

**A NEEDS ASSESSMENT OF COMMUNITY SUPPORT
WORKERS WORKING IN THE FIELD OF SELF-INJURIOUS
BEHAVIOUR AMONGST ADOLESCENTS**

by

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DECLARATION OF RESEARCHER

I declare that *A needs assessment of community support workers working in the field of self-injurious behaviour amongst adolescents* is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.



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DECLARATION OF PROOFREADER

Hereby I declare that I have language edited and proofread the thesis *A needs assessment of community support workers working in the field of self-injurious behavior amongst adolescents* by Kim Michelle Millingham for the degree MDiac.

I am a freelance language practitioner after a career as editor-in-chief at a leading publishing house.

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ABSTRACT

Self-injurious behaviour (SIB) is recognised as a difficult behaviour to work/deal with and Community Support Workers (CSW's) who work with this behaviour may not have any formal training in the field of SIB. This study was therefore aimed at assessing the needs of CSW's working in the field of self-injurious behaviour amongst adolescents. A qualitative approach was used, the study was of an explorative nature and the researcher made use of purposive non-probability sampling to select respondents who were willing to participate in one-on-one semi-structured interviews with the researcher. This data was then analysed by the researcher making use of Creswell's spiral of analysis. The data collected was sorted into themes, sub-themes and categories and interpreted according to literature.

The study identified that there are specific needs amongst CSW's who work with adolescent SIB in the specific areas of support and education/training.

KEY CONCEPTS

Self-injurious behaviour

Adolescence

Community Support Workers

Needs

Assessment

Training/education

Support

Childhood trauma

Treatment/therapy

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Self-injurious behaviour (hereafter abbreviated as SIB) usually elicits strong reactions from people, even in professionals with training (Kress, 2003:495). Self-injurers are both victims and aggressors – they seemingly go against nature by harming themselves deliberately without intending to die (Babiker & Arnold, 1997:16; Strong, 2006:29). Woldorf (2005:197) discusses the fact that SIB is utilised as a coping mechanism which converts “invisible emotional pain into visible physical pain”; it is used as a means of communicating with others and/or as a means to cope with emotional distress.

Plante (2007:01) defines self-injury as “... the intentional self-infliction of wounds by cutting, burning or otherwise damaging the skin”. Van der Kolk, Perry and Herman (1991:1665) further mention that self-injury includes a variety of methods such as cutting, scratching, burning, hitting and piercing.

Research has indicated that self-injury usually begins in adolescence, between 12 and 14 years (Cerdorian, 2005:42). A high percentage of adolescents who display self-injury are shown to have experienced childhood trauma (Van der Kolk *et al.*, 1991:1665; Babiker & Arnold, 1997:1; Milia, 2000:701; Hodges, 2005:16; Strong, 2006:xix). However SIB is increasingly being linked to individuals without a mental or organic disorder (Cerdorian, 2005:42). Walsh (2008:35) mentions this fact when he discusses the rise in this phenomenon in a new group of self-injurers – people who are socially functional, with no psychological disorder and little history of trauma.

SIB has received a large amount of media and research attention in the last decade as this behaviour becomes increasingly prevalent amongst adolescents internationally (Cerdorian, 2005:42; Wehmeyer, 2006:2; Plante, 2007:01). International research puts estimates as high as 15% of adolescents who partake in SIB (Wehmeyer, 2006:2; Brody, 2008:382; Kerr, Muehlenkamp & Turner, 2010:241). In developed nations

such as Australia, the USA and England research has shown that from 5 to 9% of adolescents have reported self-injuring (Tuisku, Pelkonen, Kiviruusu, Karlsson, Ruutu & Marttunen, 2009:1126).

Considerable time and emotional investment is required when working with individuals who self-injure. In research carried out on professionals it came to light that SIB was the most distressing behaviour for professionals to encounter in practice (Kress, 2003:495) and can be quite challenging for professionals to work with (Lieberman, 2004:1). In this regard Kerr *et al.* (2010:247) mention, “Self-injury may naturally elicit strong emotional responses from anyone, including health care professionals.” Guralnik and Simeon (2001:175) discuss three common, but not exclusive, reactions to SIB which are helplessness, rage and fear.

In Australia, specifically in the region of New South Wales, Community Support Workers also work in the field of SIB. These workers come from a variety of backgrounds (cultural and educational) and work with children, adolescents and adults in out-of-home care, providing daily care to residents who have disabilities or are in care for their own protection and/or due to challenging behaviours. Community Support Workers (hereafter abbreviated as CSW) are paid workers who are required to have knowledge and experience equivalent to a nationally recognised qualification such as a Certificate III in Welfare Studies, however they are also hired without knowledge and/or experience on the basis that they are willing to work towards this qualification in the future (NSW Industrial Relations, 2010).

The main role of CSW's is to help clients in their daily tasks, assisting in the development and implementation of development programs and integrating these clients in the community (NSW Industrial Relations, 2010). CSW's may not necessarily have had training in self-injurious behaviour but are faced with the responsibility of caring for children and adolescents who present with SIB.

Given the fact that a) SIB is potentially recognised as a difficult behaviour to work/deal with and b) CSW's may not have any formal training in the field of SIB, the researcher intended to assess their needs pertaining to taking care of adolescents who present with SIB. The researcher was motivated by both professional and

personal reasons to conduct research in this particular area. Personal reasons included personal experience of the subject, specifically with regards to its link to childhood abuse. On a professional level, the researcher was working as a CSW at the time of the research and personally experienced a lack of understanding amongst CSW's with regards to SIB.

1.2 PROBLEM STATEMENT AND FOCUS

According to Fouché and De Vos (2005a:100) the goal of problem formulation is to come up with a clearly defined question or questions which are based on the researcher's ideas together with their study of literature and existing theories. In Australia, it is not only trained professionals who work in the field of SIB (refer to 1.1), but also CSW's who have the responsibility of caring for adolescents who present with SIB. These workers may not have any formal training in this field. Given the fact that SIB is potentially recognised as a challenging and difficult behaviour to work with (refer to 1.1), the researcher wanted to assess any needs (be they educational or support oriented) that these workers may have regarding SIB and make recommendations according to the data collected.

1.3 GOAL AND OBJECTIVES

Fouché and De Vos (2005a:104) define the *goal* as the purpose or outcome of the study which the researcher wishes to achieve; whilst the *objective* is the method of attaining that purpose.

The *goal* of this research was to conduct semi-structured interviews in order to explore the needs of CSW's working in the field of SIB amongst adolescents.

Babbie (2001:109) describes the *objective* of research as the purpose of the study.

The *objectives* of this research project were:

- to conduct a literature study in order to develop a conceptual framework on self-injury amongst adolescents including the aetiology, prevalence, types, links to childhood disorders and on the responsibilities of CSW's;
- to conduct an empirical research study through the use of a semi-structured interview schedule in order to explore the needs of CSW's;
- to analyse and describe the data in order to make conclusions and recommendations to employers (who employ CSW's) and to organisations who provide training and support to CSW's according to the findings.

1.4 RESEARCH QUESTION

According to Neuman (1997:14) qualitative research is used when the researcher is personally involved in the research and when data collected is in the form of words (Neuman, 1997:329). Due to the nature of this study a qualitative approach will be followed and consequently a research question utilised. The research question is as follows:

What are the needs of Community Support Workers working in the field of SIB amongst adolescents?

1.5 RESEARCH APPROACH

1.5.1 Qualitative research approach

According to Coolican (2006:93) qualitative research is based on the following principles:

- *The approach is holistic – the focus is on the subjective information gathered by participants in their natural environment.* The researcher gathered information on the subjective views of the needs of CSW's with regards to adolescent SIB and these interviews were conducted at the CSW's place of work.

- *The researcher has a subjective influence in the research process and this influence is acknowledged by the researcher.* The researcher was a CSW at the time of the research, worked with some of the respondents and therefore had a subjective influence on the process.
- *Theory is likely to emerge from the data gathered.* The researcher identified some common themes which emerged during the course of the study and these are reported in chapter three.
- *The research is 'naturalistic' – participants are not controlled or limited by experimental procedures.* The researcher did not use any experimental procedures in the course of this research study.

Fischer (2006:xvi) describes qualitative research as a "... reflective, interpretive, descriptive, and usually reflexive effort to *describe and understand* actual instances of human action and experience from the perspectives of the participants ...” Qualitative research is used when a researcher wishes to obtain a subjective data and the study usually occurs in the natural context of the participants. Small numbers of subjects are studied with the focus on exploration and detail (Blaxter, Hughes & Tight, 2001:92).

The researcher used qualitative research methods to conduct this research study. A small number of participants (nine in total) were asked to discuss their needs with regards to working in the field of adolescent SIB during semi-structured interviews, at their place of work.

1.5.2 Type of research

Fouché and De Vos (2005a:105) subdivide research into two categories: *basic* (new theory) and *applied* (adding to existing knowledge and aiming to solve practical issues). *Basic* research adds to the knowledge base of an area of interest with new information, whereas *applied* research is aimed at solving problems in areas of interest (Neuman, 1997:22-23). Applied research is research which can result in practical outcomes or have applications to the world (Berg & Latin, 2008:311; Booth, Colomb & Williams, 2008:59).

This research project makes use of applied research. The researcher utilised existing literature to formulate a semi-structured interview schedule which was used in order to do a needs assessment of CSW's working in the field of SIB amongst adolescents. The researcher is of the opinion that the results of the study (needs identified) might then be useful to employers and/or trainers of CSW's.

Babbie (2001:109) divides objectives of research into three main categories: exploratory, descriptive and explanatory. Fouché and De Vos (2005b:134) define exploratory designs as being more qualitative in nature with the aim being to gain new information about a topic/situation. They are used when the researcher would like to examine a new area of study and/or to assess if there is a need for further diligent research.

The objective of this study was explorative. The needs of CSW's were explored through interviews in order to ascertain what the needs are with regards to their daily contact with adolescents who present with SIB.

The results of the study would indicate that there is a need for further research in this area.

1.5.3 Research design

Leedy and Ormrod (2005:135) describe five types of commonly used qualitative research designs:

Design	Purpose	Focus	Data collection methods
Case studies	In-depth understanding	One/few cases in natural setting	Observations Interviews Documents
Ethnography	Gain understanding of how behaviours reflect culture	Field site	Participant observation Interviews Documents

Phenomenological study	Gain understanding from participants' point of view	Experience as perceived by people	In-depth unstructured interviews Purposive sampling
Grounded theory	To secure a theory from natural data collection	Process of mutual influence of human actions and interactions	Interviews Data sources
Content analysis	Identify characteristics in material	Verbal/visual /behavioural communication	Identifying specific material Coding according to certain criteria

TABLE 1.1: COMMON QUALITATIVE RESEARCH DESIGNS

According to Leedy and Ormrod (2005:135) a case study is used when the objective of the research is to study something in-depth. The focus may be on one case or a number of cases such as a collective case study. Case studies are suited for gaining information, however their weakness is that the results cannot be generalised to the population with total confidence (Salkind, 2003:214). Data is collected by means of observations, interviews or documents and data analysis involves interpretation and categorisation by the researcher.

The researcher chose to use a collective case study in order to gather in-depth information on the needs of CSW's with regards to adolescent SIB by making use of semi-structured interviews.

Blaxter *et al.* (2001:71) state that case studies are ideally suited to small scale researchers involved in exploratory, descriptive and explanatory research and may occur at a researcher's place of work. The researcher worked alone and was conducting an exploratory study at the researcher's place of work.

1.6 RESEARCH METHODOLOGY

1.6.1 Research procedure

The way a researcher views his/her research is influenced by a personal world view or set of assumptions and it is this view of the world which forms a paradigm from which the study is outlined (Fischer, 2006:435; Delpont & Fouché, 2005:261). Creswell (in Delpont & Fouché, 2005:262) mentions that all qualitative researchers have a paradigm which they use to approach their research. A paradigm is defined as a "... philosophical framework" by Fischer (2006:435). The research paradigm that the researcher worked from was that of the holistic approach of Gestalt therapy.

1.6.1.1 Gestalt

Gestalt psychology and therapy place an emphasis on wholeness (the term *Gestalt* means *whole*) and came about in response to the reductionism seen in behavioural psychology and psychoanalysis (Gladding, 2000:221). According to Fischer (2006:433) *holism* implies that people are viewed as a whole rather than being seen as a set of different parts. Gestalt psychology views the environmental context and a person as being inseparable – mutually influencing and interacting constantly. An important part of the Gestalt paradigm is that something is lost when it is broken down into parts and "... creative problems should be presented and solved holistically" (Willis, 2007:265).

Gestalt theory believes that having an increased awareness of the self and others enables a person to have improved meaningful interpersonal relationships and allows for creative solutions to problems (Mackewn, 2006:125; Mental Health Association, 2009:03). Importance is placed on reaching and maintaining self-awareness and self-actualisation (Gladding, 2000:222). Gestalt theory is optimistic – change is possible and places responsibility on each individual for their actions. Problems arise when unresolved issues (*unfinished business*) arise and continue to interfere with daily life until they are dealt with and worked through (Gladding, 2000:223).

Although the researcher chose to approach the study from a Gestalt perspective, by looking at self-injurious behaviour and the needs of CSW's working with adolescent SIB from a holistic viewpoint, the study was not focused on Gestalt theory. The researcher chose to use a qualitative approach due to the holistic nature of qualitative research (Coolican, 2006:93; Blaxter *et al.*, 2001:65). There is a mutually influencing interaction between the CSW's and their clients and by asking the CSW's about their needs with regards to SIB their awareness is increased and important data is collected for trainers and employers. During data analysis the researcher viewed the results in a holistic manner, allowing themes to emerge from the parts of the data (Robbins, 2006:191).

1.6.2 Literature review

Blaxter *et al.* (2001:101) suggest that researchers read as much as possible and from as many sources as possible when conducting academic research. The researcher began the research process by conducting a comprehensive literature review on the evolving research in SIB. This review allowed the researcher to gain a holistic knowledge in the area of SIB. Areas of the literature review that the researcher concentrated on included the aetiology of SIB in adolescents including developmental, social and personal factors. The literature review included looking at the various methods/schools of treatment that have been utilised to treat adolescents with SIB and the associated research into the effectiveness thereof.

The literature review also included an investigation into the various forms of SIB, gender differences and reactions to SIB. Attention was focused on recent research, and sources included journal articles, published books, theses and dissertations, popular media and online sources.

Older works were also studied by the researcher due to the fact that these works were frequently mentioned or referred to in newer sources and appear to be classical works in the field of SIB. These classical sources include Favazza (1987); Walsh and Rosen (1988); Van der Kolk, Perry and Herman (1991); Van der Kolk and Fisler (1994); Babiker and Arnold (1997) and Conterio and Lader (1998).

1.6.3 Universe and population

Arkava and Lane (in Strydom, 2005b:193) define a *universe* as “... all potential subjects who possess the attributes in which the researcher is interested.” Reber (1995 u.w. ‘universe’, statistical) defines *universe* as a collection of something which have common characteristics/features. For the purpose of this study *universe* included Community Support Workers who work with adolescents presenting with SIB in New South Wales, Australia.

Arkava and Lane (in Strydom, 2005b:193) go on to discuss the fact that the *population* contains all the attributes a researcher would like to measure and to which the results will be generalised. The population is defined by the unit which is being sampled; geographical location and boundaries, and a representative number of cases are selected from the target population. A specific group within this population is then chosen which the researcher intends to study (target population). For the purposes of this study therefore the *population* included Community Support Workers who work with adolescents presenting with SIB in the region of Sydney.

According to Arkava and Lane (Strydom, 2005b:194) a *sample* is defined as “... a subset of measurements drawn from a population in which we are interested”. A sample is a small number of representative subjects/objects within the population which are used for the purposes of the study (Strydom, 2007b:194). A researcher selects a representative number of cases from the target population and this is the sample.

The researcher chose a sample of participants with the following *criteria for inclusion* in this study:

- practicing community support workers;
- currently working with adolescents who engage in SIB;
- with varied work experience, age and educational backgrounds;
- willingness to participate in a voluntary semi-structured interview.

Therefore the criteria for inclusion for participants in this study included CSW's, with varying degrees of experience, age and educational background working with adolescents who display SIB and who were willing to participate in a semi-structured interview. The nine participants who did participate all met these criteria for inclusion.

1.6.4 Sampling technique

Qualitative research usually makes use of purposeful sampling (Richards & Morse, 2007:195; Berg & Latin, 2008:252). According to Spradley (in Richards & Morse, 2007:195) participants in qualitative research are selected specifically due to certain characteristics which they may have and because they have knowledge of the subject under study and are willing to participate in the study.

Strydom (2005b:202) describes *purposive sampling* as the type of sample in which the researcher chooses the sample by selecting the most likely attributes of the population to be sampled. Bowling and Ebrahim (2005:606) define a *purposive sample* as one "... in which respondents, subjects or settings are deliberately chosen to reflect some features or characteristics of interest".

Purposive (judgemental) sampling is used in exploratory research and according to Neuman (1997:206) is appropriate in the following situations:

- if a researcher utilises this method of sampling in order to select unique representative cases which are informative;
- to select members of a population which is difficult to gain access to;
- to utilise *in-depth participation* with certain cases.

In-depth participation is one reason that the researcher chose to utilise purposive sampling. The main limitation of purposive sampling is that the results cannot be generalised to the population without further research.

Non-probability sampling does not involve randomisation, where each member of the population has an equal chance of being chosen (Strydom, 2005b:198), and is utilised when collecting data from experts rather than the general population (Gerard, 2003:72). According to Blaxter *et al.* (2001:163) non-probability sampling chooses typical or interesting cases. Because the sample was chosen by the researcher (due to the probability of these individuals working with this subject matter) the sampling technique which was utilised in this research project was *non-probability purposive sampling*.

Fischer (2006:xxi) states that sample size in single researcher designs ranges from one to ten respondents whilst Robbins (2005:192) states that sample size in qualitative research is typically six or fewer participants. Given that the study was qualitative research the researcher did not have a specific sample size in mind and chose to interview as many participants as possible who met the criteria for inclusion and would be willing to participate. Nine participants participated in the study which appears to be an acceptable number of participants for this type of research. Even though small samples are limited by the fact that they cannot be generalised to a large population, small samples have the advantage of providing the researcher with in-depth, rich data (Robbins, 2005:192).

1.6.5 Data collection

Data collection methods in qualitative research usually involve interviews or observation (Berg & Latin, 2008:252). Interviews may be conducted face to face or at a distance, at a person's place of work, on a one to one basis or in a group setting (Blaxter *et al.*, 2001:172). Semi-structured interviews make use of a schedule which is prepared in advance and consists of open-ended questions, however unprepared probes are also utilised during the course of the interview by the researcher according to the responses the participants give (Richards & Morse, 2007:111).

Open-ended questions are designed to allow respondents to add as much information as they like to the questions and they provide a basis from which to begin a discussion (Salkind, 2003:211). One to one semi-structured interviews were chosen as the method of data collection by the researcher and an interview schedule with open-

ended probes was drawn up by the researcher and utilised in the interviews (see appendix B).

Coolican (2006:90) discusses the advantages and disadvantages of using semi-structured interviews as follows:

<i>Advantages of semi-structured interviews</i>	<i>Disadvantages of semi-structured interviews</i>
<ul style="list-style-type: none"> • Respondents are able to relax and respond fully, which may result in in-depth, rich data • Respondents are not likely to feel that they are being evaluated which may cause apprehension • Allows flexibility for the interviewer to follow up ideas 	<ul style="list-style-type: none"> • Difficult to compare data (reliability) • Interviewer may influence data which is collected • Interviewers need to be prepared in advance in order to avoid bias • Interpretation of data is subjective

TABLE 1.2: ADVANTAGES AND DISADVANTAGES OF SEMI-STRUCTURED INTERVIEWS

Blaxter *et al.* (2001:212) discuss the fact that interviewers may not always record interviews and may choose to take notes instead. Interviews are not always tape recorded for example in cases in which it may be difficult for the researcher to gain access to a tape recorder or where the participants may refuse to be recorded.

Table 1.3 lists the advantages and disadvantages of using recording versus note taking in interviews (Blaxter *et al.*, 2001:173; Berg & Latin, 2008:253).

	Tape recording of interviews	Note taking during interviews
<i>Advantages</i>	<ul style="list-style-type: none"> • Gives an accurate record of what was said • Researcher has access to more quotes 	<ul style="list-style-type: none"> • Gives an instant record of key points • No need to acquire a tape recorder

	<ul style="list-style-type: none"> • Allows researcher to focus intently on respondent 	<ul style="list-style-type: none"> • Less time consuming when transcribing data • Taking down what the respondent says may make the respondent feel that what they say is important
<i>Disadvantages</i>	<ul style="list-style-type: none"> • Intrusive method of data collection • Respondent may be less likely to reveal confidential information • Technology is subject to failure 	<ul style="list-style-type: none"> • Can be distracting, focus is not fully on respondent • If researcher doesn't write down certain points respondent may think what they said is not important • May miss some important data

TABLE 1.3: ADVANTAGES AND DISADVANTAGES OF RECORDING VERSUS NOTE TAKING

The researcher chose to make use of note taking during the interviews. At the end of each interview the key points were read back to the respondents to ensure accuracy and at the end of the interpretation process of the data, chapter three was given to the respondents to check for accuracy in the quotes used and in the interpretations made by the researcher.

1.6.6 Data analysis

Blaxter *et al.* (2001:202) describe data analysis as the process of making abstracts and pointing out significant topics from the data collected. Qualitative analysis involves sorting and categorising a large amount of information into themes by means of

inductive reasoning (Leedy & Ormrod, 2005:150). Inductive reasoning is defined by Berg and Latin (2008:313) as "... a logical method of reasoning based on making generalisations from specific observations." The generalisations in this study are the themes, sub-themes and categories as identified by the researcher while the observations are the data collected during semi-structured interviews.

Creswell's spiral of data analysis is one way of analysing qualitative data. This method of data analysis is based on four steps but instead of following a linear, step by step process the analysis actually occurs in a circular (spiral) fashion (Leedy & Ormrod, 2005:150). The researcher chose to make use of this method of data analysis in order to deal with the data obtained from the semi-structured interviews. The steps and results are presented in table 1.4.

Steps in Creswell's data analysis spiral	Researcher's steps in the research study
1) <i>The data is organised in some sort of filing system (folders/computer databases) and broken down into smaller units of information.</i>	1) The researcher transcribed, organised and coded the interview schedules in folders.
2) <i>The data is read through a number of times in order to get a sense of the whole and notes are made of possible interpretations.</i>	2) The interview schedules were read through several times by the researcher and researcher made notes on ideas that came up.
3) <i>Classify data into general categories or themes and find meaning in the data.</i>	3) The data was categorised into themes, sub-themes and categories by the researcher and interpreted.
4) <i>Synthesis: A summary is provided and the data is integrated. Different interpretations are offered and tables/figures are drawn up.</i>	4) The researcher drew up tables of the data according to the themes, sub-themes and categories and made interpretation of the data (chapter 3).

TABLE 1.4: DATA ANALYSIS

1.7 ETHICAL ASPECTS

Strydom (2005a:57) defines *ethics* as a set of academically accepted moral principles which guide the conduct of the researcher. The responsibility is on the researcher to remain ethical in two main areas when conducting research: (1) to the subjects/respondents of the study and to (2) the scientific community (Strydom, 2005a:56). Strydom (2005a:58) goes on to sub-divide ethics into the following categories:

- *Avoidance of harm or distress*

The researcher needs to take caution to prevent causing any physical and/or emotional harm and to be aware of any possible areas or vulnerabilities in the research which can cause this harm (Strydom, 2005a:58). In this project the researcher did not foresee any potential harm or distress caused to the participants as the questions were not of a sensitive nature and respondents participated on a voluntary basis and could withdraw at any time during the research process.

- *Informed consent and confidentiality*

The researcher should ensure that the participation of the respondents is voluntary and that the respondents are correctly informed about the nature of the research project – what the research involves, what the purpose is, to whom and how the results will be provided – unless deception in one area is necessary for the nature of the research project (Strydom, 2005a:59). Participants were all given a consent form to read and sign before the interview began which explained the purpose of the research, the procedure involved and the voluntary nature of the project. The participants were advised that they would be allowed to withdraw their participation at any stage and participation was strictly voluntary (see Appendix A).

Berg and Latin (2008:21) state that in order to ensure the confidentiality and anonymity of the respondents the researcher should code research records so that only the researcher has knowledge of the identity of respondents. Babbie (2001:473)

discusses the fact that informed consent means that voluntary participation must be based on a thorough knowledge of potential risks/harm to the respondents taking part. He goes on to discuss the fact that protecting the subjects' interests and well-being as well as identity is important. The two concepts which he states are important to this goal are anonymity and confidentiality.

Anonymity implies that it is not possible to match a response to a specific respondent. A person's identity is therefore safe (Reber, 1995, u.w. 'anonymity'). Confidentiality means that the information provided by the respondent is not reported in the research results; information is not shared (Wehmeier, 2005, u.w. 'confidentiality').

Because the answers form the basis of the research project the researcher could not therefore offer the participants confidentiality; but did try to ensure anonymity. To do this the researcher ensured that the name of each participant was replaced by a code and the researcher tried to ensure that no identifying factors were included in the data categorisation.

- *Deception of respondents*

Certain types of research require deliberate deception due to the nature of the research problem (Strydom, 2005a:60). In this research project the opinions and personal input of the participants were asked for and it was not necessary to engage in any deception.

- *Competency of the researcher*

Strydom (2005a:63) discusses the importance that a researcher has adequate supervision, knowledge of the research process and ethics. A competent researcher must be able to remain objective and unbiased throughout the process. The researcher needs to have a good knowledge of the subject matter of the project.

The researcher studied a large amount of literature on this subject and was supervised by a supervisor allocated by Huguenot College throughout the process.

- *Sponsorship implications*

Everyone who is involved in funding or participating in the research process must be indicated to the respondents in order to avoid any conflict of interests (Strydom, 2005a:65). There was no outside funding involved in this project.

- *Publication/release of findings*

The researcher must produce a final written report if the research is to be of any use to the scientific community. This report must be accurate, objective and complete. The researcher must avoid plagiarism, identify all possible limitations of the study throughout and inform the respondents of the outcome (Strydom, 2005a:66). The researcher has strived to remain as objective as possible throughout the research process and has identified the limitations and problems encountered in this study in the report (refer to 4.5).

1.8 DEFINITIONS AND MAIN CONCEPTS

1.8.1 Self-injurious behaviour (SIB)

Plante (2007:1) defines self-injury as "... the intentional self-infliction of wounds by cutting, burning or otherwise damaging the skin." Van der Kolk *et al.* (1991:1665) indicate that self-injury includes a variety of methods such as cutting, scratching, burning, hitting and piercing. Simeon and Favazza (2001:1) define SIB as "... all behaviours involving the deliberate infliction of direct physical harm to one's body without any intent to die as a consequence of the behaviour." Woldorf (2005:196) adds to the definition by indicating that it is not culturally sanctioned or motivated by suicide, and is mainly used to "relieve intense negative emotions".

For the purpose of this research project the term self-injurious behaviour includes impulsive SIB such as cutting, burning or hitting behaviour where the motive is not suicide and it is not culturally sanctioned; and stereotypical SIB which may occur with a developmental disorder (such as autism).

1.8.2 Need

A need can be defined as something which is wanted because it is seen as an important requirement, not just because of its appeal (Wehmeier, 2005, u.w. 'need'). Reber (1995, u.w. 'need') defines a need as something which would advance or improve the situation of a living thing. For the purpose of this research project the term 'need' implies something which is an important requirement in order to improve a situation.

1.8.3 Assessment

Wehmeier (2005, u.w. 'assessment') defines assessment as a carefully thought out opinion or judgement. De Vos (2005a:369) defines a needs assessment as an assessment of the need for services, usually used when evaluating an existing programme. In this study the term assessment is defined as the considered opinions of the respondents.

1.8.4 Community Support Workers (CSW)

A community support worker (CSW) is a person employed to fulfil the role of providing support (welfare and social) to people in refuge or institutional care (NSW Industrial Relations, 2010). The CSW's in this study were employed on a casual, part-time or fulltime basis to assist clients in their daily living activities, both in their home and community environments. The clients in this study were adolescents in out of home care, in a residence staffed 24 hours, 365 days a year by CSW's.

1.8.5 Adolescent

Adolescence is the developmental period in a young person's life which falls between childhood and adulthood (Wehmeier, 2005, u.w. 'adolescent'). Berk (2000:06) categorises adolescence as the period between eleven and twenty years of age, as a bridge between childhood and adulthood. For the purpose of this study an adolescent is seen as a young person between eleven and twenty years of age.

1.8.6 Training/education

Wehmeier (2005, u.w. 'training') defines training as a process in which skills are learnt in order to carry out a job. Training involves a programme being implemented in order to achieve a specific outcome (Reber, 1996, u.w. 'training'). Education is a process in which knowledge is acquired and skills are developed through training (Wehmeier, u.w. 'education'). For the purpose of this study both terms training and education are used and imply the process of learning in order to work effectively with clients who present with SIB.

1.8.7 Support

Support is defined by Wehmeier (2005, u.w. 'support') as the assistance or encouragement of someone, and as being available to be able to provide assistance if required. Reber (1995, u.w. 'support') defines support as the provision of something which is lacking or needed, in order to promote improvement or well-being. For the purpose of this study support is defined as assistance which is provided (mental and physical) in order for CSW's to work effectively.

1.8.8 Treatment/Therapy

Wehmeier (2005, u.w. 'treatment') defines the term treatment as something which is carried out to cure an illness/injury; to make a person feel or look better. Treatment includes "... any specific procedure designed to cure or to lessen the severity of a disease or abnormal condition" (Reber, 1995, u.w. 'treatment'). Synonyms for the word 'therapy' include cure, healing, remedy, treatment (Spooner, 1998, u.w. 'therapy'). Reber (1995, u.w. 'psychotherapy') further divides therapy into various types and describes psychotherapy as a technique which is aimed at curing mental/emotional/behavioural disorders.

For the purpose of this research project the term will be used to mean an approach which is followed to help an individual who is using SIB as a coping mechanism to come up with alternatives for coping.

1.8.9 Childhood trauma

Trauma comes from the Greek word meaning “wound”. It is defined as a physical or psychological injury caused by external factors, force or emotional assault (Reber, 1995, u.w. ‘trauma’). The DSM-IV (American Psychiatric Association, 1994:431) defines trauma as “actual or threatened death or serious injury, or a threat to the physical integrity to the self and others ... results in a response of intense fear, helplessness, or horror.” Trauma can be a once off event – such as in an armed robbery or it can be chronic/ongoing – such as in certain cases of physical or sexual abuse.

For the purpose of this research project the term will refer to any severe physical or psychological experience (once-off or chronic) which causes psychological upset.

Childhood refers to the period between birth and adolescence (Reber, 1995, u.w. ‘childhood’).

1.9 SUMMARY

Self-injurious behaviour is a coping mechanism which is utilised to deal with strong emotions; it usually begins in adolescence and has a strong link to childhood trauma. Because this is often a difficult behaviour to treat, this study was aimed at exploring if CSW’s felt that they had a need for further training and/or support with regards to SIB in adolescent clients.

The researcher chose to utilise an exploratory design within a qualitative approach and purposive non-probability sampling was used. After an extensive literature review a semi-structured interview schedule was drawn up and the researcher interviewed participants in order to gather the data.

Chapter two will focus on the conceptual framework of the study.

CHAPTER TWO

CONCEPTUAL FRAMEWORK: SELF-INJURY IN ADOLESCENTS

*More than perhaps any other human action, self-mutilation speaks of distress, torment and pain. The act of wounding oneself **embodies** – literally – an implicit connotation of something unbearable, unutterable, that is communicated in this act*
(Babiker and Arnold (1997:1).

2.1 INTRODUCTION

SIB is a complex form of behaviour which is now recognised as distinct from suicidal behaviour. The difference between the two involves intent, whereas suicide's intent is to end one's life, SIB is used to cope with intense emotions in order to stay and feel alive (Babiker & Arnold, 1997:2). Kluger (2005:48) discusses the fact that SIB is often a secretive behaviour which is performed when the individual is alone, in private.

According to Tumolo (2005:54) Karl Menninger has been attributed as the first person to distinguish self-injury from suicide as far back as 1938. Psychiatry started displaying interest in SIB in the 1960's and public interest exploded in the 1980's when the media began putting a spotlight on this behaviour (Plante, 2007:8). It was during the nineties that celebrities such as Princess Diana (who suffered from bulimia, anorexia and SIB) and Johnny Depp (who engaged in self-cutting) made their SIB public (Farber, 2000:50-51), and SIB became a popular topic in magazines and the media (Levenkron, 2006:9).

SIB is used to communicate, relieve intense distress and control suffering which can be caused by a variety of emotional disturbances (Smith, 2005:30; Plante, 2007:3-4). SIB is a behaviour which provides relief from anxiety and depersonalisation (Strong, 2006:34); it acts as an emotional regulator, is considered to be an impulse-control disorder (Plante, 2007:8) and according to Strong (2006:47) may be used to differentiate the self from others – it distinguishes body boundaries. Strong (2006:57)

goes on to say that whereas tears are the body's natural way to relieve tension, SIB can be regarded as symbolic tears (bleeding), especially when a person has difficulty crying or feel that crying is inadequate to express their pain. Walsh (2008:7) mentions that the common types of emotions which are expressed by SIB include anger, shame, sadness, contempt and frustration.

The majority of SIB is associated with taxing and uncomfortable life experiences and usually arises as an "adaptive response" to life situations (Babiker & Arnold, 1997:57). SIB is used to cope with negative stress and is meant to be a way of surviving rather than as a self-destructive act (Babiker & Arnold, 1997:73; Cerdorian, 2005:43).

In people with developmental or sensory disorders (intellectual/hearing/visual disabilities, autism) SIB is used with the intent to harm oneself, however it is generally more rhythmical and repetitive than in other people who engage in SIB (Simeon & Favazza, 2001:5; Gal, Dyck & Passmore, 2009:343). Kress (2003:493) and Strong (2006:27) state that stereotypic SIB may be used for the purpose of managing under or over stimulation or to escape situations which cause the individual distress. Strong (2006:27) further mentions that head banging has been thought to be linked to the neonatal comfort of hearing a mother's heartbeat.

Walsh (2008:17) states that stereotypic SIB may have more of a psychological basis to it than generally acknowledged. Carr and Smith (1995:94) propose that individuals engage in stereotypic SIB in order to get attention, to get out of doing something (aversive stimulus) and/or to get something they desire. Stereotypic SIB is frequently a lifelong behaviour which begins in childhood and may continue throughout an individual's life (Matson, Cooper, Malone & Moskow, 2008:141).

Conterio and Lader (1998:16) regard SIB as a serious problem which is quickly overtaking eating disorders as a social disorder. SIB has been referred to as "... the new tattoo" for adolescents (Hodges, 2005:16). SIB is a complex behaviour which is succinctly summed up in a quote by Harrison (in Strong, 2006:xvii): "Scars are stories, history written on the body."

2.2 DEFINITION OF SELF-INJURY

For the purpose of this study self-injury is defined as any purposeful harm caused by a person to his/her body; which is not socially or culturally acceptable or sanctioned; is normally used to relieve emotions and is not intended to end one's life (Conterio & Lader, 1998:16; Simeon & Favazza, 2001:1; Woldorf, 2005:196; Plante, 2007:1; Walsh, 2008:4).

Professionally administered tattoo's and body piercings are not included in this definition, where the intent is due to fashion or to make a statement (Levenkron, 2006:23). Self-injury is not meant to end life and in most cases will at worst result in scarring, however it is driven by a desperation which needs to be addressed in a therapeutic capacity (Levenkron, 2006:23). Although SIB may not be lethal in intent there is according to Farber (2000:39), Hawton, Fagg, Simkin, Bale and Bond (2000:48), Plante (2007:3), Walsh (2008:28) and Tuisku *et al.* (2009:1133) an increased risk of suicide in self-injurers. In this regard research (Plante, 2007:9; Kerr *et al.*, 2010:241) has shown that 50% of suicide victims had a history of SIB and it is therefore important to assess for suicide risk in all self-injurers.

Self-injury has been given a variety of names over the years, terms such as self-harm, self-mutilation, self-cutting, parasuicide, anti-suicide and wrist cutting syndrome (Simeon & Favazza, 2001:1; Laye-Gindhu & Schonert-Reichl, 2005:447; Strong, 2006:xvii). More recently the term self-injury has become the most common term for this behaviour (Walsh, 2008:3) and it is for this reason that the researcher has chosen to use the term in this study.

2.3 TYPES OF SELF-INJURY

SIB occurs in various forms and includes cutting, biting, burning, scratching, punching, whipping, puncturing, inserting foreign objects, hair pulling, head banging, breaking bones, interference with wound healing and self-inflicted tattoos (Farber, 2000:19; Esherick, 2005:83; Plante, 2007:8). In stereotypic SIB common behaviours are skin-picking, hitting one self (Kress, 2003:493), self-biting, self-scratching and head banging (Matson *et al.*, 2008:141). The most common form of impulsive self-

injury seems to be cutting, usually on the arms and legs and less commonly on the torso, breasts and genitals (Babiker & Arnold, 1997:3; Farber, 2000:19; Cerdorian 2005:43; Kerr *et al.*, 2010:242), however many self-injurers use multiple methods (Plante, 2007:8; Walsh, 2008:10).

2.4 CATEGORIES OF SELF-INJURY

SIB is a complex behaviour and it varies in severity and cause. Favazza (in Simeon & Favazza, 2001:4) classified SIB into four categories according to the severity and cause of the behaviour in individuals. The categories are as follows:

- (a) *Stereotypic SIB* is mostly associated with individuals with organic mental disorders (mental retardation or developmental delay) such as autism and Cornelia de Lange syndrome. Stereotypic SIB includes head banging, self-biting, hitting, scratching and hair pulling. It occurs on a highly repetitive, fixed basis and is quite driven.
- (b) *Major SIB* involves severe, sometimes life-threatening behaviour and is usually associated with individuals suffering psychotic episodes. Examples include limb amputation and self-castration. It usually occurs in isolated incidences and may be impulsive or planned.
- (c) *Compulsive SIB* involves injury that is less severe than major SIB and usually occurs without conscious intent. An example is trichotillomania (hair pulling). It occurs on a repetitive basis.
- (d) *Impulsive SIB* is mild to moderate in severity, and is usually isolated or habitual. This led to impulsive SIB being further subdivided into *episodic* (limited occurrence) and *repetitive* (repeated occurrence). Impulsive SIB usually involves superficial cutting of the skin, but can include hitting and burning. It may be ritualised or habitual and occurs on an isolated or habitual basis.

Walsh (2008:20) categorises SIB into a simpler classification scheme. Whilst not disregarding the scheme developed by Simeon and Favazza, he proposes the simpler classification which is more user friendly for clinicians (whereas the more elaborate scheme is appropriate for research purposes).

Walsh (2008:21-28) uses and modifies a classification model of SIB developed by Pattison and Kahan (1983). This model divides SIB into:

(a) *Direct SIB* – where immediate damage is caused (such as cutting), damage ranges in severity (severe to mild) and SIB may occur on frequently or on a once off basis.

(b) *Indirect SIB* – where accumulative damage occurs (such as substance abuse, anorexia, risk-taking and medication abuse or discontinuance) and where the intent of the behaviour may be unclear.

Walsh (2008:28) emphasises the importance of clinicians assessing for both types (direct and indirect SIB) when carrying out an assessment as the two frequently co-occur in individuals.

2.5 PREVALENCE

SIB appears to be far more common than thought, however due to its secretive nature it is difficult to get an exact number of the people who engage in this behaviour (Farber, 2000:105; Strauss, 2007:58-59). Plante (2007:1) however discusses SIB as a new behaviour that “... has increased in popularity with teens ... an alarming problem among an increasing number of youths”. She goes on to discuss the fact that despite the fact that there is a variety of high risk behaviours to which teens are vulnerable, cutting is becoming an increasingly prevalent behaviour among adolescents and can almost be regarded as “socially contagious” (Plante, 2007:2).

Estimated rates of SIB amongst adolescents as high as 15% have been reported in the USA (Cerdorian, 2005:42; Fortune & Hawton, 2005:404; Brody, 2008:382; Kerr *et al.*, 2010:240). According to Plante (2007:3) there is also an increase in rates of patients (of various ages) being treated for SIB at community hospitals in the USA – a

rise from 4.3% to 13.2% between 1990 and 2000. Furthermore estimates of prevalence of SIB in youths in the USA are 1000:100 000 and adolescent inpatient incidence of SIB is at 40% (Plante, 2007:3). South African statistics indicate that 10-15% of adolescents engage in SIB (Wehmeyer, 2006:41) whereas Tuisku *et al.* (2009:1126) put estimates of community adolescent SIB in Australia, USA and the UK at 5-9%, and inpatient rates at 40-61%.

Walsh (2008:43) highlights the fact that worldwide (USA, Europe, Japan and Taiwan) an increasing number of “healthy” people (with no mental illness or serious trauma history) seem to be engaging in SIB. A variety of possible environmental, media, peer-group and internal elements may have influenced this increase in prevalence amongst socially normal people – including aspects such as increased stress, a decreased sense of community and increased media attention (Walsh, 2008:45-47).

The prevalence of SIB is particularly high in populations with severe intellectual disabilities (Mace & Mauk, 1995:104; Simeon & Favazza, 2001:7; Matson *et al.*, 2008:142). The prevalence rates in individuals with developmental delays or mental retardation in the USA range from 2 to 19% in community populations and 8 to 40% in institutionalised individuals (White & Schultz, 2000:1574).

2.5.1 Contagion

As mentioned social contagion (when others model this form of coping behaviour) appears to account for some of the increase in prevalence of SIB (cf. Cerdorian, 2005:42; Plante, 2007:4). Contagion can occur among children, adolescents or young adults in a variety of settings such as juvenile detention centres, group homes and inpatient units (Walsh, 2008:231).

Walsh (2008:235-237) feels that SIB rates in public schools in the USA have increased and that little research has been conducted with these community populations. The reasons he cites for contagion episodes include a desire for recognition, to punish someone, to shock or manipulate others, gain attention, modelling and competition for attention (Walsh, 2008:244-254).

2.6 AETIOLOGY

Research has shown that SIB (from childhood to adulthood) has been associated with a variety of disorders and these include developmental disorders (e.g. autism); personality disorders (e.g. borderline personality disorder); mood disorders (e.g. depression); anxiety disorders (e.g. obsessive compulsive disorder); schizophrenia; eating disorders; post traumatic stress disorder (PTSD) and adjustment disorders (Simeon & Favazza, 2001:8; Kress, 2003:492). Due to a lack of knowledge and understanding about SIB clients were frequently misdiagnosed as having borderline personality disorder (BPD) if they displayed this behaviour (Kress, 2003:493; Kruger, 2003:18). The link between BPD and SIB will be further discussed in 2.6.3. Today it is recognised that although there is a strong incidence of SIB in individuals with BPD, this is not the only cause of SIB (Plante, 2007:18; Walsh, 2008:33-35).

2.6.1 Link to trauma

SIB has been shown to have a strong link to childhood trauma, particularly when child abuse (physical or sexual) is experienced together with loss and neglect (Van der Kolk & Fishler, 1994:146). Trauma experienced in childhood is compounded due to the fact that in childhood the appropriate coping skills are not yet in place, and if the environment is neglectful or non-supportive it contributes to the lack of appropriate coping skills a child develops. This inability to utilise effective interpersonal skills to cope with stress has been linked to children who are abused and who grow up with neglect, loss or separation (Van der Kolk *et al.*, 1991:1665).

The link between childhood trauma (together with the lack of secure attachments) and SIB is supported by numerous authors (cf. Farber, 2000:35; Milia, 2000:70; Saxe, Chawla & Van der Kolk, 2002:313; Cerdorian, 2005:42; Strong, 2006:27). According to Milia (2000:70) trauma literature explains self-injurious behaviour as "... unconscious attempt to act out traumatic experiences upon the body."

The most common cause of SIB is childhood sexual abuse (Strong, 2006:64) and the act of self-harm possibly gives individuals a feeling of control over their body (similar to the anorexia experience), whereas they did not have this control whilst being

abused as a child. It can further serve to make them unattractive to others, consequently warding off further abuse (Strong, 2006:66). According to research (Plante, 2007:3) 62% of self-cutters have a history of sexual or physical abuse. It is interesting to note that in a study conducted by Van der Kolk and Fishler (1994:155) in 1991 on outpatient psychiatry patients (with a history of child abuse) it was discovered that the earlier the abuse began the more the aggression was self-directed.

Trauma may cause overwhelming emotions, dissociation and emotional numbing and if the person is not able to verbalise or deal with these negative emotions this may lead to SIB (Strong, 2006:118). Hyper-arousal, a symptom of trauma, can cause a person to lose the ability to distinguish between mild and severe stress where all stress is then experienced as anxiety provoking which in turn leads to self-destructive behaviour (Milia, 2000:71).

Dissociation and shame (experienced by many abuse victims) cause a problem with body image and where there is no clear boundary between the self and the world, SIB is used to draw this line (Milia, 2000:73). SIB may further be used to end depersonalisation and or to calm inner turmoil and pain – all side-effects of trauma (Milia, 2000:71).

It is important to note, however, that SIB does occur among adolescents who do not have a history of trauma and professionals must be careful not to automatically make an assumption that their client has a history of trauma (Heath, Toste, Nedecheva & Charlebois, 2008:151). SIB has a variety of contributory causative factors and each client therefore needs to be assessed individually. Besides a history of childhood trauma, contributing factors include social and peer pressure, intimacy problems, feelings of loss of control and hopelessness or attention-seeking behaviour (Cerdorian, 2005:42).

2.6.2 Link to eating disorders

SIB and eating disorders are often found concurrently in individuals (Farber, 2000:35; Simeon & Hollander, 2001:16; Kerr *et al.*, 2010:241). Statistics vary but all appear to show a significant link between the two behaviours. Various studies showed that from

35 to 80% of anorexia or bulimia females engaged in SIB, indicating a possible similarity in the pathological process (Farber, 2000:35; Strong, 2006:116; Plante, 2007:3).

Eating disorders (like SIB) most commonly emerge in adolescence and both disorders involve inner conflict issues such as body-image, boundary, sexuality, gender identity and impulse control problems (Conterio & Lader, 1998:119; Plante, 2007:19). Some eating disorders can be viewed as an attempt to keep the body in a childhood (premenstrual) state (Strong, 2006:53) and both SIB and eating disorders can be viewed as a re-enactment of trauma on the body (Strong, 2006:117). Both SIB and bingeing or purging are used to regulate mood, relieve hyper arousal and/or dissociation, express emotions and define body boundaries (Farber, 2000:39).

2.6.3 Borderline Personality Disorder (BPD)

As was mentioned earlier chronic SIB was historically almost always linked to BPD, however many individuals with self-injurious behaviour do not have BPD (cf. Favazza, 1987:236; Walsh, 2008:33). The diagnostic criteria for BPD in the *DSM-IV* (American Psychiatric Association, 1994) show it as the only disorder to include SIB as one of the five criteria for the diagnosis. Various authors (cf. Conterio & Lader, 1998:173; Farber, 2000:81; Strong, 2006:60) suggest that in the past SIB was used alone to incorrectly diagnose BPD in clients displaying this behaviour.

The fact is that although 60-80% of BPD patients do engage in SIB, caution must be exercised in making a thorough assessment to avoid misdiagnosis (Plante, 2007:18). SIB is also linked to other disorders such as PTSD, dissociative disorder, psychoses and anti-social personality disorder. However SIB also occurs in people with little history of trauma and who have adequate social functioning (Walsh, 2008:33-35).

2.7 GENDER

Whether SIB occurs more in females than in males is an area in which there is an ongoing debate. Historically females have been viewed as more likely to engage in SIB with the view that males utilise more lethal methods to self-injure (Spender,

2005:120), however recent research has cast some doubt on this assumption. There are suggestions that SIB may be as high in males as in females (Plante, 2007:2; Kerr *et al.*, 2010:241). Having stated this fact Plante (2007:16) then goes on to say that there is however general agreement that it occurs more frequently in females due to the fact that they direct their anger inwards, whilst males have a tendency to direct their anger outwards.

There is the possibility that statistics may be a consequence of under-reporting by males (Plante, 2007:17), or due to the fact that not as much research has been conducted on males as opposed to the majority of research conducted on females (Laye-Gindhu & Schonert-Reichl, 2005:448). In conclusion the general assumption amongst most authors is that it is more common among females and that there is a need for more research regarding SIB among males.

2.8 ADOLESCENCE

Most SIB (specifically among individuals without developmental disorder or psychotic diagnoses) begins in adolescence and may persist into adulthood (Van der Kolk *et al.*, 1991:1665; Babiker & Arnold, 1997:44; Conterio & Lader, 1998:95; Nichols, 2000:151; Simeon & Hollander, 2001:16; Smith, 2005:30; Strong, 2006:52; Plante, 2007:9; Kerr *et al.*, 2010:242). Walsh (2008:35) discusses a study conducted in 2002 by Ross and Heath on a community sample of high school students in Canada which revealed that 13.9% of participants had engaged in SIB; 64% of self-injurers were female and 36% male. A limitation of this study was the fact that 18% of participants had only engaged in SIB on one occasion and Walsh questioned if they should have been included in the study.

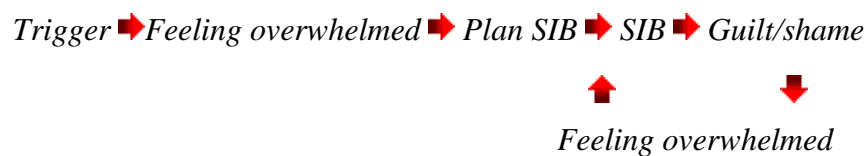
Adolescence is a period which is characterised by a renewed process of independence, a developing brain but also a lack of language ability to discuss their inner world – these factors lead to communication methods that are predominantly action and body oriented (Milia, 2000:78; Cerdorian, 2005:44). Wehmeyer (2006:7) also states that adolescence is a developmental period full of changes which include physical, emotional, intellectual and social changes. Plante (2007:4) discusses how adolescent endeavours to become independent and to form an identity and issues regarding

intimacy may lead to SIB as a means of coping. Wehmeyer (2006:20) points out the fact that adolescence is a period in which coping skills are continually developing and the adolescent who has not yet had a chance to develop the appropriate coping skills may resort to SIB as a method of coping with anxiety.

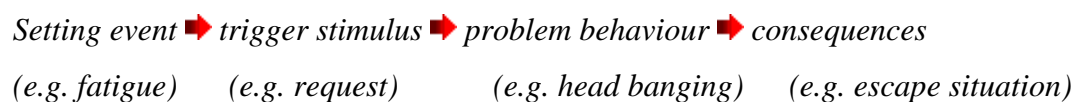
Children who suffered trauma may find puberty to be a further body violation and the development of physical sex organs may cause shame/fear/guilt in sexual abuse victims (Strong, 2006:53). Adolescence is a developmental stage where there are biochemical changes and Schwartz (in Strong, 2006:53) proposes that this activates damage from prior trauma. A complex interplay between the brain, hormones and social environment at this stage of development result in an increase in impulsive behaviour (Strong, 2006:55).

2.9 THE CYCLE OF SIB

An act of impulsive SIB may result in feelings of guilt/shame for the individual and these feelings may prompt them to engage in more SIB (to alleviate/cope with the feelings) which may lead to a cycle of SIB in some individuals (Southern Community Welfare, 2010:10) and is illustrated as follows:



Carr and Smith (1995:96) propose a conceptual framework of how stereotypic SIB occurs and continues. A setting event (such as fatigue or hunger) is present together with a trigger stimulus (a request to do something) which may together result in the problem behaviour of head banging which allows the individual to escape the situation and get out doing something. If this is allowed to continue the problem behaviour is reinforced.



2.10 REACTIONS TO SIB

Various authors discuss the reactions to SIB of professionals working in the field of SIB. In the late eighties Favazza (1987:237) already mentioned how SIB can cause anguish for therapists whilst Farber (2000:359), many years later mentions how therapists often fear that their patient may become suicidal and that they as professionals will be held liable which means that sometimes hospitalisation is chosen for the client to put the therapist at ease. In this regard Levenkron (2006:9) mentions that he regularly encountered clients who had been refused treatment by numerous therapists due to the fact that they felt that they lacked experience in treating SIB.

Deiter, Nicholls and Pearlman (2000:1188) mention that in a study conducted on 117 licensed psychologists, SIB was perceived to be the most difficult behaviour to deal with professionally in terms of causing stress and distress to these professionals. SIB may therefore lead to negative attitudes amongst health professionals (Winter, Sireling, Riley, Metcalf, Quaite & Bhandari, 2007:23), which include shock, anger, anxiety, inadequacy (Babiker & Arnold, 1997:128; Cerdorian, 2005:44) and irritation (Spender, 2005:121). Walsh (2008:222) for instance discusses some of the negative responses to SIB he personally has encountered as a professional, reactions such as agitation, insomnia, indecisiveness, fear, anger, avoidance, over-involvement and helplessness.

Woldorf (2005:199) mentions how professionals may find SIB difficult to understand. Negative associations to SIB include the fact that it is viewed as manipulative, fake or attention seeking behaviour (Cerdorian, 2005:42; Strauss, 2007:185; Walsh, 2008:224). Walsh (2008:225) goes on to categorise these negative reactions into three categories, (1) fear and anxiety, (2) anger and frustration and (3) helplessness and despair. SIB goes against the idea that individuals usually try to avoid pain and because of this SIB can cause an individual to have a recoil reaction towards the behaviour (Walsh, 2008:223). Negative behaviour on behalf of the therapists include: inattention, threats of hospitalisation, forced contracts and avoidance (Walsh, 2008:226). Levenkron (2006:19) mentions how he was shocked to discover how often psychiatrists encountered SIB and then regarded the behaviour as simply a result of severe mental illness.

In a recent survey of school counsellors in Canada there was a concern over a lack of training in SIB and a request to be more informed about SIB's occurrence and characteristics (Heath *et al.*, 2008:137). The study goes on to discuss how current school and community-based mental health professionals often felt unsure about how to treat these clients and that psychiatric services were observing an increase in referrals (Heath *et al.*, 2008:151). In general it therefore appears to be a reliance on myths about SIB in the absence of actual knowledge (Froeschle & Moyer, 2002:232). Deiter *et al.* (2000:1174) and Kress (2003:490) state that people are more equipped to help others displaying SIB when they understand the reasons for the behaviour and what functions it may serve for that individual.

2.11 TREATMENT FOR SELF-INJURY

Responses to SIB are usually emotional (concern, anguish, shock, fear, anger), and a therapist needs to avoid an emotional reaction, as well as being too positive or negative which all may result in inadvertently reinforcing the behaviour (Walsh, 2008:74-75; Wedge, 2009:22). Taylor (2003:90) discusses the importance of all staff dealing with SIB undergoing training in SIB in order to better understand their clients.

Plante (2007:65) discusses how challenging it is to look for the underlying reason for SIB and not to try to stop behaviour; successful treatment requires a calm approach and reaction. Walsh (2008:223) proposes that in order to be successful in treating SIB, a professional needs to learn not to recoil or become distressed and to always respond compassionately.

Untrained therapists may choose to focus on reducing symptoms which may cause a client to cling to the behaviour more (Farber, 2000:359). Having regular supervision and or debriefing when working with clients who engage in SIB is very important according to Reeves, Wheeler and Bowl (2004:243) and Wedge (2009:24). Farber (2000:369-370) lists qualities required by a therapist in order to successfully treat SIB. These include having clear professional boundaries, being even-tempered, flexible and creative, as well as being able to commit to long term therapy.

2.11.1 Therapy

Treatment of SIB needs to focus on the provision of empathy and support to allow for the development of alternative coping strategies and more creative methods of self-expression (Milia, 2000:81; Plante, 2007:65). A key to successful replacement behaviour substitution is to together with the client work out alternative behaviours which can replace the self-injurious behaviour. Alternative strategies include: journaling, listening to inspiring music, exercise or calling a friend (Plante, 2007:66).

Conterio and Lader (1998:253-259) make use of specific written assignments and an impulse control log in their program. According to Conterio and Lader (1998:103) the good news about adolescent SIB is that if it is discovered in adolescence the client has a good chance of stopping. An important part of therapy is to teach adolescents to utilise their minds to handle inner turmoil or stress (Plante, 2007:04).

The therapist's initial and continued reaction to the self-injury is also vital for successful treatment. Plante (2007:67) suggests a contained reaction without showing shock or anxiety and by displaying a calm, non-judgemental demeanour; this indicates to the adolescent that the therapist is competent to handle them and their issues. Walsh (2008:71) agrees with the calm, even-tempered, non-judgemental, compassionate response and adds that a respectful curiosity about the self-injury is also important. He goes on to suggest that therapists should avoid the use of suicide terms such as attempted suicide when referring to SIB which may indicate that the therapist feels that the behaviour is aimed to manipulate or is not serious.

A holistic approach is important and the family should be involved in the therapeutic process as much as possible (Strong, 2006:165; Plante, 2007:65). Walsh (2008:57-70) suggests using a cognitive behavioural assessment approach, making use of five dimensions to assess and treat SIB, which allows a comprehensive assessment and treatment approach. The following five dimensions are considered to be important:

- environmental dimension – including family history, client history and current environmental circumstances/events;

- biological dimension – looking for possible biochemical imbalances, any physical illness; eating and sleep disorders;
- cognitive dimension – examining the client’s cognitive interpretations of events and general cognitions;
- affective dimension – looking at the client’s emotional triggers;
- behavioural dimension – examining actions which occur before, during and after self-injury (Walsh, 2008:57-70).

Yip (2005:82) also suggests a multi-dimensional approach with therapy including the family and peers as well as a multi-disciplinary team to successfully treat SIB. Conterio and Lader (1998:213) however state that it is important that the client takes responsibility for their behaviour and that therapy can only be successful if the client is motivated to change.

Conterio and Lader (1998:244) are of the opinion that hypnotherapy and cathartic methods of therapy may be ill advised and instead recommend psychodynamic therapy, cognitive behavioural therapy and/or supportive therapy. Other authors such as Kluger (2005:50) and Strong (2006:173) advocate that the best proven and researched treatment for SIB to date is dialectical behavioural therapy (from a cognitive behavioural approach) which teaches adaptive coping skills. Creative methods such as art and dancing can be used to express their emotions and reduce the physical need for expressing emotions through self-injury (Strong, 2006:163).

Ultimately it is the researcher’s opinion that successful treatment of SIB involves an informed, empathetic, objective, committed therapist who is able to view each client individually and focuses on replacing SIB with socially acceptable coping skills.

2.11.1.1 Therapeutic approaches

There are numerous approaches which have been proven to be effective in treating SIB and the Mental Health Association of Queensland mentions the following specifically on their website (<http://www.mentalhealth.org.au>):

- **Supportive therapy**

This is an integration of cognitive-behavioural, psychodynamic and interpersonal therapies. In supportive therapy the therapist is engaged with the client and is encouraging and supportive. The aim of the therapy is to reinforce healthy and adaptive behaviours and thoughts by working with cognitive and behavioural attributes (Reber, 1995, u.w. 'supportive therapy').

- **Psychodynamic psychotherapy**

This approach is similar to psychoanalysis in that the focus is on the unconscious however the therapy is more intense and shorter in duration (Mcleod & Wheeler, 2006:7). Childhood experiences and parent-child relationships are seen as having an important influence on an individual's current behaviour (Gladding, 2000:357). The relationship between the client and therapist is important and both are active in the therapeutic process; however the therapist maintains a professional distance and avoids self-disclosure (Mcleod & Wheeler, 2006:7-9). The aim of therapy is to link the past and present and the process is aimed at unconscious processes and dreams (Mcleod & Wheeler, 2006: 9).

- **Dialectical Behavioural Therapy (DBT)**

This is a method which combines aspects of cognitive behavioural therapy (emotional regulation and reality testing) with Buddhist meditation and philosophy (mindful awareness, acceptance and distress tolerance). It was developed specifically to treat borderline personality disorder but has proven to be effective in treating a variety of problems including self-injury (Wikipedia, 2009, u.w. 'dialectical behavioural therapy').

Individual therapy is supportive and is aimed at improving life skills by focusing on teaching the client to identify their emotions and consequently regulate them (Barlow & Durand, 1999:394). Group therapy is aimed at the learning and practicing of the following specific life skills (Wikipedia, 2009, u.w. 'dialectical behaviour therapy'):

- mindfulness (being present in the moment);
- interpersonal skills (coping with conflict, assertiveness training);
- emotional regulation (learning to deal with and identify emotions);
- distress tolerance (to find meaning in and cope with stress).

Dialectical behaviour therapy, as mentioned earlier, is the first therapeutic approach which has been experimentally proven to be effective in treating self-injury and borderline personality disorder (Barlow & Durand, 1999:394; Wikipedia, 2009, u.w. ‘dialectical behaviour therapy’).

- **Cognitive Behavioural Therapy**

This approach arose through a combination of behavioural and cognitive therapies and is collaborative and psycho educational (Palmer & Szymanska, 2006:80). Cognitive behavioural therapy addresses dysfunctional emotions, behaviours and thoughts through the use of a systematic goal-oriented approach (Gladding, 2000:270; Palmer & Szymanska, 2006:80). Therapy is usually brief and places emphasis on the here-and-now. Common techniques used in this approach include: diary keeping; thought-stopping (replacing negative thoughts with positive ones); the practice and trying out of new behaviours, and learning relaxation techniques in order to cope with stress (Gladding, 2000:270). Sessions are structured and the content is negotiated between client and therapist (Palmer & Szymanska, 2006:81)

- **Gestalt therapy**

Gestalt therapy takes a holistic view of each individual and aims to make people aware of themselves and their environment, and how the two are mutually influencing. The Gestalt therapist has to be honest, energetic, creative and engaged with their client (Gladding, 2000:223). The therapist must provide an accepting, non-judgemental environment for the client and the aim is to assist the client to become aware of and deal with any *unfinished business* (Mackewn, 2006:126). Gestalt therapy is flexible and makes use of a variety of techniques (*empty chair, around the world, dream enactment*); however therapy is not limited to specific fixed techniques and is

open and adaptable to any technique which may suit the individual client (Gladding, 2000:227; Mackewn, 2006:123).

2.11.2 Treatment of stereotypic SIB

Methods that have proved successful in treating stereotypic SIB have included behavioural interventions, reinforcing alternative behaviours, improving communication and social skills, creating environments which are tailored to the individuals' preferences and the interference and hampering of this behaviour (Matson *et al.*, 2008:142). Other strategies which have proven useful in treating stereotypic SIB include medications such as antidepressants, neuroleptics, anticonvulsants, antipsychotics, chloralhydrates and anti-psychotics (Matson *et al.*, 2008:142).

2.11.3 The use of a no-harm contract

Conterio and Lader (1998:247) advocate for the use of a no-harm contract (written or verbal) when treating SIB. However Walsh (2008:121) recommends against using no-harm contracts as they may cause dishonesty on the part of the patient. It is felt that should a client slip up during the course of treatment, that client may consequently avoid advising the therapist of any incident/s. Strong (2006:172) also discusses this issue and states that some therapists may refuse to see the client if they self-injure during therapy whilst others believe it is more important to teach coping skills which will eventually replace the self-injury behaviour. Babiker and Arnold (1997:129) as well as Wedge (2009:24) suggest that it is not advisable to force a client to stop their behaviour. Consequently it appears to be a personal choice whether or not to use a contract (verbal or written), which must be made by the therapist on an individual basis, in the best interest of their client.

2.11.4 Medication

Medications which have proven successful in treating SIB according to Simeon and Hollander (2001:129-130), Smith (2005:31-32) and Walsh (2008:218-219) include:

- a) Benzodiazepines (Lorazepam, Diazepam) – although they may increase behaviour in some individuals.
- b) Anti-psychotics – Risperidone and Clozapine have proven effective in individuals with developmental disabilities.
- c) Mood stabilisers (lithium carbonate, valproate, carbamazepine, topiramate).
- d) Opiate antagonists (naltrexone).
- e) Alpha antagonists (clonidine, guanfacine).
- f) SSRI's (selective serotonin re-uptake inhibitors) such as fluoxetine and NSRI's (norepinephrine and serotonin re-uptake inhibitors) such as nefazadone and venlafaxine.

SSRI's (selective serotonin reuptake inhibitors) have proven to be effective in reducing impulsive self-injury by assisting in reducing impulsive and obsessive behaviour which characterises SIB, however it is important to use the medication in conjunction with therapy (Grossman & Siever, 2001:141; Strong, 2006:163). Walsh (2008:211) mentions that although SSRI's have proven their effectiveness in treating adult impulsive SIB, there is some debate over their efficacy in children and adolescents. Clearly this is an area where more research is required, particularly when medication is used in children and adolescents.

2.12 THE PARADOX OF SIB

SIB has been compared to being stuck in an unhappy relationship – something the person can't live with or without – but at the same time it is a way to keep an individual from committing suicide (Conterio & Lader, 1998:29; Farber, 2000:42). Milia (2000:74) states that SIB can be seen as a symbolic attempt to be separate from others, a way of creating distance between the self and others whilst simultaneously maintaining a connection (abused and abusers).

There is an ambivalence in SIB – a cry for help whilst simultaneously pushing others away (don't try and stop me) – which makes treatment difficult, there must be a balance between support and limit setting (Plante, 2007:67). Paradoxically SIB is a violent behaviour which actually works in calming the person engaging in it (Grey in Cerdorian, 2005:45).

2.13 THE ROLE OF COMMUNITY SUPPORT WORKERS

The CSW's who participated in this study work on a one-to-one ratio with clients who are in out-of-home care settings for a variety of reasons (refer to 1.1) including challenging behaviours such as SIB. They are employed on casual, part time or full time basis by various charitable organisations. In order to normalise life as much as possible for the clients in out-of-home care units (particularly children and adolescents) there is an attempt to duplicate a "normal family" environment as much as possible. Mealtimes are spent with clients and CSW's eating together. The CSW's are responsible for all household duties and ensuring that the clients participate in household chores and for the community support involvement of their clients (educational and social).

The CSW's role is similar to that of the role of "parents" in a household, however given the challenging nature of the work, the CSW's work in shifts which means that there are a "number of parents" who work shifts. NSW Industrial Relations (2010) states that CSW's are required to have the ability to work effectively in a team and CSW's need to work together as a team in order to ensure that their client's needs are met effectively. Each team of CSW's has a Team Leader whose job it is to provide supervision and ensure that the unit runs in an optimal manner. Given the nature of the work that the CSW's are involved in (working with adolescents who are in care due to challenging behaviours, not limited to SIB) the importance of a strong team is vital.

CSW's work with SIB clients on a daily basis and depending on the type of SIB the CSW's may encounter this behaviour on a daily or infrequent basis. White and Schultz (2000:1574) and Matson *et al.* (2008:142, 145) describe SIB as a testing behaviour for people who care for these individuals, causing physical and emotional stress on a professional and/or personal basis; SIB may result in a drain on staff and financial resources in community locations, requiring one-to-one staff to patient ratios and adapted environments. SIB often results in individuals being placed in alternative housing (Mace & Mauk, 1995:104) where staff members such as CSW's have to deal with SIB.

2.14 SUMMARY

Self-injurious behaviour appears to be an adaptive response to life stressors and is utilised as a coping mechanism by individuals of varying social functioning. It most often begins in adolescence – a developmental period characterised by multiple changes and stress. SIB is a paradoxical call for help which is usually used to avoid resorting to the more extreme form of self-harm – suicide.

Whilst SIB has historically been dismissed as a symptom of borderline personality disorder, psychoses, severe trauma or developmental disorder, it has recently begun to appear in socially functioning “healthy” adolescents as a coping behaviour. Reasons for this new trend include increased peer pressure, contagion and social pressure.

For therapists treating SIB, their initial and continued reaction to SIB is vital to the success of the therapy. A therapist must be able to stay calm, show compassion and be prepared for a long term commitment with the patient. To date, Dialectical Behavioural Therapy has proven to be most effective in treating SIB – a cognitive behavioural therapy which teaches new coping skills to replace the self-injury. Each patient/client needs to be assessed holistically and individually, with no pre-assumptions made on behalf of the people who work with them.

Increasing international statistics of SIB in adolescence indicate that this is a behaviour which demands attention. People who work with SIB need to be educated in the reasons why these clients engage in SIB and what this behaviour means to that individual in order to deal effectively with them. Regular supervision and/or debriefing are recommended for staff dealing with SIB.

Further research into non-clinical populations and in particular focusing on males is indicated.

CHAPTER 3

RESEARCH RESULTS: PRESENTATION OF FINDINGS

3.1 INTRODUCTION

This chapter focuses on the findings of the research study obtained through the use of semi-structured interviews held with Community Support Workers (CSW's) working with adolescent SIB.

As was mentioned in 1.1 and 2.9 self-injurious behaviour is a challenging behaviour to work with (White & Schultz, 2000:1574; Matson *et al.*, 2008:142, 145) and the researcher therefore wanted to explore the needs of CSW's working in the field of SIB amongst adolescents.

3.2 THE RESEARCH FINDINGS

Data was collected in the form of notes taken by the researcher during the course of the semi-structured interviews which occurred on a one-to-one basis with participants. At the end of each interview with participants, the researcher read back key points that the participant had discussed in order to confirm that the information recorded was accurate according to the participant. This also allowed the participant to add any more salient information/clear up any misconceptions in the data collected.

According to Dawson (2007:02) there are four possible methods of recording data during interviews and each has advantages and disadvantages – audio recording, visual recording, note-taking and box-ticking (refer to 1.6.5).

The researcher chose note-taking due the fact that this method did not rely on recording equipment, which can at times fail, and also to put the participants at as much ease as possible (Blaxter *et al.*, 2001:173, Berg & Latin, 2008:253).

The disadvantages of this method include the fact that eye contact could not be maintained at all times and a limited amount of verbatim quotes were taken down. The researcher transcribed all notes more fully soon after each interview in order to ensure that as much as possible of the information obtained was recorded. After completing the chapter on the research results, the chapter was given to respondents to read through and make any corrections or comments with regards to the accuracy of the quotes and on the interpretation of the researcher.

3.2.1 The participants

The sample consisted of nine participants in total, of which three were female and six male. The age of the participants varied from 20 years to 60 years of age and the length of time that the participants had been working as CSW's at the time of this research, varied from 4 months to 5 years.

Qualifications of participants also varied considerably, completed studies ranged from year 10 of High School to tertiary qualifications. Three of the participants had each completed a national qualification namely a Certificate III (Disabilities, Auslan and Aged Care respectively) and three of the participants were currently studying towards a university degree (Nursing; Occupational Therapy and Counselling).

With regards to further study in any area, the participants varied in their intent to continue their education. Four participants indicated that they have intentions to further their studies (Bachelor of Arts degree, Certificate IV Disabilities; Masters Degree in Nursing; Masters Degree in Paediatrics); two indicated that they would be open to future learning provided to them and three of the participants indicated that they have no intentions of studying further in any field at this stage.

Five of the participants worked with stereotypic SIB and the remaining four worked with impulsive SIB.

The types and frequency of SIB encountered by the CSW'S who took part in this study are summarised in table 3.1:

<i>Stereotypic SIB</i>	<i>Impulsive SIB</i>
Encountered on a daily basis	Encountered infrequently (very few incidences of SIB to many incidences of SIB)
Types: Head banging Scratching Hand biting Self-hitting Falling on the ground	Types: Wrist cutting/slashing Insertion of objects into skin (blocks, pens) Self-biting (lip) Hanging Wound picking Punching walls Burning self Threats to stab themselves

TABLE 3.1: FREQUENCY AND TYPES OF SIB ENCOUNTERED BY RESPONDENTS

3.2.2 Empirical findings

According to Patton (in De Vos, 2005b:333) qualitative research analysis involves converting the data obtained from the study into findings by analysing the data, searching for themes and relationships which arise.

The researcher identified two main themes from the data collected by the study. These two themes were then further subdivided into sub-themes and categories which are represented in table 3.2 and table 3.3 respectively.

<u>MAIN THEME 1</u>	<u>SUB THEMES</u>	<u>CATEGORIES</u>
PARTICIPANTS EXPRESSED A NEED FOR SUPPORT	<ul style="list-style-type: none"> • <u>Team support</u> 	<ul style="list-style-type: none"> ✓ Client discussion ✓ Full client background before dealing with the adolescent ✓ Confident staff

	<ul style="list-style-type: none"> • <u>Physical support</u> 	<ul style="list-style-type: none"> ✓ Formal and informal counselling for staff ✓ When adolescents hurt participants in process of harming themselves
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TABLE 3.2: MAIN THEME 1 – PARTICIPANTS EXPRESSED A NEED FOR SUPPORT

3.3 MAIN THEME 1: PARTICIPANTS EXPRESSED A NEED FOR SUPPORT

The researcher coded information under the main theme of participants’ need for support, utilising the definition of support as encouragement and assistance (Wehmeier, 2005, u.w. ‘support’). According to the information obtained from participants during the interviews this theme of support was further subdivided into the sub-themes of Team support and Physical support.

3.3.1 Team support

As was indicated in 2.13, CSW’s need to work together as a team in order to ensure that their client’s needs are met. From the empirical data a consistent need among respondents with regards to team input was identified and all but two of the respondents mentioned the importance of team input into the planning and care of their clients. With regards to team support the following categories namely client discussion, full client background, confident staff and formal and informal counselling for staff were identified and will be subsequently discussed.

3.3.1.1 Client discussion

It is required from the CSW’s to have the ability to recognise any areas in which the team may be further advanced and to advocate for changes which can lead to improvement in their daily work (NSW Industrial Relations, 2010). Four of the nine respondents mentioned the importance of the team being involved in devising and

reviewing behaviour plans. These plans are drawn up by a clinician on each client in care and are reviewed according to their effectiveness.

The participants indicated that although they are currently involved in drawing up these plans, they would like more involvement. One participant stated that they "... would like more team input where we get around a table and discuss [the plans] as a team. We should be more involved in what they are doing, not just a clinician who comes in briefly."

Clinicians are external professionals (psychologists) who come in during certain team meetings and draw up behavioural plans and interventions for each client in care. The participants, who are involved in the day to day care of the clients, and consequently know them quite well, in other words would like to be given the opportunity to have more input into the development of these plans.

Another suggestion by participants was that the plans needed to be reviewed and discussed on a more regular basis. A participant working with impulsive SIB stated that, "They [the clients] change and we need to add to it [behavioural plans] on an ongoing basis. They [plans] should be assessed once a month in team meetings and discussed. They [the clients] keep coming up with new ways to test boundaries."

Individuals who engage in SIB often have problems with attachment and trust and the SIB may serve to fill the space of this lack of interpersonal closeness (Levenkron, 2006:94). SIB may also occur because an individual may unconsciously feel that getting negative attention from hurting oneself is better than getting no attention at all, in other words as an attention seeking behaviour (Levenkron, 2006:112).

Adolescence on the other hand is a developmental stage in which there is an urge for autonomy and conflict may result from this independence seeking which in turn may result in adolescents engaging in rebellious behaviour. The skin is a type of boundary and a history of trauma (where physical boundaries have been violated) together with an urge for independence may lead to acts of SIB (Conterio & Lader, 1998:100-101).

CSW's care for clients who are in out-of-home care due to a variety of circumstances (may be due to a history of abuse or challenging behaviours) and given this fact, the clients are likely to have problems with attachment and boundaries. Adolescents for instance who may not have appropriate coping skills to deal with anxiety and conflict may therefore use SIB to either gain attention, push someone away or draw boundaries (Carr & Smith, 1995:94; Milia, 2000:71; Strong, 2006:66). This developmental phase may cause adolescent clients to display various forms of boundary testing behaviours and CSW's would like plans to be updated on a more regular basis in order to keep up with these changes.

3.3.1.2 Full client background

Having an awareness and knowledge of a client's behaviour is an important part of working as a CSW. Each client is unique and CSW's need to know what the needs of each client are and how to meet these needs (NSW Industrial Relations, 2010). One participant mentioned that although the behavioural plans and files meet some of these needs, not all files are complete and "... knowing a client's full background before coming to the house would be helpful to us."

Given that SIB has a strong link to childhood trauma (Van der Kolk & Fishler, 1994:146), knowing as much as possible of the client's history would be beneficial to people working with these clients. A participant working with impulsive SIB mentioned that:

... the [background] files are important, it is important to know what the danger signs are, sometimes there is no antecedent behaviour and it may not always be obvious as to the reason why [the SIB occurs] ... with triggers we are trying to look for patterns developing such as times of day, things that happened before.

CSW's would like the background files to be more complete, to contain a fuller history of the clients in care, which would assist them in having a clear picture of the possible triggers and reasons for the SIB. The clients have often passed through various organisations and the information gathered at each organisation is not

necessarily passed on with them. Having someone within the company take on the task of tracking down as much of this historical information as possible from varied sources (schools, parents, medical practitioners and government agencies) on each client would be useful to CSW's and anyone who cares for these clients.

3.3.1.3 Confident staff

According to Wehmeier (2005, u.w. 'confident') "confident" is defined as a feeling that one has when one is sure about one's ability to do something successfully. CSW's work with clients who have multiple needs and they need to be able to understand and meet these needs whilst keeping the clients' best interests and safety first and foremost (NSW Industrial Relations, 2010).

A participant working with impulsive SIB mentioned that "... having one person who is confident ..." in handling challenging behaviour with on duty is important in terms of preventing SIB. The participant was referring to both threats of and actual instances of impulsive SIB and the benefit of having a confident staff member as someone who knows what to say and how to react appropriately in such instances. In other words having a team staffed by CSW's who not only know the clients, but are also trained and confident in handling and preventing instances of SIB is a good way to meet the best needs of clients.

3.3.1.4 Formal and informal counselling for staff

Formal counselling in this context refers to counselling provided on a one-to-one basis by a professional psychologist in private at the premises of the psychologist. Informal counselling in this instance refers to counselling provided by a person at a managerial level from within the organisation, on a one-to-one or group basis at the place of work. Supervision, where guidance and feedback is given with regards to an employee's work, is provided by the team leader of each team of CSW's and should occur on a regular basis with people dealing with SIB.

In light of the fact and given that this has been mentioned before (refer to 2.10) SIB is a challenging behaviour to work with and may result in physical or emotional stress

for the people working in this field. Regular supervision and/or debriefing therefore are important when working with SIB (Reeves *et al.*, 2004:243; Wedge, 2009:24). One participant indicated that the idea of formal counselling, offered by qualified psychologists, would be beneficial to individuals in teams which were not cohesive. However in a strong cohesive team, the participant made the suggestion that informal counselling with a manager within the company who has knowledge of the clients would be desirable.

3.3.2 Physical support

From the empirical data it was evident that the participants have a need for physical support when working with adolescent SIB. A lower than average IQ or mental retardation is linked to school failure and an increased risk of delinquent behaviour which is defined as impulsive behaviour (refer to 3.4.1.3) which may result in property destruction and violence towards others (Berk, 2000:331). Stereotypic SIB is commonly associated with challenging behaviours such as violence towards others and property damage (Matson *et al.*, 2008:141). Conduct problems such as aggression may arise in adolescence due to a complex interplay combination of factors including temperament, cognitive deficits, Attention Deficit Hyperactivity Disorder (ADHD) together with ineffectual parenting, peer rejection and deviant peer influence (Berk, 2000:513). Autism is related to both SIB (refer to 1.1) and aggressive behaviour towards others (Osterling, Dawson & McPartland, 2001:442). Some of the adolescent clients in care are there due to their challenging behaviours (SIB, property destruction and aggression towards others) and consequently CSW's experience overt aggression from their clients. The following need for physical support has been identified and will therefore subsequently be discussed.

3.3.2.1 Physical support when adolescents hurt participants in the process of hurting themselves

The need for physical support was brought up by two female participants working with stereotypic SIB. One participant suggested that it would be beneficial to have someone to physically support them when clients became aggressive towards CSW's in the process of self-injuring. Another participant mentioned the importance for them

of having a variety of different types of support at times when a client was physically aggressive (towards self and others). In this regard the participant mentioned the following: “I need to know that there will always be a support. Knowing that there is a lock on the door, a person to turn to, for my safety and mental support.”

From these findings it appears to the researcher that female CSW’s have a need for physical support and assurance of support when dealing with aggression from clients. Allowing the female staff members to have physical support by structuring the daily routines in such a way to ensure that they are not left alone with a client, but instead that there will be the necessary back-up of another team member on hand should they require it. It seems as if these aspects would be beneficial to the safety of female CSW’s.

3.4 MAIN THEME 2: PARTICIPANTS EXPRESSED A NEED FOR EDUCATION AND/OR TRAINING

<u>MAIN THEME 2</u>	<u>SUB-THEMES</u>	<u>CATEGORIES</u>
<p>PARTICIPANTS EXPRESSED A NEED FOR EDUCATION AND/TRAINING</p>	<ul style="list-style-type: none"> • <u>General education</u> • <u>Appropriate skills to deal with SIB</u> 	<ul style="list-style-type: none"> ✓ Specific knowledge with regards to SIB ✓ Autism and SIB ✓ Developmental conditions ✓ Current, up-to-date knowledge and research on SIB ✓ Basic Counselling skills ✓ How to deal with SIB in a developmentally appropriate manner

	<ul style="list-style-type: none"> • <u>The use of different strategies</u> 	✓ Appropriate proactive and reactive interventions to prevent and deal with SIB
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TABLE 3.3: MAIN THEME 2 – PARTICIPANTS EXPRESSED A NEED FOR EDUCATION AND/OR TRAINING

One area which appeared to generate a large amount of input from most of the participants was the topic of education/training. “Education” is defined as a process in which knowledge and skills are acquired (Wehmeier, 2005: u.w. ‘education’). The majority of participants discussed areas in which they would like further education/training. From the data collected the researcher divided this theme into three sub themes: general education; appropriate skills to deal with SIB and the use of different strategies.

3.4.1 General education

In order to work successfully with SIB, Taylor (2003:90) suggests that all staff dealing with SIB undergo specialised training relating to SIB. Knowing why individuals use SIB and what functions it may serve for the person may assist people to deal more effectively with this difficult behaviour (Deiter *et al.*, 2000:1174; Kress, 2003:490). From this sub-theme the researcher identified the following categories in which participants would like to receive more training.

3.4.1.1 Specific knowledge with regards to SIB

In light of the fact that the participants who work in the field of SIB expressed a need for further training in SIB the researcher probed them during the course of the interviews on their knowledge and understanding of why their clients engaged in SIB. The answers generally varied according to the type of SIB which the participants were working with (stereotypic versus impulsive) and are listed in table 3.4.

Reasons for adolescents engaging in SIB

- coping mechanism (*impulsive & stereotypic SIB*)
- way to get their needs met (*stereotypic SIB*)
- to express emotions (*stereotypic SIB*)
- to get attention (*stereotypic & impulsive SIB*)
- type of ‘tic’ (*stereotypic SIB*)
- communication most common reason (*stereotypic SIB*)
- for the sensation, to get a high (*stereotypic SIB*)
- mental illness (*impulsive & stereotypic SIB*)
- control issue – way of controlling the amount of pain they feel (*impulsive SIB*)
- a cry for help (*stereotypic & impulsive SIB*)
- use physical pain to block out mental pain (*impulsive SIB*)
- family abuse history – SIB distracts them from their emotional pain (*impulsive SIB*)

TABLE 3.4: PARTICIPANTS’ UNDERSTANDING OF WHY ADOLESCENTS ENGAGE IN SIB

According to Cerdorian (2005:45) reasons that individuals engage in SIB are usually complex and include a history of abuse, loss, peer conflict or intimacy issues and can be used as an attention seeking behaviour or a form of self-punishment. SIB is a way of communicating especially when it is difficult for a person to communicate appropriately, for example a person who is non-verbal (Kruger, 2003:17).

Walsh (2008:57-69) discusses that the reasons an individual engages in SIB can be explained by means of a multi-dimensional model, where many factors may be involved and are mutually influencing and is summarised as follows:

Dimension	Possible factors involved/causes
Biological dimension:	- possible deficiencies in limbic system of the brain (regulates emotion)

	<ul style="list-style-type: none"> - serotonin level dysfunction; decreased levels of serotonin linked to impulsive aggression and SIB - inherited weakness with regards to emotional regulation - pain results in an opiate release in the brain which provides relief from distress - diminished pain sensitivity in some people who self-injure
Cognitive dimension:	<ul style="list-style-type: none"> - negative thoughts about oneself and coping - flashbacks/thoughts of trauma
Emotional dimension:	<ul style="list-style-type: none"> - negative emotions such as self-blame, depression, anxiety - intense emotions - trauma-related emotions and/or dissociation
Environmental dimension:	<ul style="list-style-type: none"> - family influences - trauma - stress
Behavioural dimension:	<ul style="list-style-type: none"> - in order to get a response and/or communicate - to control the body - cleansing function - unable to verbalise - connect body and mind - pain relief - revenge - rescue fantasy

TABLE 3.5: MULTIDIMENSIONAL MODEL OF REASONS FOR SIB

Participants who worked with stereotypic SIB (non-verbal clients) mentioned the fact that SIB is used as a form of communication, to get a sensation, as a type of “tic” to express emotions such as frustration and as a way to get their needs met. The participants who worked with impulsive SIB identified that SIB is used by their clients due to an abusive background to block out mental pain and to feel in control. Participants from both groups identified that SIB was used by their clients as a means of coping, to get attention, due to mental illness and as a cry for help.

Based on the reasons that the participants mentioned and the literature on the reasons why SIB is utilised by individuals, the participants appear to have a fairly good general understanding of why their clients engage in SIB. However the participants still feel that they would benefit from further education in SIB. Participants for instance made suggestions of training that they thought would be beneficial to all CSW’s working with SIB. Suggestions included *what SIB is, the types of SIB, links to other disorders, reasons/intentions for SIB* and *known triggers for SIB*. One participant made the comment that there is a general lack of knowledge about SIB, particularly in the *different forms* that SIB may present itself.

One participant was of the opinion that “... you can’t help something you don’t understand” and was therefore of the opinion that training should provide an understanding of why clients engage in SIB. Another participant agreed by stating that, “To get more understanding, it will help. It will help make my life and theirs [the clients’] life easier. With that information we are more prepared.” This participant was of the opinion that by being educated the CSW’s would feel better equipped to deal with SIB as a challenging behaviour.

One participant informed the researcher that they regularly completed training on a monthly basis and in their own time on various *mental health topics* in order to keep themselves up-to-date. This participant however was of the opinion that “... the more training they offer the better”. The same participant further commented on the fact that training may assist in retention of staff as “... half of the staff are untrained.

When I started I was thrown in the deep end, that's why there is a high rotation of staff.”

One participant went on to express the general frustration with the training provided by commenting that, “On training days there is so much more that they could be teaching us.” Suggestions of topics in which the participant had received training during tertiary studies and which had proven useful in dealing with SIB included *developmental conditions, brain injury, developmentally and age appropriate handling, instinctive reflexes, sensory seeking and avoidance, various diagnoses relevant to the clients and presentations of disorders*. The participant felt that these topics would be useful for all CSW's.

From the above mentioned comments it is clear that participants feel that more training/education on SIB would equip them to work more effectively with their clients. It must be noted that there was one participant who participated in the study that could not identify any needs regarding SIB specifically and expressed contentment with the training they were receiving at the time. This participant however indicated that there was a lot more to learn about SIB and was also willing to undergo more training in any area that was provided.

3.4.1.2 Autism and SIB

Autism is linked to stereotypical SIB (refer to 2.4) and the reasons that autistic clients engage in SIB are thought to manage stimulation levels or to escape distressing situations (Kress, 2003:493; Strong, 2006:27). Types of SIB which are common in autism include hand-biting, self-scratching, head banging, self-hitting, self-pinching and hair pulling (Simeon & Favazza, 2001:8). Five of the participants who took part in this study worked with autistic clients (stereotypic SIB). The link between stereotypic SIB and developmental disorders such as autism were mentioned as an important topic in which further training was required by three of the participants. In order to equip participants with understanding and to deal with these behaviours effectively, the researcher would suggest that training on the various forms of SIB and on the topic of autism and the link between the two would be beneficial to all CSW's dealing with these clients.

3.4.1.3 Developmental conditions

The link between SIB and other organic mental disorders (besides autism) was identified by some participants as being an important topic for further education. These disorders include Cornelia de Lange syndrome, Lesch-Nyhan syndrome, Tourette's and mental retardation (Wehmeyer, 2006:14). Cornelia de Lange syndrome is characterised by severe mental retardation and about 50% of individuals with this disorder engage in SIB such as lip biting, self-scratching and slapping (Simeon & Favazza, 2001:7). Lesch-Nyhan syndrome is a genetic disorder which occurs in males and is characterised by severe mental retardation, aggression and SIB such as head banging, chewing of lips and fingers (Reber, 1995, u.w. 'Lesch-Nyhan syndrome'; Simeon & Favazza, 2001:7).

According to MaClean, Miller and Bartsch (2001:542) mental retardation is a developmental disability which causes an individual to have problems with adapting to the demands of society. The criteria for a diagnosis of mental retardation are 1) a significantly lower than average intelligence quotient (IQ); 2) problems with adaptive functioning and 3) it occurs prior to the age of 18 years. Behavioural problems, such as aggression may occur in individuals with mental retardation (MaClean *et al.*, 2001:549). Prader-Willi syndrome, one cause of mental retardation, is associated with behavioural problems including skin picking and hair pulling (MacLean *et al.*, 2001:554; Simeon & Favazza, 2001:7).

Tourette's disorder (TD) is characterised by the presence of both motor and vocal tics (echolalia, obscenities, noises) which occur several times on a daily basis (Matthews, Matthews & Leibowitz, 2001:342-343). According to Eisenhauser and Woody (in Matthews *et al.*, 2001:342) other symptoms of TD include periodic self-mutilation or aggressive behaviour.

Clients with these disorders present with challenging behaviours (including SIB) and may go into residential care because of this. Because CSW's work in residential care units they have a strong possibility of encountering clients during their career with these disorders. The researcher feels that training in the presentation, aetiology and

appropriate interventions with regards to these disorders would be of benefit to anyone who has to work with them on a daily basis.

3.4.1.4 Current up-to-date knowledge and research on SIB

During the course of this research study the researcher discovered a large amount of literature on the subject of SIB in the form of published works, internet websites, journal articles and popular media. This is a topic which appears to be generating a large amount of interest amongst health care professionals. The researcher found articles and research on SIB in a variety of disciplines, psychology, medicine and education. This is not surprising as adolescents who engage in SIB may come into contact with some or all of these disciplines.

The participants indicated that having access to current and up-to-date knowledge and research on SIB would be important. An idea of a way to keep staff up to date would be to enlist someone specifically or for staff to take turns looking up and presenting new information and research on SIB and related topics at team meetings. This information could then be discussed within the team.

Publishing journal articles/synopsis of findings in the company newsletter could further add to the education of staff on the latest findings and research on this topic. As frontline staff, dealing with SIB, having a good knowledge of SIB and what works and what doesn't can only add to the positive handling of this difficult behaviour.

3.4.2 Appropriate skills to deal with SIB

If SIB is handled incorrectly the behaviour may become more entrenched rather than improve (Farber, 2000:319). In light of this it is therefore important that CSW's are equipped to handle this challenging behaviour as effectively as possible in order to look after the clients' best interests. Empirical findings from the study supported this need for appropriate development of skills to deal with SIB. The researcher divided this sub-theme into two categories namely basic counselling skills and how to deal with SIB in a developmentally appropriate manner.

3.4.2.1 Basic counselling skills

According to Wehmeier (2005, u.w. 'counsel') the definition of the word "counsel" is to listen and provide support to someone who needs help. Reber (1995, u.w. 'counselling') defines "counselling" as the process of advising/questioning/guiding individuals with problems. Findings from the study indicated that the participants working with impulsive SIB would like training on how to effectively listen and respond to a client who engages in the threat of and/or after SIB.

Given that CSW's are with clients on a daily basis and are often the ones who the adolescent comes to talk to about urges to self-injure, having training in listening skills and skills on how to provide support is important. One participant commented on the importance of developing a good relationship/rapport with the clients for success and commented that, "A helpful strategy that I learnt [from tertiary studies] is to remind clients that you want them to succeed [in life]." Another participant emphasised the importance of having good counselling skills in order to "... develop a working relationship with their clients, showing empathy, they know that they can come and talk to us first."

As can be seen from the literature in chapter two (refer to 2.10), dealing appropriately with SIB is of vital importance in assisting people with this behaviour. People who work with SIB are more equipped to assist individuals when they understand why these individuals engage in this behaviour (Deiter *et al.*, 2000:1174; Kress, 2003:490) and successful handling involves a calm approach and reaction (Plante, 2007:65). A too negative or too positive response to SIB may result in the behaviour being inadvertently reinforced (Taylor, 2003:90).

CSW's work on a frontline basis with SIB and therefore there is a need for CSW's to be able to listen and respond appropriately to this behaviour. Morgan (2006:233) discusses the fact that counselling access for disabled clients in residential care settings are limited and staff working with clients who have communicative difficulties should preferably have specialised training in counselling skills. Basic counselling skills which involve effective listening and responding to individuals in

distress should, according to the findings of the study and the opinion of the researcher, be included in the training programme of all CSW's.

3.4.2.2 How to deal with SIB in a developmentally appropriate manner

The participants in this study all work with adolescents and participants indicated that having skills to specifically deal with adolescent SIB would be advantageous. Training on the changes that occur during adolescence (physical, emotional, intellectual and social) and how to respond most effectively to clients at this developmental stage would assist participants to respond effectively. A participant commented that with regards to further training possible topics might include "... developmental conditions, brain injury, be relevant to clients' disorders, age and developmentally appropriate handling." Most impulsive SIB begins in adolescence (refer to 2.8) and given the fact that adolescence is a period which is fraught with changes, having a thorough understanding of this important developmental stage is important for all people working with adolescents.

3.4.3 The use of different strategies

The sub-theme of having more than one strategy available to deal with SIB was another area in which participants felt that they could benefit from. According to Wehmeier (2005, u.w. "strategy") a "strategy" can be defined as "... a plan that is intended to achieve a particular purpose."

A suggestion from a participant was meeting up with other teams of CSW's who work with SIB in order to discuss various strategies that they have tried which had been successful and would provide an opportunity "... to bounce off ideas with each other ... as little things can make a big difference." The participant is referring to tried successful strategies/ways of preventing and reacting to SIB which can be shared amongst various teams. The "little things" can be ways of responding or what is said during times of actual or threatened SIB which have proven useful in the past with various CSW's.

From personal experience the researcher is aware of the fact that CSW's are provided with training on how to deal with physical aggression from the clients directed at workers, utilising techniques which prevent physical harm to themselves and clients. One participant commented on the fact that although this training was helpful in protecting staff, it did nothing to stop the self-injury that was occurring at the same time. Findings from this study indicate that training on how to prevent clients hurting themselves would be useful.

Participants mentioned that they would like to have more of both proactive and reactive strategies/interventions to deal with SIB among their clients. In this regard a participant mentioned that "[The behavioural plans] are good as a guide, but you need to be able to think outside the box. You really have to come up to a situation and learn to respond to them in your own way. They need to give us more options in plans." Participants indicated the need for more proactive strategies, in order to prevent the behaviour from occurring in the first place and more reactive strategies "... in order to know how to react appropriately" after the behaviour has occurred.

3.5 SUMMARY

This chapter outlined the research findings and presented these findings in the form of themes, sub-themes and categories. Nine participants voluntarily participated in a one-on-one semi-structured interview with the researcher.

The next chapter will include a discussion of the results with regards to the research question, limitations and problems encountered by the researcher and suggestions for possible future research.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The results of this empirical study were presented in chapter three which identified needs amongst Community Support Worker's who work with SIB. This chapter revisits the goal and objectives of the study, advises on the limitations which may have had an influence on the outcome of the study and makes recommendations to employers/trainers about areas in which CSW's have needs. This chapter concludes with recommendations made by the researcher regarding areas of future research in the field of SIB and CSW's.

4.2 GOAL OF THE RESEARCH STUDY

The goal of this research was to conduct semi-structured interviews in order to explore the needs of CSW's working in the field of SIB amongst adolescents. In order to meet this goal the researcher began the study by conducting a comprehensive literature review on the subject of SIB in adolescence. From this literature review the researcher undertook a conceptual framework for the study and formulated a self-developed semi-structured interview schedule (see Appendix B).

The researcher obtained permission to conduct the research and began the sampling process. Nine participants participated in one-on-one interviews with the researcher in order to explore their needs (if any) regarding their work with adolescent SIB. The results of the interviews were then transcribed, analysed and sorted into themes, sub-themes and categories by the researcher. These themes, sub-themes and categories were discussed in chapter three.

4.3 OBJECTIVES OF THE RESEARCH STUDY

The researcher identified three main objectives in order to carry out this research study:

- To undertake a conceptual framework on self-injury amongst adolescents including the aetiology, prevalence, types, link to childhood disorders and on the responsibilities of CSW's.

The researcher began the research process by conducting a comprehensive literature study. This involved collecting information on the topic of adolescent SIB from journal articles, published academic books, autobiographical books, popular media and computer based materials (labour and mental health websites, specialist treatment centres, e-books). This information was used to undertake a conceptual framework on which the study was based and which was presented in chapter 2.

- To undertake an empirical research study through the use of a semi-structured interview schedule in order to explore the needs of CSW's.

A semi-structured interview schedule was developed by the researcher with a focus on exploring the needs of CSW's working in the field of SIB amongst adolescents. CSW's who worked with adolescents who engaged in SIB (impulsive and stereotypical) took part in one-on-one interviews with the researcher on voluntary basis. The data was collected by means of hand-written notes taken during the interviews.

- To analyse and describe the data in order to make conclusions and recommendations to employers (who employ CSW's) and to organisations who provide training and support to CSW's according to the findings.

The notes taken by the researcher were analysed by means of Creswell's spiral of analysis (refer to 1.6.6) as follows:

- 1) The data was organised by being transcribed by the researcher after each interview and the interview schedules coded in order to protect the anonymity of the respondents.

- 2) The interview schedules were then read through several times by the researcher in order to gain an overall interpretation of the findings.
- 3) The researcher identified themes, sub-themes and categories (refer to Table 4.1).
- 4) The last step involved integrating and summarising the data which was presented in chapter three.

<u>MAIN THEMES</u>	<u>SUB-THEMES</u>	<u>CATEGORIES</u>
1. PARTICIPANTS EXPRESSED A NEED FOR SUPPORT	<ul style="list-style-type: none"> • <u>Team support</u> • <u>Physical support</u> 	<ul style="list-style-type: none"> ✓ Client discussion ✓ Full client background before dealing with the adolescent ✓ Confident staff ✓ Formal and informal counselling for staff ✓ When adolescents hurt participants in process of harming themselves
2. PARTICIPANTS EXPRESSED A NEED FOR EDUCATION AND TRAINING	<ul style="list-style-type: none"> • <u>General Education</u> 	<ul style="list-style-type: none"> ✓ Specific knowledge with regards to SIB ✓ Autism and SIB ✓ Developmental conditions ✓ Current, up-to-date knowledge and research on SIB

	<ul style="list-style-type: none"> • <u>Appropriate skills to deal with SIB</u> • <u>The use of different strategies</u> 	<ul style="list-style-type: none"> ✓ Basic counselling skills ✓ How to deal with SIB in a developmentally appropriate manner ✓ Appropriate proactive and reactive interventions to prevent and deal with SIB
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TABLE 4.1: IDENTIFIED THEMES, SUB-THEMES AND CATEGORIES

4.4 RESEARCH QUESTION

The research question for this explorative qualitative study was as follows:

What are the needs of Community Support Workers working in the field of SIB amongst adolescents?

From the above mentioned discussions it is clear that the research question has been answered. The needs which participants indicated were around the themes of support (physical and mental) and education and/or training.

The researcher therefore came to the following conclusions with regards to the specific needs of CSW's who work in the field of SIB amongst adolescents:

- With regards to support the participants identified a need for a strong, confident team of people who are trained in dealing with SIB.

- Female participants identified a need for physical support from other team members by structuring the roster so that there is always someone on hand to back them up physically if required.
- Having a holistic picture of each adolescent's background before dealing with them was considered to be important to the participants.
- The idea of counselling was also identified as a means of mental support, in the form of informal and formal counselling.
- Education and/or training were areas in which most participants indicated a need. The areas of general training/education specified by the participants included more information specifically on SIB (what it is, triggers, and reasons, current up-to-date research findings), developmental conditions (including autism) and mental health topics.
- Participants identified the importance of being educated on the various developmental stages, particularly that of the adolescent developmental stage.
- Training in appropriate skills in order to deal with SIB effectively was also identified by participants (basic counselling skills and appropriate handling) as well as effective proactive and reactive strategies which could be used to handle SIB.

4.5 LIMITATIONS AND PROBLEMS ENCOUNTERED

According to Willis (2007:210) research in the field of social science "... is a subjective activity, and the researcher should make the reader of a study aware of his or her biases." Limitations are defined as incidents or occurrences which may have an effect on the study (Berg & Latin, 2008:313).

The researcher identified the following problems and limitations to this study:

4.5.1 Literature study

The researcher encountered a large amount of literature on the subject matter with the amount of literature on this subject increasing in recent decades and the researcher had to sort through a large amount of literature from many sources (published and on-line) in order to find relevant information. A further problem with the literature study was the fact that so many varied terms are used to describe self-injury (self-mutilation, self-harm etc) and some research did not clearly distinguish between self-injury and attempted suicide. This problem occurred particularly with statistics in Australia, with data including both categories under one umbrella. These factors meant that the researcher spent a lot of time sifting and reading through a vast amount of literature.

4.5.2 Sampling

In this study the researcher made use of non-probability purposive sampling in order to obtain information from the targeted population and which has certain limitations. When using non-probability purposive sampling methods, the results according to Fife-Schaw (1998:111) and Strydom (2005b:202) are to be viewed with caution in that the subjective judgement of the researcher may have influenced the study. The fact that the researcher chose to use non-probability purposive sampling in this study also means that the results cannot be generalised back to the population without caution (Salkind, 2003:94).

4.5.3 Personal bias of the researcher/Hawthorne effect

According to Berg and Latin (2008:207) the Hawthorne effect is a threat to a study's internal validity. When participants are participating in a study and are aware that they are under scrutiny, then their behaviour is consequently influenced by this knowledge and this may have an effect on the results.

The researcher worked as a CSW with some of the participants who participated in this study (stereotypic SIB) and consequently knew some of the participants on a

professional basis prior to conducting the research. The researcher did work on remaining objective throughout the research process, particularly during interviews, however the fact that some participants were known to the researcher and all participants were aware that they were being studied, may have inadvertently caused some personal bias and/or effect on the results.

4.5.4 Selection bias

When a sample is selected in a non-random manner, as in non-probability purposive sampling, there is a chance that the research results may be influenced by selection bias. Selection bias can be explained by the fact that participants who did participate in the study were possibly more motivated in the subject area under scrutiny than those who did not choose to participate and this may have an affect on the results of a study (Berg & Latin, 2008:204). The participants who participated in this study did so on a voluntary basis and the results may therefore have been influenced by the fact that those who did take part were more motivated to identify needs than those who did not participate.

4.6 VALIDITY OF THE STUDY

Berg and Latin (2008:316) define validity as "... the extent to which an instrument measures what it is supposed to measure." Breakwell (1998:238-239) mentions that one way of ensuring that the data collected from interviews is as reliable and as valid as possible, is to control interviewer effects. One way to do this is for one interviewer to conduct all the interviews; in this study the same interviewer conducted all the interviews (namely the researcher).

The validity of a study is of vital importance to a qualitative study (Niewenhuis, 2007:113-115; Maree & Van der Westhuizen, 2007:38). The researcher took the following steps to ensure the validity of the study:

- Sources of data: In this study only CSW's were used as a data source and all the CSW's who participated met the criteria for inclusion.

- Data was verified: During the interview process the interviewer verified that what had been taken down by the researcher was accurate, by reading back a summary of the notes taken from each participant's answers at the end of each interview.
- The interview schedules were coded and analysed by only the researcher to protect the identity of the participants.
- Findings were verified: After the results were interpreted the relevant chapter was given to the participants to peruse and advise if there were any problems with the quotes used and/or the interpretation of the study.
- Avoidance of generalisation: Qualitative analysis results in data which cannot be generalised to the general population. The data from this study is only relevant to the population which was applicable to this study.
- The choice of quotations that were used in the research report was chosen with care and the researcher tried not to use them out of context.
- Anonymity and confidentiality: Interviews were coded by the researcher and neither the name of the organisation for which the participants work, nor the participant's names were mentioned in order to protect their anonymity and confidentiality.
- Limitations of the study were expressed by the researcher in 4.5.

Willis (2007:221) discusses a further way to increase the validity of a study, namely that of peer reviews. A peer review may involve other academics and gathers their opinions and suggestions as the research develops. The researcher was guided by a supervisor from Huguenot College throughout the research process and by the opinion of a clinical consultant (Ms E. Read) whilst formulating the interview schedule and research approach.

4.7 RECOMMENDATIONS

CSW's who participated in the study, indicated a need for more support and education and/or training. With the research results in mind the researcher makes the following recommendations to employers and trainers of CSW's:

- More training in the subject of SIB (aetiology, various presentations, links to other disorders, latest research) for all CSW's who deal with this behaviour;
- More training in general on mental health topics and childhood development;
- Training in basic counselling skills for all CSW's;
- Keep staff up to date with the latest research by enlisting someone to look up new information and research on SIB and related topics and present this information at team meetings or in a regular newsletter;
- Encouragement and support for CSW's to pursue tertiary studies such as a national qualification, for example a Disability Certificate IV;
- Training on how to deal with impulsive SIB, how to support clients who advise that they want to harm themselves and how to support clients after they have harmed themselves;
- Provide more proactive and reactive strategies, drawn up in consultation with CSW's;
- Training on how to handle stereotypical SIB and advice on which behaviours to stop and which to ignore;
- The behavioural plans are updated on a more regular basis and in consultation with the CSW's;

- Informal counselling made available in addition to the formal counselling offered;
- Keeping a ratio of one worker to one client where required and providing extra staff in cases where the clients require more attention with regards to more challenging behaviour towards self and others.

4.8 FUTURE RESEARCH

Based on the findings of this study the researcher is of the opinion that a larger study which covered a larger geographical sample would provide some valuable information for both employers and trainers of CSW's. Other areas for potential research which the researcher feels would add to this field are:

- A study into other needs that CSW's working with adolescents presenting with challenging behaviour (not limited to SIB) may have;
- An investigation into the idea of teaching clients presenting with impulsive SIB about their SIB in order to explore how this may be helpful in their recovery process;
- An investigation into the reasons that CSW's resign, collating information in order to identify any areas which could be improved in their opinion;
- Qualitative studies with the adolescents who present with SIB and who are in the care of CSW's in order to gather information as to what the adolescents feel CSW's need to know and what has helped or would be helpful to their SIB.

4.9 FINAL REMARK

This empirical study, although small, identified areas in which there are needs according to CSW's who work with adolescent SIB. The researcher is of the opinion

that these CSW's would be better equipped to support their clients if they are provided with more knowledge and understanding on the subject of SIB and adolescence and by having a more holistic view of their clients.

SIB has been recognised as a complex and challenging behaviour to work with and the more knowledge CSW's have regarding the aetiology and functions the SIB serves for their clients, the more these clients will benefit.

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APPENDIX A

CONSENT TO PARTICIPATE IN RESEARCH

A needs assessment of Community Support Workers working in the field of self-injurious behaviour amongst adolescents.

You are asked to participate in a research study conducted by Kim Millingham, Hons BA Psychology (Unisa), from the Child, Youth and Family Studies department at Huguenot College (and the University of South Africa). The results of this research will contribute to a dissertation required for completion of a Masters Degree in Play Therapy. You were selected as a possible participant in this study because you are a practicing Community Support Worker who works with adolescents who display self-injurious behaviour.

1. PURPOSE OF THE STUDY

Given the fact that (a) self-injurious behaviour (SIB) has been recognised as a challenging and difficult behaviour to work with and (b) Community Support Workers who work with self-injurious behaviour may not have any formal training in the field of SIB, the researcher wants to identify any needs that Community Support Workers may have with regards to working with self-injurious behaviour and make recommendations to employers and/or trainers accordingly.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to participate in an unstructured one-on-one interview relating to self-injurious behaviour in adolescents that you may have encountered in your work as a Community Support Worker. The interviewer will ask some questions on your experience of SIB and any needs you may have regarding this topic and you are encouraged to provide extra information/comments should you wish to do so.

You will be interviewed once only. The time required for the interview will be about 30 minutes.

3. POTENTIAL RISKS AND DISCOMFORTS

The researcher will work to ensure that your anonymity is maintained. Your answers will be recorded but your name will not be recorded in the research report. The researcher does not foresee any potential harm or distress caused to respondents.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The researcher hopes to identify if there are any needs amongst Community Support Workers involved in the daily care of adolescents who present with self-injurious behaviour. The potential benefit to you is that any needs which are identified by this research may be recognised and brought to the attention of the employers and/or trainers who employ Community Support Workers such as yourself.

5. PAYMENT FOR PARTICIPATION

No payment will be offered for your participation. Your participation will be voluntary.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of coding the interviews, no names will be recorded on the interview schedules and the data will be stored on a personal computer with limited access (access is limited to the researcher's fingerprint).

The results of the study will be published in a dissertation but no names of participants will be included.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be part of this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:

Kim Millingham (**Researcher**)

kmillingham@gmail.com

5 Lambeth Road, Schofields, NSW, Australia, 2762

Ms. Issie Jacobs (**Supervisor**)

ijacobs@hc.sun.ac.za

PO Box 16, Huguenot College, Wellington 7654, South Africa

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

I, the respondent, have read and understood that my participation in this research is voluntary.

Signature of respondent: _____

Date: _____

APPENDIX B

INTERVIEW SCHEDULE

What are the needs of Community Support Workers who are involved in the daily care of adolescents who present with self-injurious behaviour?

Demographics:

a) Sex: female male

b) Age:

c) Length of time working as a CSW:

d) Qualifications:

e) Current/future intended studies:

MAIN QUESTION:

What are your needs with regards to working in the field of caring for adolescents who display SIB?

PROBING QUESTIONS:

1) What do you know/understand about self-injurious behaviour in adolescents?

- 2) How much/what kind of SIB have you personally encountered working as a CSW?

- 3) What do you understand about the reasons that your clients engage in SIB?

- 4) In what way do the behaviour plans and guidance/training provided to you assist/do not assist you in handling SIB in your clients?

- 5) Are there any areas of knowledge and or support that you feel you would benefit from regarding your work with SIB? (emotional, educational, resources etc.)