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Factsheet: **Self Injurious Behaviour**

What is Self-injurious Behaviour?

Self-injurious behaviour (SIB) has been defined as:

"Any behaviour, initiated by the individual, which directly results in physical harm to that individual. Physical harm will be considered to include bruising, laceration, bleeding, bone fractures and breakages and other tissue damage" (Murphy and Wilson, 1985).

The following is a list of behaviours exhibited by people with learning disabilities and/or autism that may be regarded as self injurious:

- face-slapping/striking face and chest with knees
- Head slapping, rubbing or banging against surfaces
- Trichillotomania (pulling out your own hair)
- self-induced vomiting/vomiting and re-ingesting
- hand-biting
- eating inedible substances (pica), eating faeces (corprophagia)

Possible reasons

It is possible that self injurious behaviour occurs for some of the following reasons:

- Communication and interaction difficulties
- Over or under stimulation in ones environment
- Due to a sensory deficit disorder
- As a result of complex neurological damage
- Severe and profound learning disability
- As a result of a specific condition or syndrome such as Autism, Lesch Nyhan Syndrome, Prader Willi Syndrome
- Serotypies, which are repeated body movements
- Poor physical health or an undiagnosed health problem
- Poor emotional wellbeing
- Lack of personal control over one's life
- To gain tangibles or obtain attention
- To avoid social situations or avoid contact with others

- skin-picking/picking at wounds
- gouging of ears, mouth, nose, eyes, rectum and sexual organs
- kicking or hitting body parts against hard surfaces

Collacott (1998) suggested self- injurious behaviour was present in 17.4% of the population of adults with learning disabilities, and in 1.7% of that population the self-injurious behaviour occurred frequently and was severe.

Identifying the predisposing factor (function) or any underlying condition can assist in the support and management of the self injurious behaviour.

Wiseley et al (2002) identified that endogenous opioids produce a morphine-like effect and suggest that this may lead to the development of the self injurious behaviour.

There are two common hypotheses that have been suggested in relation to self injurious behaviour in the population of people who have learning disabilities:

- that self injurious behaviour stimulates the production of endogenous opioids, creating an analgesic effect on pain
- that self injurious behaviour produces pleasurable feelings and euphoria.

Guess and Carr (1991) describe a three-stage interpretation to describe the development and maintenance of self injurious behaviour:

Stage 1: A child with learning disability begins to display self-regulatory, communicative or coping behaviours such as rhythmic rocking, which are interpreted as an inevitable consequence of the learning disability
Stage 2: These behaviours begin to provide self-stimulatory arousal and become more intense

Stage 3: Finally, the behaviours become self-injurious resulting in stigmatisation, social isolation and negative labelling – all of which make self injurious behaviour more likely to become functional to the person.

Self injurious behaviour is extremely difficult to work with, for two main reasons:

- It is extremely resistant to change and behavioural change interventions
- It creates an emotional reaction to the behaviour in others which has an impact on their interactions with the person concerned.

Further to this Beail (2007) suggests that vicarious traumatisation can occur as a result of supporting people who exhibit self injurious behaviour:

‘Empathic engagement with self injuring or harming clients may involve being exposed to graphic descriptions or witnessing the act of harm in the here and now, over an extended period of time and across clients’

The Need for Support

It is important to consider how we support those who are exposed to self injurious behaviour as professionals, carers and family member.

We should identify:

- What support, de-briefing and counselling is available to people exposed to self injurious behaviour?
- Who is best placed to support the individual and their family?
- How often should intervention packages be reviewed?

In summary, self injurious behaviour is extremely difficult to understand and it presents many challenges to those of us who are supporting someone who presents such behaviour.

This is a short summary fact sheet; it is not a comprehensive guide to self injurious behaviour and is intended to give readers an overview of the topic. Further reading material is available through the BILD library service.

References

Beail N, *Staff Emotional Reactions to Service user Self Injury,* (2007), Changing Practice Reducing the Risk, BILD Conference 2007

Collacott R.A, Cooper S.A, Brandford D & McGrother C *Epidemiology of Self Injurious Behaviour in Adults with Learning Disabilities.* British Journal of learning Disabilities 173;428 -432(1998)

Guess D, Carr E (1991) *Emergence and maintenance of stereotype and self-injury.* American Journal of Mental Retardation 106 (2) 299-319.

Murphy G, Wilson B (1985): *Self-injurious Behaviour.* British Institute of Learning Disabilities, Kidderminster.

Wisely J, Hare D, Fernandez–Ford L (2002): *A study of the topography and nature of self–injurious behaviour in people with learning disabilities.* Journal of Learning Disabilities 6 (1) 61-71.

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