in the study exhibited SIB; 16.6% were in the less severe group and 19.2% in the more severe group.
- Duerden and colleagues surveyed parents of children and adolescents who were participating in a larger study on the genetics of ASD – results indicated that 52.3% of children and adolescents with ASD had engaged in SIB at some point in their lives. More severe forms of SIB such as self-hitting and self-biting occurred in 34% and 26% of children in the study, respectively, and there was a trend for older children (aged 12–19) to engage more in severe forms of the behaviour.

ASD, Fragile X and Down Syndrome

- Richards et al compared a cohort with ASD with Fragile X and Down Syndrome
- Self-injurious behaviour was displayed by 50% of the ASD sample: a significantly higher prevalence than in the Down syndrome group (18.4%) but broadly similar to the prevalence in Fragile X syndrome (54.5%).
- Self-injury was associated with significantly higher levels of autistic behaviour within the Down and Fragile X syndrome groups.
- Within the ASD group, the presence of self-injury was associated with significantly higher levels of impulsivity and hyperactivity, negative affect and significantly lower levels of ability and speech.

Persistence of SIB

- . Dimian and colleagues studied the evolution of SIB precursor behaviours in a group of infants and toddlers (N = 235) at high risk for a diagnosis of ASD. The point prevalence of SIB was 39% at 12 months of age and 32% one year later. SIB persisted in 48% of children at the one-year follow-up. The relative risk of engaging in SIB at 24 months of age was 1.85 times higher for children who went on to meet clinical criteria for a diagnosis of ASD (20% of the total sample) versus those who did not.
- Rice et al . Self-injury displayed by individuals with PWS and individuals with ASD was compared with that reported in a group of individuals with intellectual disability due to mixed aetiology (ID group). Three self-injurious behaviours (head banging, skin-picking and hitting and/or biting self) were measured on five occasions over 18 years. Rates of skin picking were higher in individuals with PWS and hitting and/or biting self was higher in individuals with ASD compared to the ID group. Rates of head banging were similar across the three groups.
- Over time skin-picking and head banging increased with age for individuals with ASD and hitting and/or biting self increased for the PWS group. In the PWS and mixed ID groups head banging decreased with age.

SIB and Individual Characteristics

- Cooper et al reported prevalence of 4.9%; and a remission rate of 38.2% (higher than previous studies)
- Investigated risk markers for persistence of self-injury - demonstrated that lower ability, ADHD, visual impairments, compromised communication and ASD were associated with SIB - but that only lower ability, ADHD and visual impairments were independently associated with self-injury over time.
- When considering challenging behaviour more broadly, Felce and colleagues report a positive association between challenging behaviour and reaching a threshold on psychiatric screen - but McCarthy et al demonstrated no association with psychopathology when gender, age and ID are controlled for.
- They report that only a diagnosis of autism predicted challenging behaviour, not psychiatric conditions.

Risk Factors for SIB

- Risk factors include individual characteristics and aspects of the physical and social environment.
- A meta-analysis of 22 prevalence and case-control revealed that the likelihood of displaying SIB was significantly increased among individuals with ASD and those with more severe intellectual and communication.
- Murphy and colleagues studied 157 children with ASD ages of 3–14 who were receiving ABA intervention to determine the prevalence of challenging behaviour - one-third of children displayed SIB along with aggression and stereotyped behavior. The more common forms of SIB included self-biting and head hitting. More severe SIB was associated with greater impairments in cognitive functioning.
- McTiernan and colleagues used multiple regression to identify predictors for the frequency and severity of SIB in 174 children with ASD ages of 3–14 who were enrolled in ABA programs or received varied interventions. Overall, 48.9% of children in the study displayed SIB; having a lower IQ was associated with a higher severity and frequency of SIB.
- Duerden and colleagues used hierarchical regression analysis to identify predictors of SIB in 250 children and adolescents with ASD with differing levels of cognitive abilities. Significant factors in predicting SIB also proved to be core features of ASD – i.e., sensory processing abnormalities, insistence on sameness, and social communication impairments. A lower non-verbal cognitive ability was also predictive of SIB.
- Dimian and colleagues used logistic regression to identify child characteristics that predicted SIB at 24 months of age for infants who were at high risk for a diagnosis of ASD. The results indicated that the presence of SIB at 12 months and lower developmental skills were predictive of SIB one year later.

Risk Factors for SIB continued

- Richards and colleagues studied the persistence of SIB after three years in a group of children with ASD. When the sample was separated into groups based on the presence or absence of SIB at follow-up, children from the persistent SIB group demonstrated lower levels of verbal communication and self-help skills, as well as greater problems with low mood, social interactions, impulsivity, and stereotyped, compulsive, and repetitive behaviour.
- The investigators speculated that severity of ID and ASD symptomatology and problems with behavioural inhibition were important correlates of SIB. They went on to state that low mood and SIB may be related to the presence of untreated pain

Risk Factors for SIB cont.

- Soke and colleagues used data from two large monitoring and treatment networks for children with ASD ages of 2–18 to investigate the risk factors for SIB. Significant relationships were found between SIB and low skill levels, a history of developmental regression, the presence of sensory impairments and neurological conditions, and younger age, as well as the co-occurrence of challenging behaviour and sleep problems.
- Richards and colleagues added health conditions and problems with behavioural inhibition to the list of potential correlates of SIB. Their sample consisted of 424 children and adults aged 6–61 who were receiving specialized ASD services. In line with the results of previous studies, SIB was prevalent (occurring in 45.7% of children and 49.1% of adults), with severe SIB being found in a smaller subset of children (18%) and adults (19.9%). Predictors of severe SIB in children included potentially painful digestive and skin problems along with greater impairments in functioning and impulsive and overactive behaviour.

Risk Factors for SIB – genetically-determined syndromes

- Self-injury has been regarded as a core feature of Cri du Chat syndrome (Collins and Cornish, 2002); to have a higher prevalence in people with Cornelia de Lange syndrome than other people with severe learning disabilities generally (Hyman et al., (2002); and to be associated with Lesch-Nyhan Syndrome, Rett Syndrome, Smith-Magenis Syndrome and others (Oliver and Petty, 2002; Mikhail and King, 2001; Deb, 1998).
- It is possible that self-injury is not syndrome-specific but related to underlying brain abnormality or damage (Deb, 1998).



MODELS OF SIB

Models of SIB – Behavioural model

- Different models have been offered to account for the emergence and persistence of SIB in individuals with ID, many of whom have a diagnosis of ASD.
- One of the most influential models for SIB comes from the field of applied behaviour analysis.
- Carr summarized a number of hypotheses regarding the motivation or “reasons” for SIB - individuals with ID learn over time to associate the occurrence of SIB with what happens afterward (“consequences”).
- The likelihood of SIB occurring again in the future is increased as a result of the desirable outcome that is produced following its occurrence. Some of the outcomes that increase the future probability of SIB occurring may be socially mediated, i.e., the provision of social attention or access to a preferred item or activity (positive reinforcement) or the opportunity to avoid or escape from an unpleasant or painful situation or stimulus (negative reinforcement).
- SIB can also be non-socially mediated, i.e., serves a self-stimulatory function and occurs in the absence of external consequences.
- Carr also proposed that SIB may be related to but not driven exclusively by biological or organic factors that could give rise to physical conditions or altered pain thresholds.

Neurobiological Models of Pain in SIB

- Sandman proposed an opiate hypothesis of SIB in individuals with ASD, arguing that individuals may engage in the behaviour to bring about the release of endogenous opiates (such as endorphins) which result in a “high” that can become addictive. He also postulated that individuals with ASD may have altered sensory thresholds, possibly due to high circulating levels of endorphins which rendered them less sensitive to pain.
- Symons proposed a link between behavioural and biological models of chronic SIB. Factors such as where SIB occurs on the body and the intensity of SIB may have a bearing on the sensation of pain or noxious stimuli. For instance, hits to the head and face may be reduced when naltrexone is administered but not when SIB is directed toward other areas of the body. Varying intensities of SIB may be regulated by different sensory pathways and neurochemicals.
- Symons also presented evidence of abnormal gaps between epidermal nerve fibers (ENF) in individuals who engage in chronic SIB, which could alter or disrupt pain sensitivity and the resultant aversive qualities of SIB.
- Peebles and Price raised the possibility that pain thresholds may be normal in some individuals with ID and SIB, but the amplification of pain signals may be diminished so that pain doesn't act as a deterrent for SIB or a more intense pain stimulus is required to activate anti-nociceptive processes via descending inhibitory neurons.

Functions of self-injury

- Linehan (1993) suggests possible functions of self-injury in her work about the development of borderline personality disorder. She argues that when emotional vulnerability and invalidating environments interact self-injury may function to regulate painful emotions that cannot be tolerated.
- Other research has also conceptualised self-injury as an emotion-regulation strategy. Gratz (2003) reviewed literature about self-injury and concluded that clinical and empirical data suggest that self-injury may operate as a form of emotional avoidance, functioning to escape, avoid or alter unwanted emotions.
- Klonsky (2007) reviewed 18 studies that directly addressed the functions (i.e. motivating and reinforcing variables) of self-injury for individuals. He found that affect-regulation was mentioned in all 18 studies. People who self-injured commonly spoke about their self-injury stopping 'bad feelings', relieving feelings of anxiety or terror, and reducing anxiety and despair.

Functions of self-injury

- Several studies also provided strong evidence for a self-punishment function. Other functions that received moderate support included:
 - To end the experience of depersonalisation or dissociation
 - To seek help from or manipulate others
 - To generate exhilaration or excitement
 - To replace, compromise with or avoid the impulse to commit suicide
 - To assert one's autonomy or a distinction between self and other.
- Tantum and Huband (2009) suggest a number of additional functions of self-injury. These include:
 - Subconscious means of resolving conflict over sexuality
 - Redirected social aggression
 - Control of others
 - Communication and expression
 - Repair of faulty boundaries.
- The authors, however, suggest that self-injury may serve several different functions for some individuals. In others, the meaning of self-injury may be undetermined; it may be extremely important for the person concerned, but it may completely lack any easily-defined purpose or meaning.



MANAGEMENT OF SELF-HARM

Pharmacological Management of SIB - antipsychotics

- Oxford Textbook of Psychiatry of Intellectual Disability notes many guidelines suggest anti-psychotics for first line treatment of SIB, however evidence to support their use is weak.
- Cochrane review failed to find any studies of antipsychotics that met their criteria for inclusion in a meta-analysis.
- Some studies of Risperidone suggest there is value for repetitive and stereotypical SIB.
- One retrospective review suggested efficacy for aggressive behaviours, but not SIB.

Pharmacological Management of SIB - antidepressants

- With regards to antidepressants, a Cochrane review in 2013 include 5 studies.
- Of the studies, only the effectiveness and safety of Clomipramine fo SIB was a prospective, randomised, double-blind, placebo-controlled trial and had a crossover design. The age of participants ranged from 21 to 39 years, and 38% were female. All participants were diagnosed with severe to profound ID.
- Both Cochrane and NICE considered that there was weak evidence that Clomipramine was more effective than placebo for those demonstrating SIB.
- “We were unable to examine the efficacy of antidepressants other than clomipramine, antipsychotics, mood stabilisers or beta-blockers as we did not identify any relevant placebo-controlled trials.”

Pharmacological Management of SIB - naltrexone

- Cochrane review also noted 4 trials of naltrexone.
- One of the naltrexone versus placebo trials reported that naltrexone had clinically significant effects ($\geq 33\%$ reduction) on the daily rates of three of the four participants' most severe form of SIB and modest to substantial reductions in SIB for all participants; however, this study did not report on statistical significance.
- Another trial reported that naltrexone attenuated SIB in all four participants, with 25 mg and 50 mg doses producing a statistically significant decrease in SIB (P value < 0.05).
- Another trial (eight people) indicated that naltrexone administration was associated with significantly fewer days of high frequency self injury and significantly more days with low frequency self injury. Naltrexone had different effects depending on the form and location of self injury.
- Another trial with only 26 participants found that neither single-dose (100 mg) nor long-term (50 and 150 mg) naltrexone treatment had any therapeutic effect on SIB.
- Due to sparse data, an absence of power and statistical significance, and high risk of bias for four of the included trials, we are unable to reach any definite conclusions about the relative benefits of naltrexone or clomipramine compared to placebo

Behavioural Management

- Behaviour management strategies include the use of contingent and non-contingent reinforcers of behaviour. Reports of behavioural approaches to 'problem' behaviour began to appear in the research literature around 1960 and the use of behaviour modification techniques followed a few years later (Halliday and Mackrell, 1998). The treatment of choice came to involve the application of aversive stimuli or events contingent upon the behaviour – i.e. 'punishment'. Punishment was found to be effective in the short-term, but limitations with the techniques and ethical concerns led to efforts to develop non-aversive approaches.
- The increased use of functional assessments that investigate the function of the behaviour for the individual promoted interventions that focus on teaching the person to communicate needs and desires in a more socially acceptable way, so replacing 'challenging behaviour' with communication (Halliday and Mackrell, 1998). Oliver and Petty (2002) identify a number of studies that demonstrate the success of this strategy although Kahng et al., (2002), in their analysis of behavioural treatments over a 36-year period for people with severe or profound learning difficulties who self-injure conclude 'it is discouraging to find that self-injurious behaviour continues to be a disorder that is very difficult to treat'.

Behavioural Management continued

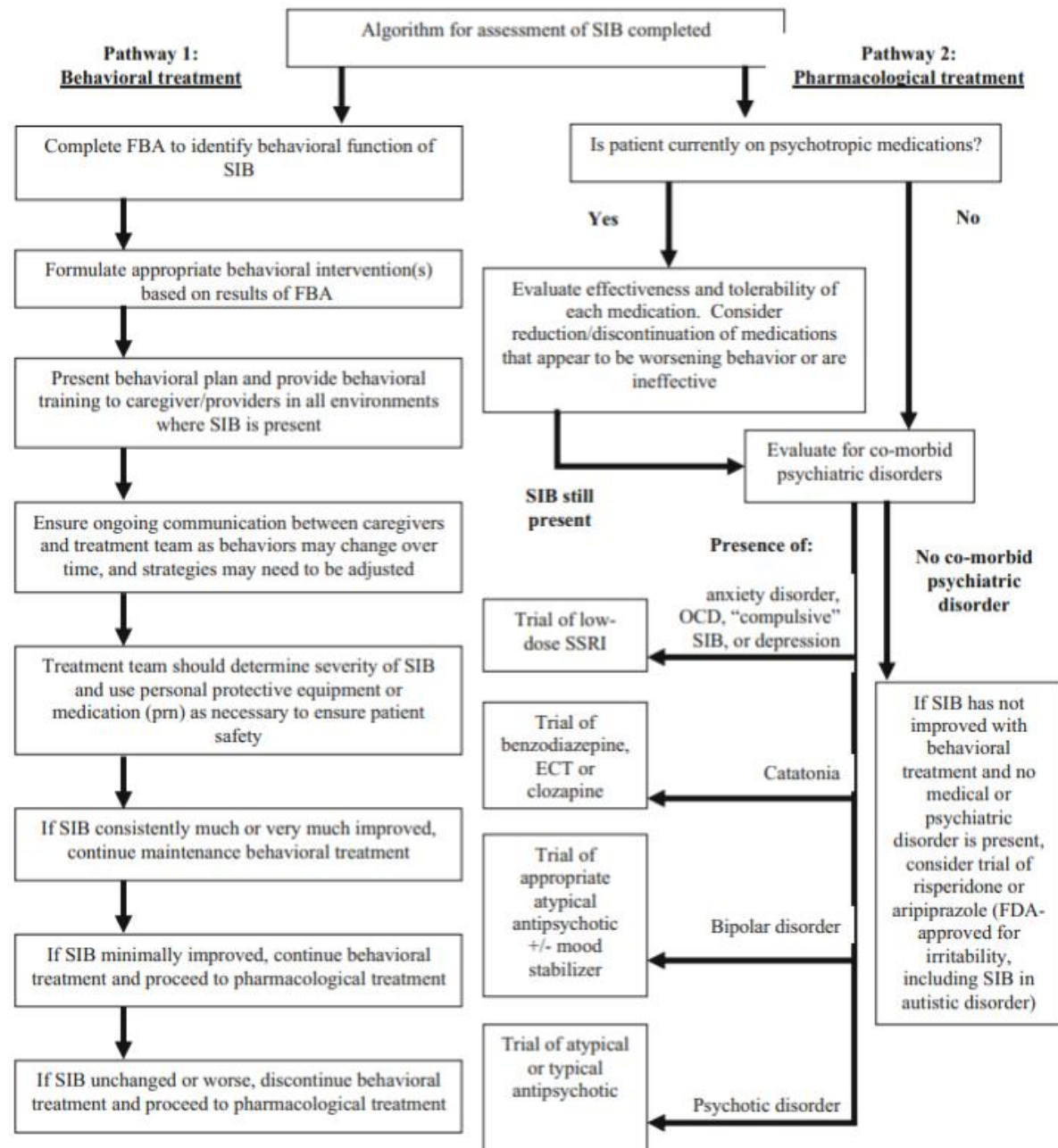
- More recently Positive Behavioural Support (PBS) techniques that are based on person-centered values and systems change have become more commonplace. PBS aims to increase quality of life and decrease problem behaviours. The first step of an individual PBS plan, and the corner-stone of the approach, is Functional Behavioural Assessment. This seeks to describe the behaviour, and the environmental factors and setting events that predict it, in order to guide the development of effective support plans. Some of the most commonly used approaches in PBS are:
 - modifying the environment, antecedents to behaviour, or routine
 - providing positive reinforcement for an appropriate behaviour
 - changing expectations and demands placed upon the person
 - changing how people around the person react.

Psychological Interventions

- A psychological understanding of self-injury frames it in terms of the individual trying to manage cognitively and emotionally their anger and distress arising from disability and trauma (Halliday and Mackrell, 1998).
- Self-injury is the person's best attempt to deal with their distress arising from an environment that is 'regarded as frightening, meaningless or traumatic' (Jones et al., 1995).
- Psychological interventions therefore need to address environmental, interpersonal and intrapersonal factors, and an individual's ability to respond to individual therapy, whatever their level of cognitive functioning, should not be under-estimated (Halliday and Mackrell, 1998).
- Nevertheless, people with learning disabilities experience a comparative lack of access to psychological therapies (Hollins and Sinason, 2000).

Multidisciplinary Approach

- Minshawi et al proposed a multidisciplinary approach in their paper “Multidisciplinary Assessment and Treatment of Self-Injurious Behaviour in Autism Spectrum Disorder and Intellectual Disability: Integration of Psychological and Biological Theory and Approach”
- Sought to integrate behavioural theory, noted previously, with neurotransmitter systems implicated in pathopsychology of SIB, namely: dopamine, glutamate, opioid, gamma-aminobutyric acid (GABA), and serotonin (5-HT) systems (Buitelaar 1993).
- (A significant amount of this research has been conducted in animal models. In most animal models of SIB, the behaviour must be induced or provoked after specific brain lesions have been made, whereas in humans, SIB often occurs chronically and frequently without any apparent induction (Bruhl et al. 1982; King 1993). Animal models continue to provide a platform for hypothesis generation but results should be equated to human SIB with caution, as precise causal mechanisms cannot yet be recreated and studied.)



g. 2 Algorithm for behavioral and pharmacological treatment of B. *SIB* self-injurious behavior, *FBA* functional behavioral assessment, *SSRI* selective serotonin reuptake inhibitor, *OCD* obsessive-

compulsive disorder, *prn* as needed, *ECT* electroconvulsive therapy, *FDA* food and drug administration

Remission

- Results in terms of remission are highly discrepant – with rates ranging from 3.7% to 96%.
- Additionally, Windahl (reported in Emerson 1992) is said to have found that 87% of people who remained in a Swedish special hospital, and 97% who had been discharged (primarily to other institutions) still had SIB 10 years later in 1985.
- Kiernan & Alborz (1996) reported that for 20 people with SIB who lived with their parents, and were aged 19–26 years, 75% still had SIB 6 years later (but didn't include those who had left the home)
- Leudar et al. (1984) reported that the presence of SIB remained relatively stable after a period of 20–24 months; however, it is unclear how many persons included in the study actually had SIB.
- Cooper et al point prevalence of SIB was 4.9%, the two-year incidence was 0.6%, and two-year remission rate was 38.2%. “SIB is not as enduring and persistent as previously thought; a significant proportion gains remission in this time period. This should provide hope for families, paid carers and professionals, and reduce therapeutic nihilism.”



EXPERIENCES OF PATIENTS AND STAFF

The experience of people with a learning disability

- The subjective experiences of self-injury from the perspective of a woman with mild learning disabilities were explored by Harker-Longton and Fish (2002). For the woman concerned 'Catherine', self-injury appeared to be an important coping strategy. She obtained relief from self-injury which she used when she was upset, spoke about the need to punish herself, and described the need for people to see that she had injured herself as a form of communicating her distress. Her feelings of failure and that she was not being trusted within the medium secure service in which she lived increased her negative thoughts, as did the use of negative labels and terminology. Catherine perceived some interventions as a form of punishment; she was clear that the improvements that she would like included respect, understanding and acceptance.
- James and Warner (2005) obtained the perspectives of a small number of women with learning disabilities who self-injured and were living in a medium secure unit. Their accounts emphasised that self-injury was meaningful to the women concerned and that it formed one strategy for coping with the complex needs they had. The women were variously coping with past traumatic experiences, current relationships and issues around privation and security, as well as internalised anxiety, hurt and guilt. The study also suggested that some aspects of interventions, such as exerting control, may actually increase the likelihood of self-injury.
- The perspectives of nine men and women with learning disabilities also living in a medium secure unit were reported by Duperouzel and Fish (2008). The participants described the need to talk about their self-injury, but said that the staff were reluctant to do so and avoided having such discussions with them. They saw self-injuring as their choice and as a right, and it was futile of the staff trying to prevent them from self-injuring. The participants felt punished, judged and misunderstood, and perceived there to be a lack of trust and understanding towards them.

Factors influencing self-injury – patient reports

- External factors:
 - Being in disempowering circumstances
 - Having a lack of control within one's own living environment
 - Having the opportunity to do so
- Interpersonal Factors
 - Being bullied
 - Arguments
- Internal Factors
 - Physical health issues
 - Having particular thoughts or memories

Managing self-injury – patient reports

- Talking to someone
- Distraction
- Internal thoughts/dialogue
- Trying to calm oneself down
- Being in company, or being alone?

Unhelpful forms of support – patient views

- Being told off
- Being ignored
- Being told to stop self-injuring
- Other support perceived to be unhelpful

Helpful forms of support – patient views

- General support
 - Someone to talk to and someone to listen
 - Having access to someone to talk to
 - When talking is difficult
 - Who to talk with
 - What participants want to talk about
- Supporting a person specifically in relation to their self-injury
 - Help with looking after one's injuries
 - Being told or encouraged to stop self-injuring
 - Knowing someone else who self-injures
 - The qualities or attitudes of supporters which are valued most
 - Therapeutic input and/or longer term strategies for addressing self-injury

Helpful qualities in those providing support – patient views

- The 'Top Six' qualities or attitudes that participants found most helpful in a support worker were, in order of frequency:
 - being easy to talk to and a good listener
 - being non-judgemental, accepting and respectful
 - being trustworthy and honest
 - being caring, generally kind and nice
 - being understanding and perceptive
 - the support worker's own sense of calmness, and their ability to help others calm down

Staff Factors

- Snow et al looked at care staff attributions toward self-injurious behaviour exhibited by adults with ID.
- Suggested staff made causal attributions about SIB that were internal, uncontrollable, unstable and specific. (Factors that within the individual, but are beyond the control of the individual)
- Staff appeared to be experiencing moderate levels of emotional exhaustion, low levels of depersonalization and high levels of personal accomplishment. There was a positive relationship between emotional exhaustion and personal accomplishment and the number of clients who engaged in SIB.
- There was no relationship between burnout and other demographic variables such as age, or length of time having worked with people who have intellectual disabilities. Only one significant relationship between burnout and causal attributions was found: emotional exhaustion was associated with making few stable attributions about self-injurious behaviour.
- The lack of other significant relationships between attributions and burnout may be related to the finding that this sample of staff were not experiencing high levels of burnout.
- There was limited evidence that workload may be associated with burnout, in that carers who worked with more clients with SIB tended to report higher levels of emotional exhaustion.



CONCLUSIONS

Summary

- Undertaken an overview of self-harm in intellectual disability
- Examined key terminology, prevalence and associated risk factors; along with models for understanding self-injurious behaviour.
- Reviewed management approaches, including pharmacological treatment, psychological input and behavioural approaches; along with an algorithm for incorporating these factors.
- Examined the lived experience of those who engage in self-harm and the staff who support them; including a list of helpful forms of support and helpful qualities in those supporting; and factors involved in burn-out.

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