

**Residential Youth Care Workers' Perceptions
of Self-Harm and Interventions**

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**A thesis submitted to the Department of Child and Youth Study in partial
fulfillment of the requirements for the degree of Masters of Arts (Child and Youth
Study)**

April 2006

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Your file *Votre référence*
ISBN: 978-0-494-39953-8
Our file *Notre référence*
ISBN: 978-0-494-39953-8

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ABSTRACT

This qualitative research examined the perceptions of eight youth care workers regarding self-harm in youth. The types of self-harm encountered, the differences in self-harm between typically developing youth and youth with disabilities, and effective interventions in dealing with self-harm were addressed. The progression of youth care workers and their understanding and treatment of youth who self-harm were also examined.

The types of self-harm found in the research included compulsive self-injurious behaviour, stereotypic self-injurious behaviour, and impulsive self-injurious behaviour. Three forms of self-harm emerged that were difficult to classify as they had not been previously discussed in the literature; 1) tattooing, 2) cutting off oxygen with a belt (strangulation), and 3) placing fingers in the wheels of a wheelchair (breaking bones).

Low self-esteem, emotional pain, sadness, and inner turmoil were identified as characteristics common to both youth with disabilities and those who are typically developing. Behavioural disorders were also identified for both groups of youth. Differences between youth who self-harm according to whether they are typically developing or have special needs were as follows. Typically developing youth were perceived to have psychological disorders, while youth with special needs were believed to have cognitive disorders. The participants perceived the actual disability to be the root cause of self-harm for the youth with special needs. Hypersensitivity to the environment, limited verbal skills with a concomitant inability to express themselves, loneliness, and craving attention were also attributed to youth with disabilities. In contrast, typically developing youth were perceived as engaging in self-harm due to a specific intent or

explicit purpose. This purpose was to release stress, and to replace their emotional stress by acute pain. Typically developing youth were also perceived as engaging in self-harm for acute attention seeking.

The youth care workers reported a number of supportive interventions that they used with youth who self-harm. These included medication supplemented by emotional support, using “safe areas”, taking away objects used in self-harm, confidence boosting, and positive reinforcement. Verbal redirection and extensive discussion regarding self-harm were found to be effective with typically developing youth, while physical redirection was used more extensively for youth with special needs.

Youth care workers had received limited training in self-harm prior to their employment. They described the dichotomous feelings of being intrigued and shocked, while also having feelings of sadness and pity, when they first encountered self-harm. Due to both their lack of training in self-harm and lack of agency policy, the participants felt confusion and uncertainty in how to deal with self-harm.

Findings from this research are discussed within the context of confusion and uncertainty of youth care workers in understanding self-harm, interventions found to be effective in dealing with self-harm and the need for training and professional development on self-harm for youth care workers.

ACKNOWLEDGEMENT

I take this page to dedicate my sincere gratitude and thanks to all the people who supported me during this process. My thesis advisor, Professor Harriet Field, has exceeded any expectations that I was anticipating. She had become a mentor in my life and I am thankful for her support throughout my research. I would like to thank my thesis committee members, Dr, Carmel French and Dr. Anne MacCleave, for their support and guidance.

I would like to thank my family and friends for their support and confidence in my endeavours. I could not have completed the work without my loved ones. As well, I thank God for allowing me to complete this chapter in my school journey. Thank you to all, words cannot say enough.

TABLE OF CONTENTS

Chapter I: Introduction

A. Statement of Problem-----	4
B. Personal Reflection-----	8
C. Purpose and Aim-----	9
D. Research Questions-----	10
E. Definitions-----	10

Chapter II: LITERATURE REVIEW

A. Introduction to Self-Injury-----	12
B. Classifications of Self-Injury-----	13
C. Characteristics of Individuals who Self Injure-----	15
D. Relation to Other Mental Illnesses-----	19
E. Treatment of Self-Injury-----	23
Therapeutic Interventions -----	24
Paratherapeutic Interventions-----	30
Interventions for Persons with Disabilities -----	34

Chapter III: METHOD AND SAMPLE

A. Framework-----	37
B. Measures-----	38
C. Data Collection-----	39

D. Participants-----	40
E. Procedure-----	40
F. Data Analysis-----	42
G. Ethical Considerations-----	43

Chapter IV: RESULTS

A. Introduction-----	45
B. Response Rate-----	45
C. Participants-----	45
D. Responses to research Question 1-----	47
Responses to research Question 2-----	52
Responses to research Question 3-----	58
Responses to research Question 4-----	63
E. Summary-----	69

Chapter V: SUMMARY, DISCUSSION, AND RECOMMENDATIONS

A. Summary-----	73
B. Discussion-----	75
i. Uncertainty and Confusion-----	75
ii. Effective Interventions-----	77
iii. Lack in Training and Policy for Self-harm-----	81
iv. Summary-----	83

C. Limitations-----	84
D. Recommendations-----	85
Chapter VI: REFERENCES-----	88
 Chapter VII: APPENDICES	
A. Letter to Directors of Residential Youth Care Facilities-----	94
B. Letter of Permission to Residential Staff-----	96
C. Interview Consent Form-----	99
D. Demographic Information-----	101
E. Interview Questions-----	104

CHAPTER 1

INTRODUCTION

A. Statement of Problem

The act of self-injury conjures images that are repellent. Persons who engage in this act are often thought of as emotionally disturbed. Since the intentions of self-harm are unknown, the behaviours are often misunderstood. The numbers of people who self-harm are difficult to determine due to the secret nature of the act. In the United States alone, estimates are that at least 2 million self-injure between the ages of fifteen and thirty five (Winkler, 2003). Although some men self harm, females tend to be the majority who engage in these actions. Men, however, use more violent forms of self-harm, for example, females tend to use razor blades while males use sharper objects (Strong, 1998).

Self-injury involves such things as cutting, burning, self-hitting, picking wounds, pulling hair, and breaking bones (Winkler, 2003). It is a coping method and a way to feel alive. It is important to define the act of self-injury in order to come to a clearer understanding of the act. For the purpose of this study, Winkler's (2003) definition of self-injury will be used. "Deliberately doing harm to one's own body, doing it alone (without the help of another person), and doing something serious enough to damage tissue and, often, leave a scar" (Winkler, 2003, p.14). Other terms used that essentially have the same meaning; are self-harm and self-mutilation. The four categories of self-harm include 1) stereotypic, 2) major, 3) compulsive, and 4) impulsive. Stereotypic includes behaviours such as head banging, face slapping, and self-biting. These stereotypic behaviours are often associated with intellectual handicaps and developmental

delays. Major self-harm is severe or potentially life threatening and includes injuries such as castration, eye enucleation, and limb amputation. Compulsive self-injury consists of repetitive hair pulling, skin picking, and nail biting of mild and moderate severity. Finally, impulsive self-harm is the most prevalent form discussed in the literature, and these impulsive behaviours include skin cutting, burning and self-hitting of a mild to moderate severity (Kress, 2003).

Although harming oneself with intention is not a new topic, it is often a taboo subject and one that people do not know how to deal with effectively. Research indicates that forms of self-harm have been evident for years. Even in the mid 19th century, cases dealing with self-harm were discussed in psychological literature (Strong, 1998). Islamic healers in Morocco as a ritual would slash open their heads. Then a person who was ill would dip bread and sugar cubes in the head of the healer as a medicine (Strong, 1998). This led Strong (1998) to think that self-harm is more about healing oneself than an act of hurting with intention to die. In fact, it may be a part of many cultures yet misunderstood. Perhaps as Strong suggests (1998) it is not about death, but about healing, religion, and interpersonal amity (Strong, 1998).

Currently, youth care workers in residential group homes struggle to have a clear understanding of the intention of the acts of self-mutilation, self-harm, and self-injury. There are a number of reasons why a person self-harms. However, listening to personal stories can help a person in understanding the intentions first hand. Winkler (2003) wrote about a young person who cut to feel emotions and feel alive, "I was punishing myself" (p.13). Conterio and Lader (1998) wrote about someone who looked at self-harm as "a friend that I can turn to at any point in the day" (p.15). Researchers have addressed the

emotional, personal and the physical reasons or intentions for self-harm. In regards to the emotional aspect, people self-harm as a relief from feelings and intense emotions. Other emotional reasons include a way of coping to make themselves feel better, and a way to make themselves feel “real.” The emotional aspects of self-harm include an individual trying to nurture themselves and heal their inner wounds and to “take control of something in their lives” (Winkler, 2003). Individuals self-harm to feel something when they are emotionally numb (Winkler, 2003). The physical factors that influence an individual who self harms include the rush of pleasure they experience, it is often compared to that of a runners “high.” Finally, each individual self-harms for his or her own personal reasons. They often want to communicate to others the extent of their pain by expressing this emotional pain (Winkler, 2003). This expression of pain may take the form of re-enacting physical or sexual abuse. It is pertinent that workers try to understand the act instead of making judgements. It is important to remember that people that intentionally hurt themselves must want to stop the act in order for the interventions and suggestions from staff to be effective. Researchers have determined that the act of self-harm is a secretive act and staff should be sensitive when dealing with others. People who self-injure do so because of an internal dynamic, and not in order to anger or irritate others (Martinson, 1998). Often staff in emergencies have little tolerance for those who self-harm and have refused anaesthesia to give stitches to wounds that require them (Martinson, 1998).

Staff in group homes and shelters are often unclear how to deal with self-harm and attempt to stop the procedure. However, staff should educate themselves on the various forms of self-harm to gain an understanding of the purpose of the act.

Communication is the key to providing effective help to those who self-harm. An understanding of the act can allow a staff and a person who self-harms to work together to come up with effective strategies to stop or diminish the behaviours.

Youth care workers are also not prepared to intervene with an individual who self-harms. There is much confusion and often disgust by the act of self-harm. For example, Best (2004) conducted research on teacher's reactions to self-harm, and the emotions that were triggered were not pleasant. Statements were made by teachers that included such words as anxiety, shock, upset, distressed, repulsed, bewildered, sorrow, and frustrated (Best, 2004). Levenkron (1998), a therapist, also noted a case where he had been referred a young girl who engaged in self-mutilation. As stated, "Other therapists could not help me because they didn't know much about it, which made me feel like a freak" (Levenkron, 1998). These responses are an indication that more needs to be learned about the act of self-harm. The problem is that people do not understand how or why someone would hurt their own body and find it disturbing. This in turn makes it difficult for others to help when they do not understand.

This is especially a challenge for youth care staff who work with persons with disabilities who self-harm because the person often cannot communicate what they are feeling. People with disabilities are usually unable to tell staff what it is that causes enough distress for them to hurt themselves (Fragmented Mind, 2005). Often people with disabilities know they are different and this results in them feeling rejection, alienated, silenced and excluded (Fouse & Wheeler, 1997; Fragmented Mind, 2005). This is a natural feeling for people who self-harm (Fragmented Mind, 2005). Ultimately, whether

an individual is typically developing or they have a disability, self-harm has become a way to continue to exist.

B. Personal Reflection

Attempting to understand why someone would intentionally hurt his or her own body was difficult for me to understand. I started as a youth care worker six years ago and I did not know what to do the first time that I was witness to the act of self-harm. It was disturbing, as this young woman cut herself with a razor blade, and I had hoped to never see it again. However, as a youth care worker this was unrealistic. I questioned why we never really covered the topic of self-harm in school, and as a youth care worker new to the field, I was not prepared.

I had once asked a young girl I worked with what she received from cutting herself. She described it as a Styrofoam container in a microwave, unless a person cuts a hole in the top of the container while it cooks, it will eventually explode. She said that it was the same way for her, she had an extensive amount of pain inside, and if she did not cut, she would explode like the container. As I have discovered there is not much information on interventions to help individuals who self-harm stop this behaviour. There is sufficient information on the types of self-harm and people's confusion over the act, but the question is whether there is a proper way to intervene.

I now work with persons that have been identified as individuals who are disabled. Since starting, I have heard that, when autistic children punch themselves, it is just a part of the disorder. One staff member informed me that she did not see this autistic child as self-harming but a natural part of her disability. I question if I can help this

person at least minimize the intensity with which she hurts herself or the manner in which she engages in self-harm.

C. Purpose and Aim

Current research in the area of self-harm informs the reader about the terminology and personal stories associated with individuals who self-harm. There are numerous reasons why individuals claim that they inflict injury upon themselves that have been explored through research. While such research is beneficial, there is a lack of research that focuses on youth care workers and the ways they intervene to assist youth in stopping or diminishing these harmful behaviours. Often staff in residential facilities do not know how to help a self-harmer and they refer them to a person specialized in the area (BBC, 2005). However, the reality is that staff need training in order to intervene and cope with various types of self-harming behaviours, because ultimately they are the ones who deal with the residents on a daily basis.

Self-harm can be a disturbing thing to witness and it is a way that people cope. This research will provide an opportunity to discover youth care workers perceptions of effective methods to aid the self-harmer. The desired outcome of the research is to discover successful interventions used by youth care workers for people who self-harm. No one method has been developed to help all self-harmers but what interventions work best for youth living in residential facilities and the most effective interventions are called for (Turner, 2002).

Finally, staff will be asked how they have progressed in their professional development pertaining to their manner of dealing with self-harm. Participants will be

asked how their reactions toward self-harm have changed and what new methods they have developed. Asking the staff in residential facilities is an integral part of the research; they are the people who are witnesses to the act of self-harm. Participants in the research have the opportunity to discover the most valuable methods for dealing with the different types of self-harm.

D. Research Questions

1. What types of self-harm do youth care workers report they have encountered in residential group care facilities?
2. How do youth workers perceive the self-harming behaviours and concomitant interventions of youth who have disabilities and those who are typically developing? Do the behaviours and interventions vary between the two populations?
3. What interventions do youth workers report they use to address issues of self-harm and which interventions do they perceive as successful?
4. How do youth care workers perceive that they have progressed over the years in their understanding and treatment of youth self-harm?

E. Definitions

Self-Injury: For the purpose of this study, Winkler's (2003) definition of self-injury will be used. "Deliberately doing harm to one's own body, doing it alone (without the help of another person), and doing something serious enough to damage tissue and, often, leave a scar" (Winkler, 2003, p.14). The term self-harm and self-mutilation will be used interchangeably with self-injury and have essentially the same meaning.

Stereotypic Behaviours: Includes behaviours such as head banging, face slapping, and self-biting that are more likely associated with intellectual handicaps and developmental delays (Kress, 2003).

Major Behaviours: Severe or potentially life-threatening injuries such as castration, eye enucleation, and limb amputation (Kress, 2003).

Compulsive Behaviours: Consists of repetitive hair pulling, skin picking, and nail biting of a mild and moderate severity (Kress, 2003).

Impulsive Behaviours: Consists of skin cutting, burning, and self-hitting of a mild to moderate severity (Kress, 2003).

Paratherapeutic Interventions: In addition to the therapist, it is important for self-harmers to have a non-professional support system. For the purposes of this paper, the term paratherapeutic support persons will be used.

Therapeutic Interventions: These are therapeutic techniques that the therapist utilizes in the sessions and these consist of behavioural reframing, guided imagery, self-esteem rebuilding, praise in accomplishments, journals, contracts, and cathartic release.

Chapter 11

LITERATURE REVIEW

A. Introduction to Self-Injury

Self-injury has existed for many centuries, yet it is often a taboo topic. Indeed deliberate self-injury is mentioned in the Bible, “night and day he would cry aloud among the tombs and cut himself with stones” (Turner, 2002, p.112). Self-mutilation resulting from religious beliefs has occurred since before the time of Christ (Turner, 2002). During medieval times, a number of women who wanted to imitate the sufferings of Christ would deliberately starve or punish themselves by whipping (Turner, 2002). When one reads of these topics one may cringe in disgust, not understanding why someone would deliberately hurt him or herself.

Mayan Indians and Chinese women modified their body to conform to their culture’s idea of beauty. Before 1930, they would bind their feet until the bones broke and each foot took on the shape of a curled lotus flower (Strong, 1998). The Mayan Indians and Chinese considered this a sacrifice for beauty; the lotus foot was considered sexy. The act of breaking the bones began at the age of six and was considered a cultural acceptance (Strong, 1998).

The first published article in the medical literature on self-injury dates back to 1846. A case was reported about a forty eight year old that took out both of her eyeballs (Turner, 2002). In 1934, Karl Mennigar wrote about self-mutilation, he believed that self-mutilation contained three essential elements. The first element is aggression turned inward, often that which is felt toward an external love-hate object, usually a parent.

Regardless of what has occurred in many families, a connection exists. However, the pain one has experienced in their families has to be dealt with in some form and for some this involves intentionally hurting one's body. Another element is stimulation, with either a sexual or a purely physical intent. A third element is a self-punishing function that allows the person to atone for an aggressive or "sexual" sin (Turner, 2002), such as allowing a person to heal from such an act as sexual abuse.

B. Classifications of Self-Injury

There are four major forms of self-injurious behaviours and to provide proper treatment, one must understand the different types. Depending on the type of self-injurious behaviour, the treatment varies. Certain types of self-harm are because of physical or mental illness or it can be due to trauma from their past experiences.

The first classification is stereotypic self-injurious behaviour. The behaviours associated with this type include head banging, face slapping, lip and hand chewing, self-biting, and hair pulling (Kress, 2003). Such behaviours are conceptualized as organically based and biologically driven because they are usually seen in people who are intellectually challenged or who are developmentally delayed, for example in people with autism, Tourette's syndrome, temporal lobe epilepsy, and Cornelia de Lange (Kress, 2003, Fritz, 2004). Strong (1998) describes the behaviours associated with this type of self-injury as rhythmic and monotonously repetitive behaviour.

The second type of self-harm is major self-injurious behaviour. This is the most severe and often uncommon form (Fritz, 2004), and is characterized by severe and potentially life threatening behaviours such as castration, eye enucleation (removal of an

eye), and even limb amputation (Fritz, 2004; Kress, 2003; Thompson, 1996). This form of self-injury most often happens during periods of severe intoxication, psychosis, and severe character disorder (Strong, 2003). There are some individuals who engage in this type of self-mutilation who claim they are directed by God to do such, meaning they are delusional or hallucinating, as penance for sexual sins (Strong, 1998). Amazingly, people who engage in this form state they felt no pain at the time of the act. According to Kress (2003), “they experience a calm before, during, and after the self injury occurs” (p.491).

The third type of self-injury is compulsive self-injurious behaviour. Often people who are compulsive injurers experience intense anxiety and it is compared to obsessive-compulsive disorder (Strong, 1998). This behaviour consists of repetitive hair pulling, skin picking, and nail biting of a mild and moderate severity (Kress, 2003). An example is trichotillomania, this act entails people yanking out hair strand by strand in such places as eyebrows, scalp and pubic area (Kress, 2003, Strong, 1998). Women who want to “get out” blemishes even ones that do not exist (Strong, 1998) mostly do compulsive skin picking.

The final type listed and the most prominent type is impulsive self-injurious behaviour. This consists of skin cutting, burning, and self-hitting of a mild to moderate severity. These behaviours tend to be isolated or habitual and are often done in private so others do not find out about the act (Fritz, 2004, Kress, 2003,). The most common forms are cutting and burning (Fritz, 2004). Cutting of wrists or forearms is the most common form of this type of self-mutilation (Kiselica & Zila, 2001). Individuals tend to use any sharp object that is available, such as needles, fingernails and razors (Kiselica & Zila, 2001). Youth often claim they have a particular object that they feel most comfortable

using. Another form of self-injury that is frequent is burning of the skin, usually with things like matches and cigarettes. Other types of impulsive self-harm are self-hitting, picking wounds, pulling hair, biting the body, and inserting objects underneath the skin (Kiselica & Zila, 2001; Winkler, 2003).

Self-injurious impulsive behaviour can be either episodic or repetitive. Episodic is when the self-injury occurs only a limited number of times throughout a person's life. Repetitive self-injuries are reoccurring and are described as addictive (Kress, 2003). Strong (1998) notes that repetitive self-mutilators believe that without cutting, they are void inside, and if they could not do it, they would fall apart, go crazy, or cease to exist (p.27). Impulsive self-injurious behaviour deals with intense emotions such as anger and emptiness.

C. Characteristics of Individuals Who Self Injure

Most often people who self-harm claim they do it to feel emotions or to focus on something other than their trauma. Others cut to punish, "I felt by cutting that I was punishing myself and it was right that I should punish myself" (Winkler, 2003, p.13). Self-harmers tend to act on their current state of emotions rather than thinking long term (Palace, 2004). Staff who deal with self-harmers should have a clearer understanding of the self-harmers' past in order to help one stop or lessen the frequency and intensity of the act. As well, workers must remind themselves that self-harmers generally have not experienced a stable home environment and helping them will not be easy.

Family issues from ones' past provide valuable information for those who engage in self-harm. According to Turner (2002), the best way to determine the background of a person who self injures is to inquire about their family history. Most often, a person who self injures will have answered affirmatively to inquiries that pertain to their father's alcoholism, their sexual or physical abuse as a child, and their emotional abuse. The alcoholic fathers are regularly sexually seductive toward their daughters (Strong, 1998). In one study, results showed that 50 percent of self-injurers were sexually abused as children (Winkler, 2003, p.23). They were neglected as a child and had experienced severe trauma in their life. Individuals who self-harm often lacked a mother figure and if they had a mother, she was not emotionally available. The mothers were often cold, punitive, and judgemental (Strong, 1998, p.33). Self-harmers often state that they experienced a lack of affection, touching, and hugging from others who should have been there for them as a child (Turner, 2002, p 26). Children who have been severely neglected are at a very high risk for psychological problems (Turner, 2002). The childhoods of self-injurers have been difficult and as adults, they struggle with others who want to help. The youth were expected as children to deal with the parent's sexual, emotional, and physical needs. Often individuals who have experienced childhood abuse hate to have a pelvic exam, and respond with disgust to menarche (Kiselica & Zila, 2001). The children who are victims of sexual abuse struggle with the issue of their developing sexuality.

Other children come from a chaotic household with no structure, and to deal with the confusion, they cut because they feel they have done something wrong to contribute to this environment (Winkler, 2003). Generally, individuals who self-harm are from middle to upper class backgrounds, of average to high intelligence. The majority are female, and

the first act of self-harm is 13.5 years of age with behaviours usually lasting five to ten years (National Mental Health Association, available on line; Turner, 2002; Winkler, 2003). People who self harm were exceptionally good as students in school for the most part.

Characteristics in self-injurers include such personal issues as a strong dislike for themselves and they often invalidate themselves (Palace, 2004; Turner, 2002). They tend to suppress their anger, tend not to plan for a future; they do not see much of a future and have a sense of impending doom. Furthermore, they are chronically angry and disappointed in themselves, have high levels of aggressive feelings, tend toward irritability, and are hypersensitive to rejection. Therefore, a rejection from a job or a person may be internalized and they feel worse. There are numerous other reasons why a person would cope by intentionally harming himself or herself. These reasons include the person being more impulsive and lacking in impulse control. This leads them acting in accordance with their mood at the time and they do not see themselves as skilled at coping or having a flexible repertoire of coping skills. A broken glass may be the last straw for that day and they hurt to cope with this frustration.

Thompson (1996) wrote that self-harmers tend to be perfectionists, are unable to handle intense feelings, struggle to express their emotions, dislike themselves and their body, and have severe mood swings. Others may not tell what they are doing to their bodies from a feeling of shame for the act. Fritz (2004) has researched the personality traits of self-harmers and has further discovered traits such as mood swings, low self-esteem, sadness/tearfulness, and anxiety. Other factors include the propensity to dress in long sleeves and long pants, even during hot weather and a resistance to being unclothed

(Fritz, 2004). Self-injurers have a tendency to invent excuses to avoid participation that require undressing or exposing their skin such as during physical education classes, sporting events, and outdoor summertime activities.

Turner (2002) wrote about a model that other researchers have developed to include the syndromes that are apparent in a person who intentionally hurts their body. The model has eight aspects and they include such things as an onset in late adolescence, multiple episodes, and types of self-harm, low lethality and a behaviour that continues over the years. Often people who self-harm are angry, show despair, anxiety and have a cognitive constriction. They do not have a strong social support and abuse drugs and alcohol. Self-harm does not have its own separate entity in the Diagnostic and Statistical Manual of Mental Disorders, yet it is often listed as aspects of other mental illnesses such as anorexia and bulimia (Conterio & Lader, 1998; Turner, 2002). Finally, people who self-injure are often depressed and suffer from psychosis (Turner, 2002). When self-harmers are depressed and suicidal, this increases the difficulty in dealing with daily life and functioning as a contributing member of society. The chronic anxiety causes one to be avoidant, which in turn exacerbates the struggle to cope. Regrettably, self-harmers do not think that they have much control over how or whether they cope with life, and consequently they do not see themselves as empowered.

Turner (2002) writes that there are emotional and psychological symptoms that occur frequently in self-injurers. The emotional aspects include such things as an increasing sense of agitation, anxiety, and anger. Furthermore they are depressed or in an agitated-depressive mood quite often. When someone self harms it is not about suicide and suicidal ideation is not typically present. It is a way of coping to release the pressure

of the painful emotions bottled up and to feel alive. One who self-harms feels trapped in an intolerable situation and struggles to problem solve or to think of other ways to cope. The possibility to think of reasonable alternatives to self-harm is overpowered by a need to feel the relief they experience from the act. They struggle to cope and feel that they have no control over intolerable situations. As Turner (2002) writes, “there is a sudden and recurrent intrusive impulse to hurt one-self, without the perceived ability to resist” p.15). Additionally, there is the sense of psychic relief after the act of self-harm (Turner, 2002).

D. Relation to Other Mental Illnesses

Self-injury is in the DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, but it is not listed as its own mental illness. Rather, self-injury is listed as a “symptom” for a number of mental illnesses, although there is debate if self-injury should be its own separate entity. The mental illnesses that contain the criteria of self-harm include borderline personality disorder, posttraumatic stress disorder, anxiety disorders, impulse control disorder, and eating disorders. Other problems that are associated with self-harm are alcohol and drug abuse (Turner, 2002).

Borderline Personality Disorder is one of the most common diagnoses given to self-injurers (Brown, 2001; Conterio & Lader, 1998; Kress, 2003; Turner, 2002). More people that have Borderline Personality Disorder engage in self-harm than people with other diagnoses (Brown, 2001). It is a complex personality disorder marked by mood swings, high-drama behaviours, emotional (especially anger) outbursts, serious problems with close interpersonal relationships, and an intense fear of abandonment (Kress, 2003;

Turner, 2002, p.107). Other symptoms include impulsivity and an unstable self-image (Turner, 2002). Often individuals who were sexually abused as children have borderline personality disorder and a characteristic of self-harmers is a past of abuse (Conterio & Lader, 1998).

A person may develop post-traumatic stress disorder (PTSD) because of an extremely traumatic event. PTSD is defined by intrusive re-experiencing of a trauma, avoidance of traumatic reminders, and persistent physiological arousal (Turner, 2002, p.95). Children who are victims of trauma and develop PTSD can dissociate from their mind and/or body. Dissociation is the ability to “numb out” and feel nothing (Turner, 2002). Events that cause PTSD are sexual or physical abuse, rape, kidnapping, mugging, and others. Often people who self-injure are victims of such events and are given the diagnosis of post-traumatic stress disorder. Individuals who have posttraumatic stress disorder claim that they self-harm to feel alive or to feel emotions. As well, the self-injury serves as a vehicle for the expression of feelings and needs (Turner, 2002). The person can express anger, sadness and other emotions through the act of self-harm. Self-harm can be utilized for a number of reasons and one includes the re-enactment of the original trauma. The re-enactment allows a person to manage a situation where they once had no control (Turner, 2002). Another reason includes the ability to reorganize the self and to regain physiological and emotional balance (Turner, 2002). Self-injury serves as a conduit to feel emotions.

Post-traumatic stress disorder is an anxiety disorder. Self-harm is also associated with other types of anxiety disorders including generalized anxiety disorder, panic attacks, and obsessive-compulsive disorders. Generalized anxiety disorder includes

excessive anxiety and worry (Turner, 2002). Young people who have generalized anxiety disorder can be excessively worried about their performance, may be perfectionist, and may do a task over and over until they get it right (Turner, 2002). These characteristics are apparent in those who self-injure. Panic attacks include an extreme anxious reaction with sudden onset that involves intense fear and feelings of doom and an urgent desire to “escape” (Turner, 2002, p.101). Self-harmers often feel an anxious feeling before they hurt themselves and to exacerbate this intensity they cut, burn or use other methods to stop this anxiety. A decrease in anxiety is experienced after the act of self-harm (Brown, 2001). Obsessive-compulsive disorder involves recurrent thoughts, impulses, or images, along with repetitive behaviours to attempt to alleviate the anxiety and distress (Kress, 2003; Turner, 2002, p.101). The obsession in people who self-harm comes from their constant nagging, “to cut or not to cut” (Turner, 2002). The continuations of the cutting, burning, and other methods are the compulsions (Turner, 2002).

Self-harm is also a symptom of impulse control disorder and is classified by increasing tension prior to the act and the gratification after the act (Kress, 2003). An example of self-harm that entails this feature is trichotillomania. Trichotillomania is the recurrent pulling out of one’s own hair for the relief of tension (Kress, 2003; Turner, 2002, p.102). The hair pulling is severe enough to be noticeable, but the person feels relief from the act. Most of the hair pulling occurs from the scalp region, hair pulling from the eyebrows, eyelashes, beard, and pubic area (Kress, 2003). The hair pulling may be limited to one area or involve many areas (Kress, 2003).

People who are diagnosed with a mood disorders such depression and bipolar disorder often engage in the act of self-harm (Kress, 2003; Turner, 2002). Depression

manifests in the form of anger, hopelessness, sadness, or despair. A majority of people who self-injure (Brown, 2001; Conterio & Lader, 1998) experiences high levels of depression. Self-injury develops as a strategy to blot feelings out of their conscious awareness (Conterio & Lader, 1998). Bipolar disorder appears as either an extreme sadness or an elevated happiness (mania). In order to deal with these emotions, especially during the mania phase, people self-harm to regulate the state of their mind (Conterio & Lader, 1998).

According to literature, individuals who have an eating disorder often self-harm (Thompson, 1996, Winkler, 2003). Often times people who self-harm control their body and their emotions by intentionally hurting their body. The issue of controlling one's body can manifest in the form of an eating disorder. Therefore, there is often a connection made between the eating disorder and self-harm. Disturbance of body image, self-directed aggression, and indirect self-destructive behaviour are key factors in the correlation between eating disorders and self-mutilation (Kiselica & Zila, 2001). As with the eating disorder, self-harm is a way to control emotions and a way of feeling emotions.

There is agreement that there is often a relationship between substance abuse and self-harm. The frequency of substance abuse among people who self harm is high (Kiselica & Zila, 2001; Turner, 2002). Males tend to abuse alcohol and drugs more frequently than females (Stewart et al., 2003). People are not necessarily harming when they are abusing substances but they are using the substances for the wrong reasons. The reason being is that self-harmers state they abuse substances to feel good and make the bad go away (Kiselica & Zila, 2001; Turner, 2002). They are using substances to escape their emotional pain (Turner, 2002). When a person who self-harms and abuses

substances admit that they want to stop they must admit, they have a problem with substances. It is vital to their recovery that they acknowledge this problem (Turner, 2002). Research in this area is lacking and it is only in recent literature that the relation of self-harm and substance abuse is acknowledged.

E. Treatment of Self-Injury

Research on self-harm has indicated that there is not one particular method that is considered the most appropriate treatment for all persons. Rather, various methods are utilized in particular situations to assist in stopping the self-harming behaviours, so that one engages in a healthier way of coping with their emotions or lack of emotions in certain cases. There is no one way to stop self-harming behaviours but there are varieties of strategies that workers can utilize. Children with disabilities often times cannot be as proactive in setting their goals, so they must work in consultation with their worker. There may be a period of trial and error for staff to determine the most beneficial method. Although, there may be one particular method that works, a combination of techniques is generally most helpful.

There are two distinct types of support persons involved in assisting persons who self-harm, including the professional and the non-professional such as family and friends. Some therapies are used under the guidance of a professional. More general therapies such as relaxation techniques can be used with the assistance of non-professional support persons. A therapist is the professional who helps the client work on changing the behaviour. The therapist is the person who guides the client through this difficult time and suggests therapeutic techniques they can utilize. The therapist can be such people as

psychologists, psychiatrists, social workers, and youth workers. The support outside this therapeutic environment is equally important. This is where family and/or friends can have a positive influence, and can be an integral part of the support system. The family and friends have to realize that this person does not have a healthy personality (Levenkron, 1998). The goal for the people helping is to develop an influence with the self-harmer (Levenkron, 1998). Often the person who self-harms has distrust for others so the helper must reassure them that they are there without judgement. Unfortunately, not all people who self-harm have this non-professional support system.

For the purposes of this paper, the term therapeutic interventions will be used when referring to intervention techniques used by a professional therapist and the term para-therapeutic interventions will be used when referring to intervention techniques used by non-professional support persons.

i). Therapeutic Interventions

There are therapeutic techniques that the therapist utilizes in the sessions and these consist of behavioural reframing, guided imagery, self-esteem rebuilding, praise in accomplishments, journals, contracts, and cathartic release. Some effective treatments for self-harm includes a combination of medication, cognitive/behavioural therapy, interpersonal therapy, and other services as needed (National Mental Health Association, 2004; The Brown University Child and Adolescent Behaviour Letter, 2004; Thompson, 1996; Winkler, 2003). The therapist may suggest in collaboration with the client that they engage in healing techniques for the self such as getting a haircut or helping others by volunteering in the community.

Self-injury most often is related to other mental illnesses and as a result, there are a variety of medications that might be prescribed. Medication is an intervention commonly used in treating depression, anxiety, obsessive-compulsive behaviours, and the racing thoughts that accompany self-harm (Conterio & Lader, 1998; Levenkron, 1998; National Mental Health Association, 2004). Dr. Richard Gerhardstein, a psychiatrist who works with self-injurers, claims that frequent self-harmers have a disturbance in their brain cells and require medication to help control the impulse to hurt (Winkler, 2003). People who use the medication have to understand that the medication is used as a chemical support to help them make changes necessary for diminishing or eradicating their self-harming behaviours (Levenkron, 1998). The combination of medication and emotional support is necessary for change. Recovered cutters continue to use medication to aid in the prevention of relapse into depression or anxiety (Levenkron, 1998).

Winkler (2003) writes about methods such as behavioural reframing or cognitive-behavioural treatment that therapists utilize. These techniques are referred to as “re-thinking” techniques because the goal is to have the client begin to think differently about their behaviour and learn healthier coping methods (Winkler, 2003). For example, if a person were always yelling and angry the therapist would help them use that anger appropriately, and to not hurt themselves when they are angry (Winkler, 2003). Self-harm is a learned behaviour driven by negative thoughts and beliefs but this behaviour can be “unlearned” (Strong, 1998). The therapist should work with their patient to devise strategies and alternatives to prevent giving into the behaviour (Strong, 1998). The patient has to learn to think differently by consciously resisting the urge to hurt and learn how to deal with their emotions by speaking about them (Strong, 1998). The cognitive

behavioural treatment often times consists of one hour per week of individual outpatient therapy and group therapy; this is especially helpful for people who have borderline personality disorder (Strong, 1998). The intensive therapy improves the patients' quality of life by teaching adaptive solutions (Strong, 1998).

Another method that therapists often use is guided imagery. The therapist helps the person find a relaxing place to go in their mind when the stress becomes unbearable (Winkler, 2003). Guided imagery is the use of the imagination to create positive images in order to bring about healthful changes in both the body and the mind (Medicomm Corporation, 2001). Therefore, if a person imagines doing better and eliminating the hurting behaviour, they can get better. The role of the therapist is to get the patient to relax on the couch and then guide the person through breathing exercises to a state of relaxation (Medicomm Corporation, 2001). Therapists can help patients discover a place that only belongs to them when they need a place to escape. During the guided imagery, a person may see other ways to cope besides intentionally hurting oneself. However, they may bring images to the surface that they have to deal with in order to recover. Stopping the cycle of self-harm is a long process and it will involve bringing up memories from one's past.

Often a person who self-harms suffers from low self-esteem and the therapist can help to find the positives about their patient to raise their self-esteem (Winkler, 2003). A raised self-esteem may cause the person to want to stop hurting and causing permanent damage to their bodies. People who self harm often come from abusive backgrounds and they take the negative opinions and actions of their abusers literally. It is important that they examine the source of the negativity and begin to build up their self-esteem. It is

helpful when starting the process of rebuilding self-esteem that a person writes down positive qualities about themselves despite the initial difficulty of this task (Turner, 2002). Another helpful task can be for the self-injurer to engage in activities that they are good at and this can build self-esteem (Turner, 2002). When they feel good about what they are doing, their self-esteem improves.

It is important that the professional praise any changes that a self-harmer makes (Winkler, 2003). No matter how small the change may appear, acknowledgement is important to recovery. For example, if the person was hurting everyday and has decreased to five days a week it is important to acknowledge this progress. Positive reinforcement can increase self-esteem and self-worth. The helper must accept that the recovery has to be at a pace that a self-injurer can handle and realize that she cannot be pushed.

Another strategy that a therapist may use is encouraging the person to keep a journal. Writing down things that triggers a person can help the therapist and the person work through the triggers (S.A.F.E. Alternatives, 2002; The Brown Child and Adolescent University Behaviour Letter, 2004; Winkler, 2003). The journal may show patterns that are evident, such as the time of day they harm or the people that may trigger the urge to hurt. This can be a way for the therapist and client to discover what causes the self-harm and work through ways to improve the harmful patterns. Writing in the journal before a person decides to hurt him or herself can help the person share their feelings at that time before the act. Often people have trouble expressing their emotions after self-harming. The journal writing can be a less emotionally invasive technique to work through the thoughts associated with the act. The journal can be written in different forms such as

poetry, free flow, song, e-mail, or conversational (Turner, 2002). If it is a youth living in a group home, the journal can be a safe way to communicate. Often it is difficult for a person to share their thoughts with others and a journal can be a non-invasive way to correspond. As well, there is often fear of interruptions from other staff and other youth living in the group home when you are meeting with the person who self-harms. The journal is an effective way to keep up a correspondence and the worker can respond back to the youth's thoughts. Writing is a therapeutic way to get the emotions elsewhere that they cannot verbalize to others.

A "no-harm contract" can be used as encouragement. This contract would include a written promise not to harm, a list of people to call for help, a hotline number, and a list of objects that the person will avoid (Galley, 2003; Turner, 2002). Realistically the contract will serve as a reminder of what the individual is attempting to change. The therapist and the client should agree upon the contract and the goals have to be realistic. It is important that the client remain honest in their writing. Often the act of writing things down makes them seem real and this encourages the person who self-harms to follow through on appropriate goals to get better (Turner, 2002). When the client reviews what they have written they are able to recognize how far they have advanced in their treatment. On the contract, alternate options must be listed so when the desire to hurt arises the contract is accessible and has a list of coping methods outlined, such as suggesting a bath when the desire to hurt is occurring. The contract must contain things that the person finds realistic to complete and if a particular strategy is not working, it can be removed from the contract. The contract should be reviewed during all sessions, initially once a week is the most ideal. The contract should contain phone numbers and

places that a person can utilize when the therapist is not available. The contract has to be signed by the therapist and the client and the client has to commit to the treatment by following the contract and following through on appointments (Turner, 2002). If they live in a group home, it would be beneficial for the primary worker to be involved as a support outside the therapy sessions. The contract should outline the consequences of not following through (Turner, 2002). As well, it should contain reasons for not hurting, such as "I will have scars forever" (Turner, 2002).

There are cathartic techniques that the therapist can suggest to the self-harmer to deal with the desire to self-harm. These cathartic techniques will assist the self-harmer with alternate methods that involve a cathartic release that will assist the self-harmer to cope with aggression in a socially accepted manner. Therefore, the therapist can suggest alternate methods that involve a cathartic release, that do not leave lasting scars. One cathartic technique involves wearing an elastic around the wrist and snapping it when they want to self-harm. The elastic band is a substitute for the chosen pattern of self-harm and allows the self-harmer to focus their energy elsewhere. They are still able to hurt themselves and feel the pain but it is not as dangerous and it defuses the energy that would go into the act of self-harm. It is still an emotional release and the physical aspect of the act is still present. As well, one can scratch draw a picture in a piece of wood or use a screwdriver and stab at a piece of wood for relief. Punching a pillow, screaming, yelling, and crying can be a great release for any pent emotions or fears. For example, a youth living in a group home can go to the basement and scream as loud as possible to release their emotions. The self-harmer can use a red pen to mark on the place they normally hurt (Turner, 2002). Youth claim that they still get to focus their pain on

something, such as cleaning the pen mark, but it is less harmful than cutting. Drawing a picture of whom or what is making them mad and tearing it up, or throwing it away is a healthier form of release (Turner, 2002). For example, they may chose to draw a picture of their abuser to tear up and take the pain and anger out on the picture instead of themselves.

ii). Paratherapeutic Interventions

In addition to the therapist, it is important for self-harmers to have a non-professional support system. For the purposes of this paper, the term paratherapeutic support persons will be used. Such persons are involved in paratherapeutic interventions. These interventions are often times initiated by the therapist and then the paratherapeutic support people assist the self-harmer in actualizing these interventions. The people that help the self-harmer must be committed to help the person who self-harms and must follow through on the course of action initiated by the therapist. The desire to cope with the act of self-harm is overwhelming at times. A person who self-harms must be ready to work on stopping the behaviour and it helps in the process when a trusted person, such as a family member or friend takes on the role of a paratherapeutic support persons. The support person has to be a person of strong character and committed to helping the self-harmer. The self-harmer may have to change their current social support. Many people who have been involved in the self-harmer's life may have been a negative influence. Their current network of friends can be a negative influence and such friends have issues they must deal with themselves. For example, they may be involved in their own self-harming behaviour or drug and alcohol abuse. Self-injurers often have a history of unhealthy or destructive relationships and have to learn how to form meaningful and new

relationships (Turner, 2002). This is where the importance of developing a positive relationship with one or more appropriate paratherapeutic support person or persons becomes essential.

Useful strategies that support persons can utilize to diminish the act of self-harming include elimination of harmful objects and providing the self-harmer a safe place to go. It can be difficult to ensure that all things they use to injure themselves are gone because objects used for the purpose of self-harm are often times readily available. The self-harmer may have to get their support persons to remove the objects they use to harm. Often people who self-harm have one item they prefer to use and removing the item may decrease the incident of self-injury. For example, if they live in a group home, the primary worker can be the support person to aid in this process. If the person lives at home, the primary caregiver can help with this and if the person lives alone, a supportive friend could come to the home to assist in removing the object. As well, the self-harmer must feel they have a safe place to go when they are feeling vulnerable to the act of self-harm. They could designate a safe place to be a friend's house or they may have a special place to go for a drive or a walk. The support persons can provide supportive consultation assisting the self-harmer in reaching their safe place.

A variety of relaxation methods comprises yet another effective type of intervention strategy. The non-professional can be involved with general relaxation techniques, physical activities, and household tasks. However, the self-harmer often times utilizes these techniques alone, but the support person is aware of the techniques and provides encouragement for the self-harmer to be engaged in such techniques. Other relaxation techniques include creative tasks, and community work such as helping others.

Many of these relaxation techniques are of a physical nature. Such activities include deep breathing, relaxing in a hot bubble bath, yoga, gym, and walks. Deep breathing allows the self-harmer to focus their energy on the proper breathing techniques. A hot bubble bath is soothing and allows for alone time. Going to the gym or doing yoga is a physical relaxation method that can allow the self-harmer to focus their energy elsewhere. Joining a yoga or gym class enables the self-harmer to meet new people and get out of the environment that may be adding to the urge to self-injury. The physical relaxation techniques are also beneficial when used in combination with one another. The support person encourages the self-harmer to go for walks yet they may not want to be alone, so suggesting they go for walks with others can be beneficial. They can listen to music on their walk, enjoy nature, or draw a picture of the surroundings, especially using colors. Physical exercise is a natural way to release endorphins and provide energy (Turner, 2002).

Further relaxation techniques that involve a more creative aspect include listening to or writing music lyrics, writing poetry, writing of any form, and coloring and painting. Finding an instrument to play can lead to a sense of accomplishment upon completion and success with the activity. A suggestion may be for the individual to go to a music store and enjoy the listening stations. Colors are good for emotional expression, it can bring back good memories from childhood when learning about bright new colors, and it can put someone in a better mood (Turner, 2002). The person may decide to paint their room a bright color to brighten their mood.

Other therapeutic methods may be to engage in activities that are beneficial for the self or they may be beneficial for the community by helping others. Exercising the

mind by doing crossword puzzles can be relaxing for some individuals (Turner, 2002). If funds are available going to get a new hair cut or shopping can be therapeutic (Turner, 2002). The haircut can make a person feel better about the way they look and in turn, they may realize that self-harming does not make a person ultimately feel better.

Shopping is often therapeutic and if the funds are unavailable, the person can window-shop and find things that they like or a new style of clothing that peaks an interest. A suggestion to help the members of the local community is to take a neighbourhood family pet for a walk or volunteer at a local shelter to take animals out and this contribution to society can increase self-esteem. Cleaning out a clothing closet and donating unused items to charity can develop a positive attitude (Turner, 2002).

Another intervention strategy pertains to household tasks that the person can do as a diversion and this includes cooking, sewing, ironing, and cleaning. They can cook and bake for others and prepare a meal perhaps for an individual who is a positive influence in their life. It is important that the chosen activity be enjoyable or otherwise it can lead to unwanted frustration. In turn, the self-harmer may feel hopeless and feel they are not good at any activity. The key is to find something enjoyable. These activities can be a way to distract the person and they find a hobby that peaks their interest.

It is important that support individuals, both professional and non-professional, not be invasive when suggesting these ideas, and realizes that they may not always work. It is valuable that the person who self-injures make a list of why they want to stop cutting. The empowerment they can feel from this process of inclusion is a great stepping-stone to recovery; they gain an increased sense of control they feel is lacking in their life.

iii) Interventions for Persons with Disabilities

People with disabilities such as autism do engage in self-injurious behaviours, and such behaviours are called stereotypic self-injurious behaviour. Unfortunately, there is not a lot of research completed on individuals with disabilities who self-harm and most research focuses on autism. Furthermore, there is limited research on how to help a person with disabilities diminish any harmful behaviour. The self-injurious behaviours for person with disabilities manifest in both a physical or verbal manner. Verbal aggression includes yelling, threatening to hurt others, and using profanity (Fouse & Wheeler, 1997). Physical aggression includes kicking, hitting, biting, pushing, and property damage, throwing objects, grabbing and pinching (Fouse & Wheeler, 1997). The most common forms of self-injurious behaviour include head banging, hitting self, biting self, pulling own hair, pinching or scratching self, picking at skin or nails, and eye gouging (Fouse & Wheeler, 1997, p.266). Among these common forms head banging, hitting, biting and eye gouging are more prominent in persons with disabilities than typically developing persons. These behaviours have been documented in commentary form. Yet there is limited research on the physical differences of self-harm. In the past people with disabilities were often restrained to stop them from hurting but now there are less invasive methods utilized (The University of Kansas Merrill Advanced Studies Center, 2002).

An important consideration in helping the self-harmer with disabilities is to be aware of the warning signs of an outburst, which leads to the self-injurious behaviour. Some of the warning signs are increased agitation, decreased performance, increased attempts to withdraw, decreased problem solving skills, increased demands, decreased

compliance, marked change in impulsivity, more abrupt body movements, and increased muscle tension (Fouse & Wheeler, 1997). When these signs are apparent it is necessary for the caregiver to remember to engage in interventions that may be beneficial.

The interventions that are most commonly used with persons with disabilities include redirecting inappropriate behaviours, decreasing stimulation, giving choices, and maintaining non-threatening tone of voice and body language (Fouse & Wheeler, 1997). The person has to know that how they are acting is inappropriate. For example, they need to know behaviours such as threatening others, swinging their fists, and hurting themselves is clearly unacceptable. The person should be moved to a place where there is a decrease in stimulation and where they are unable to use objects in the room to hurt themselves. For example if they are in the living room in the home, they have to be directed to their room. The room should only have the necessities, for example, the bed and other potentially harmful items should be placed in a locked closet. During the time when a person is, self-harming there should one person providing cues to the self-harming individual (Fouse & Wheeler, 1997). More than one person speaking can overwhelm the individual and this person has to give brief commands. For example, repeating, "stop hitting" is the best way to get the persons attention, too many commands leads to further frustration. If possible, physical restraint should not be utilized because this act can make the person feel worse. In certain instances a vacuum is used to bring the person out of the self-harming behaviour, the noise allows them to refocus there anger on something else. The person needs to express their frustrations but a safe room must be provided. However, for their own safety if the person is hurting himself or herself, such as head banging, a helmet may have to be used so brain damage will not be caused

(Fouse & Wheeler, 1997). How the caregiver deals with the behaviour varies on an individual basis depending on the severity of the disability.

If a person with disabilities is living at home with their family, all family members should be involved as support persons in the process of stopping the self-harm. The family's therapist works to change the relationship between family members until the behaviour of the client changes to healthier coping methods (Turner, 2002). The therapist has an important role in guiding the family members to provide the appropriate support for the self-harmer. Often times the relationship between the family members have to be addressed by the therapist, so they can best assist the client in developing healthier coping methods. The goal is to have the family members communicate effectively between one another (Turner, 2002).

There is some research on the types of self-harm behaviours and the intervention techniques that can be effective (Fouse & Wheeler, 1997; Turner, 2002). The therapist and the paratherapeutic support persons use these techniques to help the self-harmer. No research is available that compares and contrasts the types of interventions between people with disabilities who self-harm and people without disabilities who self-harm. Interventions such as cathartic techniques, and guided imagery, do not work on someone with disabilities, as they do not have the intellectual capacity to benefit from such interventions. There is some literature that distinguishes the different manifestations of self-harming behaviour between the two groups (Fouse & Wheeler, 1997; Turner, 2002). There needs to be research to distinguish which interventions work best with each group. Therefore, persons can receive the most appropriate support in curtailing their self-harming behaviours.

CHAPTER III

METHOD

A. Framework

Qualitative research was developed to enable researchers to study social and cultural phenomena and to “help researchers to understand people and the social and cultural contexts within which they live” (Myers, 1997). Qualitative research is descriptive rather than predictive (Qualitative Research Consultants Association, 2003). The researcher can probe the participants’ responses to understand how and why they feel the way they do regarding the topic (Qualitative Research Consultants Association, 2003). The results of qualitative research allow the researcher to gain knowledge from others based on first hand knowledge of their perceptions and experiences. A qualitative approach was chosen as appropriate for this study, given the intention to explore and discover youth care workers’ perceptions of youth that self-harm and their approaches to intervention. Qualitative research is beneficial as it provides the researcher with the advantage of getting a participant’s perspective on their world. As well, it allows for an interactive process between the researcher and the participants and it provides a personal description (Marshall & Rossman, 1989).

Qualitative research is often used to probe opinions of current social issues and to help researchers develop questions for their research. As well, qualitative research, can help a researcher understand the feelings, values, and perceptions that underlie and influence behaviour (Qualitative Research Consultants Association, 2003).

This study on self-harm utilized qualitative research methods. Data was collected through individual in-depth interviews and a demographic questionnaire. Individual in-depth interviews were selected as the primary means of data collection for this research because such interviews have the potential to offer a unique view of the respondent's attitudes, and reactions toward the topic, and their provision of real life anecdotes (Rosenthal Marketing Services, 1998). Since the topic of self-harm is both sensitive in nature and complex in content, individual interviews were deemed an important means of data collection.

The demographic questionnaires provided general information on participant's experiences pertaining to youths' self-harm. This allowed for a certain amount of quantitative data to augment, conceptualize, and supplement the qualitative data.

B. Measures

a.) Interview Questions

A series of questions were developed for interviews with residential youth care workers to examine their perceptions of self-harm among youth in their care and interventions used in treating such individuals. These questions are based on the researcher's personal experience in youth care facilities, dialogue with colleagues, a review of relevant literature, and consultation with my thesis supervisor. Issues covered included questions about past and previous experience in working with people that self-harm and their perceptions of effective interventions. Interview questions were designed to gather information on staff's perceptions of self-harm and what methods were

perceived to be most effective to help a self-harmer stop the behaviour. Examples of the interview questions are contained in **Appendix E**. These questions focus on types of populations with whom participants have worked, types of self-harm they have witnessed, and the types of interventions they have utilized and found to be effective.

b). Demographic information, such as types of facilities worked in and length of experience was gathered before the interview. Participants in the research were asked to provide information such as the types of self-harm they have witnessed, the training they have, the interventions they have utilized, age range of individuals worked with and the types of facilities they have worked in. (See **Appendix D**).

C. Data Collection

The sources of data for this research were interviews with youth care workers who were employed in residential facilities for individuals who are typically developing and those with disabilities within the Halifax Regional Municipality. These programs provide 24-hour care and supervision; they can include short and long-term stays and are focused toward assisting youth in developing independence. The facilities for typically developing youth provide a safe environment for youth to work on personal issues and the stay is usually based on their daily progress toward independence. Youth who have disabilities are provided with long-term shelter and care, and the stay can be for years in a home-like environment.

A second source of data was the demographic questionnaires that all participants were requested to complete.

D. Participants

Eight youth care workers who were employed in three residential youth care facility within Halifax Regional Municipality were selected as participants. All youth care workers had worked in facilities both with youth who have disabilities and also with typically developing youth. Participants had at least two years experience as youth care workers.

E. Procedure

When ethics approval was obtained from the University Ethics Review Board at Mount Saint Vincent University, the executive director of a provincial organization was contacted and permission was obtained to contact the supervisor of the group homes from this organization within the Halifax Regional Municipality. Once this permission was granted the researcher contacted the director from the HRM and a meeting was arranged. There are six homes within the HRM and three of these homes were randomly selected for the study. When the researcher met with the supervisor for each facility, a letter was provided. The supervisor's letter explained the purpose of the study and asked permission to carry out the study at the facility. (**Appendix A**). The supervisors of the facilities that participated were requested to distribute envelopes to all of the staff employed at the residence. Envelopes included a letter to the youth care workers describing the study and their rights as a participant (**Appendix B**), an informed consent form (**Appendix C**), a

demographic questionnaire (**Appendix D**) and a return envelope. Each informed consent form and demographic questionnaire was coded. Staff willing to participate placed the signed consent form and the completed demographic questionnaire in the envelope provided. They then sealed the envelope and placed it in a pick-up box in the executive director's office. A time was arranged for the researcher to pick up the participants' envelopes. After receiving the potential participants' envelopes, the researcher randomly select eight participants.

Interviews were arranged and conducted in a private room convenient for the participants. Each interview lasted between thirty to sixty minutes. When the author and the participant met to conduct the interview the researcher went over the informed consent form to participate in the interview. The information on this form included agreement to participate in the study with understanding of assured confidentiality, the proper storage of documents (i.e., locked file cabinet and electronic files will be password protected), and destruction (i.e., shredding, university departmental disposal box) of all research materials (i.e., audiotapes, transcribed notes) upon completion of the study. The researcher explained that the session would be audio taped and that the participant could request to stop the tape recorder and terminate the interview at any time. The participants were informed that the interview was completely confidential, and no names or places of employment were identified. They were informed that they had a right to view and edit the interview transcript. The interview process then began and the researcher asked questions pertaining to the youth care workers' experiences with self-harm. A set of open-ended questions were asked. The interviewer only prompted the participant with directives such as "please tell me a little more about that." The information included in

the interview was asked in a way that kept the participants at ease at all times. Once the interview was over the participant was thanked and the audiotapes were numerically coded to ensure confidentiality. Each tape was transcribed verbatim.

F. Data Analysis

Descriptive qualitative methods were used in analyzing the data. An in-depth analysis of the data was utilized using a modified “grounded theory” approach (Strauss & Corbin, 1990). Grounded theory was originally developed by Glaser and Strauss, and is a qualitative methodology of collecting and coding data from which themes can be identified. The methodology borrowed from Grounded Theory in this research included the use of open-ended questions in order to obtain depth and detail pertaining to youth care workers of types of self-harm and the concomitant interventions used; differences in self-harm between youth with disabilities and those who are typically developing; and youth care workers developmental progression in dealing with youth’s self-harming behaviours.

A two-stage process of coding was used in the data analysis; open coding and focused coding (Esterberg, 2002). A variety of events, ideas and categories were identified in the initial process of open coding. Such events, ideas and categories were then analyzed to detect recurring themes. The focused coding began once several recurring themes were identified (Coffey & Atkinson, 1996). Emerging patterns were identified between questions within individual interview transcripts during the focused coding process. Finally, a comparative analysis between participants’ transcripts was undertaken.

A content analysis based on specific classifications of self-harm noted by the youth care workers was also undertaken (Shank, 2005). These classifications included stereotypic self-injurious behavior, major self-injurious behavior, compulsive self-injurious behavior, and impulsive self-injurious behavior (Fritz, 2004; Kress, 2003; Thompson, 1996). A second reader read 25% of the transcripts following the researcher's analysis of the data in order to ensure inter-rater reliability for both the content analysis and the modified Grounded Theory analysis.

G. Ethical Considerations

All participation in the research was voluntary and uncoerced. Prospective informants were fully knowledgeable of the nature of the research and participation, including their right to withdraw from the research at any time without negative consequence. Confidentiality, anonymity, and strict sharing of information, were assured to all volunteers. Study participants were also advised of procedures for the storage and disposal of tapes and transcripts were carried out in accordance with University procedures. Further, prospective study informants were told of the approval of the research project by the University Ethics review Board as a neutral third party for discussion of the research. Informed consent was obtained from each willing participant.

There was no pressure placed on people to participate in the research. They shared the information they were comfortable with and they were in charge of the interview process. The possibility of harm in this study was deemed low. However, due to the sensitivity of the topic there was the possibility that risk existed. The questions may have caused the participant to recall an incident that was upsetting. The researcher was vigilant

in observing the emotions of the participants. The researcher provided the telephone numbers and location of support services available to the participants of the study.

The researcher was obliged to inform the participants that any disclosure of alleged abuse would have to be reported to appropriate authorities. No disclosure occurred, and no psychological services were required for any of the study participants.

Chapter IV

RESULTS

A. Introduction

Interviews were transcribed, coded, and analyzed using a modified grounded theory techniques. This chapter addresses the four research questions and an analysis of the data gathered. Appendix E contains a sample of the interview questions.

B. Response Rate

Three youth care facilities within a major youth care organization in the Halifax Regional Municipality were randomly selected for this research and eight staff in total were interviewed. Ten staff had agreed to participate in the study and through random selection, eight participants were selected to interview.

C. Participants

Eight staff were interviewed in total, two males, and six females. Four participants held university degrees and the other four had college diplomas. All of the staff had at least two years experience in the field of youth care. Three of the participants had more than twelve years of experience working with youth. Only one participant had less than five years of experience, this person has two years. The facilities selected for this study mainly provide long-term care for youth who have disabilities. However, all participants had experience working with both typically developing youth and youth with disabilities.

The participants had worked with youth ranging in age from eight to twenty-four years. They had worked in places such as group homes, small option homes, the YMCA, nursing homes for youth with disabilities, cadets, and a treatment centre in the United States. They had mostly learned about self-harm through work experience as they progressed in the field. However, the participants had taken behaviour modification courses, psychology courses, workshops and had read articles and journals to enhance their knowledge pertaining to self-harm. Table 1 summarizes the information on the participants obtained from the Demographic Questionnaire.

Table I

Summary of Demographic Data on Participants

GENDER	Female	6
	Male	2
AGE	20's	1
	30's	5
	40's	2
EDUCATION	College	4
	University degree	4

D. Responses to Research Questions

Research Question #1: What types of self-harm do youth care workers report they have encountered in residential group care facilities?

There were numerous forms of self-harm that the participants had encountered during their careers. Of the four types of self-harm discussed in the literature review, the participants identified three of the types being present in their youth care practice. These included stereotypic self-injurious behaviour, compulsive self-injurious behaviour, and impulsive self-injurious behaviour. Major self-injurious behaviour had not been encountered by any of the participants.

The behaviours reported by the youth care workers associated with stereotypic self-injurious self-harm included head banging, self-punching, slapping, kneeling, self-biting, hair pulling, self-hitting, chin banging, self-kicking, banging knees on the floor, and purposely throwing their body on the floor. These types of self-harm occurred mainly with youth who had disabilities. Head banging was done on objects such as doors or the floor. As well, the youth used such body parts as their fist or feet in banging their heads. One participant described the banging as follows;

“One guy I worked with had a tendency to bang himself on the chin, on the floor and stuff like that.”

Another type of stereotypic self-injurious behaviour noted by the participants was biting. These biting episodes could be very severe. The biting occurred on the arms and legs and one participant stated that he/she had witnessed a youth taking chunks from her body.

“She would bite to a point where she would take chunks from her arms.”

The participants often viewed stereotypic self-injurious behaviours as a part of the disability. Most of the youth care workers described the youth with special needs as engaging in self-harm that was an intrinsic part of the disability. Comments such as the following were prevalent. One participant noted;

“People with disabilities were considered different and have their own unique behaviours, so you thought oh well that’s just that.”

Another youth care worker reported; “Where as with a youth with a disability, it [self-harm] just happens.” One youth care worker described youth with low cognitive abilities as being particularly vulnerable to engaging in acts of self-harm.

“Low functioning people are trapped...It is part of their behaviour, part of who they are.”

One theme that emerged from the research was that self-harm in youth with disabilities was just a part of the disability. Unfortunately, the participants felt that there were not any interventions that could be used to stop these actions, since these behaviours were integral components of the disabilities.

The second type of self-injury identified by the participants was compulsive self-injurious behaviour. These behaviours included repetitive hair pulling and skin picking. The hair pulling was done in places such as the eyebrows, pubic area, and the head. One participant had experienced both types of self-harm. She spoke of a young girl she worked with in Newfoundland, “One girl would pull clumps of hair from her head.” Another youth worker had worked with a youth who pulled her eyebrows out.

Chronic skin picking proved to be problematic in that it left the youth's skin in a dangerous and infectious state. Participants explained that skin picking often resulted in youth scratching themselves raw. One youth care worker stated:

"You take say He would scratch and scratch until he rubbed himself raw."

The last type of self-injury identified by the participants was impulsive self-injurious behaviour. The behaviours that the participants identified were cutting, burning, self-hitting, ingesting poisonous objects, inserting objects under the skin, and biting the body. These behaviours were reported more often for youth who were typically developing than for youth with disabilities. Often times youth endeavoured to hide the areas on their bodies where the cutting occurred. Cutting was carried out with a number of objects, including razor blades and broken glass.

"One girl cut herself with razor blades and she used to hide the marks and scars and when we tried to combat it she would cut in areas we could not see, like her feet and basically places that she could cover."

"She would self-mutilate with broken light bulbs or pretty much anything she could get her hands on."

Burning was often times done on the arms or fingers. A variety of methods were used for burning their bodies.

"She would burn her fingers on a heater."

Youth swallowed a variety of objects as a form of self-harm. A very severe, and potentially poisonous form of ingestion was reported by one of the youth care workers, wherein a male youth swallowed batteries.

“...One young man would take two batteries and swallow them to get a reaction.”

One participant reported a youth who inserted needles under her skin. These needles were inserted in places such as the cheek. The youth care workers also described youth who inserted objects in their vagina or rectum.

“She used to self-mutilate with broken glass and stick pins in her...underneath her skin, needles you sew with so you couldn’t get them out.” (Participant pointed to the cheek region).”

There was one type of self-harm that participants witnessed that did not necessarily fit into any specific type of self-injurious behaviours that have been previously reported in the literature. Youth purposely carved their skin to have a tattoo like the other youth in the group home where they resided. The tattooing was done by cutting the skin with a pen or a knife. The participants questioned whether this was self-harm or not because the youth wore their tattoos with pride, rather than hiding their manifestations of self-harm. There was a great deal of uncertainty as to whether this was self-harm or not. As one participant noted;

“The girls did it for their own reasons and all the girls were doing the tattoos because they just thought it was cool to have a tattoo....I don’t know.”

Other types of self-harm mentioned for youth with special needs involved their using a belt to cut off their oxygen. This was a sexual act that did not necessarily fit into the pre-determined categories of self-harm, due to its sexual nature.

“There was a young man that would use a belt, he would put it around his neck and cut off oxygen, and he would have orgasms.”

Participants also mentioned that youth would injure their fingers by sticking them in the wheels of a wheelchair. This act also did not seem to fit into any pre-determined self-harm category.

A prominent theme seemed to be the secrecy of the self-harming act, while at the same time it was viewed as a cry for help. Youth workers often stated they were uncertain why a youth would self-harm. They wondered whether it was a cry for help and if it was why was it often hidden from the staff. One participant noted this dichotomy between hiding the self-injury and a cry for help in the following way;

“It is something they can focus on in a physical way...at times it may be a cry for help, but at the same time when it is done in places that could be hidden, how is that a cry for help if we don't know that it is there?”

One participant had worked in the field for the past ten years and stated, “It is not something I know a lot about.”

Another youth care worker who had worked in the field for more than twelve years said that the knowledge of self-harm has always been there. However, he stated, “If you deal with a lot of nonverbal [youth], it is hard to say what the problem is and how to get to the root. So you are unsure how to help most effectively.” Despite the years of experience youth workers continue to struggle with the topic of self-harm.

Research Question #2: How do youth workers perceive the self-harming behaviours and concomitant interventions of youth who have disabilities and those who are typically developing? Do the behaviours and interventions vary between the two populations?

The participants identified many differences in the self-harming behaviours between youth who have a disability and those who are typically developing. However, there was one common cause identified by participants for both groups. This characteristic was inner turmoil.

“It is to release a rage inside them that needs to come out.”

“It’s almost painful to be in their own skin....the common denominator I would say is the inner turmoil with them all.”

There were a number of other similarities pertaining to the causes of self-harm that the participants noted for each group of youth. Some of these characteristics were internal to the youth and others were external and caused by circumstances in the youth’s environment. Some of the similarities, which were internal, included low self-esteem, emotional pain and sadness, and inner conflict.

“It is usually inner conflict and turmoil that causes them to do this.”

“I am going to say that a lot of their self-abuse was internal and they were angry at people and didn’t know how to express themselves.”

The youth care workers identified external causes for self-harm as low family income and childhood abuse, including sexual abuse.

“The person who cuts, that was a result of a life long [history] of childhood abuse, sadness, and complete numbness.”

“They were definitely sexually abused and had very low self-esteem.”

Disorders were also discussed as a characteristic for all youth who self-harm.

Behavioural, cognitive, and psychological disorders were specifically mentioned. As one participant noted concerning the difference between both types of youth:

“I am thinking of the person who used to pull their eyebrows out and bang their head [youth with a disability], I think that was more of a psychological response. Whereas, the other attention seeking ones [typically developing youth] were more cognitive, more of an anxiety going on in their minds mentally.”

The participants reported that each youth self-harms for their own reasons, yet they do believe there is a difference between youth who have a disability and youth who are typically developing. As mentioned previously, the participants felt that youth with a disability often self-harm because it is a part of the disability. Other reasons offered by participants as to why youth with disabilities self-harm included hypersensitivity to the environment, limited verbal skills, inability to express themselves, loneliness, and a withdrawn personality. In describing hypersensitivity to the environment, the participants particularly noted the negative effect of noise and the manner in which youth with disabilities respond to noise and other environmental stimuli. As one participant stated;

“They bang their head against a wall because they can’t stand the noise and that type of thing.”

“People who are hypersensitive can’t stand to be in their body.”

“Another person, who is autistic, banged their head on the wall to self-harm because they were hypersensitive to their environment.”

Another youth care worker described the challenges in working with cognitively

impaired youth who self-harm and have limited language. As one participant noted:

“It is different with the developmentally delayed, it is tough to read if what you are doing is working, you wait for a reaction, and look at the non-verbal cues....It is a challenge. They can't communicate what they want and they get frustrated.”

It was reported that in order to be effective for youth with disabilities that programs must be used that can help release the sensitivity to their environment. One participant used a program that she believed helped address this hypersensitivity to the environment by involving the youth in washing the walls when they were agitated. She felt this prevented inappropriate self-harming behaviours as it redirected their energy in a more appropriate manner.

“I would make her wash the walls down to get that anxiety out. When she started banging her head on the wall I would say, ‘no you are not doing this’, and we would get a bucket and cloth and I would say ‘start scrubbing’. She would start to get upset and she knew she had to do four walls before she could finish, I would say, ‘if you start to do that, you are going to have to do it all over’. She knew she had to do four walls before she could finish. She was physically exhausted and she would come right out of it and she would sleep a little bit.”

Other characteristics that participants noted about youth with disabilities who self-harm were that some of the youth craved attention, they generally had low cognitive abilities, and exhibited less control over their actions than their typically developing peers who self-harm.

One youth care worker described a young male with whom he worked. He

speculated that the youth had only received physical contact from his parents through abuse. Loving physical contact was unknown to him. When the youth had to be restrained in the youth care facility, he was not resistive to the restraint because it provided him with some needed physical contact, even though such contact was uncomfortable for him.

“One case I worked with, he would see other parents coming in and hugging their kids...His parents weren't around so much, so I think for him the only touch he got was in an abusive situation where we had to restrain. A lot of what had to do with restraining was physical contact.”

Participants had difficulty judging whether or not youth with disabilities were engaging in self-harm because of their limited cognitive and verbal abilities. One youth care worker approached this uncertainty within the context of not knowing whether this self-harm was attention seeking or not.

“Now with non-verbal [youth] their mentality is lower, so maybe it is attention seeking. I don't really see that as coping...It is not something I know a lot about.”

Another participant who had been in the field for 10 and a half years expressed that she was still uncertain as to why youth with disabilities self-harm. She attributed this uncertainty to a lack of communication on the part of the youth. She explicitly noted the difficulty communicating with youth with autism.

“Not being able to express themselves in some way communication wise. Youth that had limited verbal skills or autistic people could not express what they were thinking.”

The youth care workers reported a number of differences in self-harming behaviours for the typically developing youth as compared to the youth with disabilities.

The typically developing youth in residential facilities with whom the participants had worked were high-risk youth who had encountered multiple difficulties in their interactions with their families and peers, and on times with the justice system. Such negative encounters contributed to their having a variety of behavioural problems and emotional difficulties. The youth care workers reported that the actual reasons for the youth's self-harm included such things as anxiety, stress, inner turmoil, and inner conflict. They noted that these typically developing youth harmed themselves intentionally for an explicit purpose. This purpose was to release the youth's stress and to displace their emotional stress by acute pain.

“The verbal ones [typically developing youth] lack coping skills and cannot deal with anxiety or stress.”

“It [self-harm] is something they can focus on in a physical way and feel the physical pain as opposed to the emotional pain.”

One youth care worker described the severity of the stress inherent in typically developing youth who harm as analogous to a pressure cooker.

“A youth that I worked with that cut, self-harmed because he felt like a pressure cooker and when he harmed it released the tension.”

Participants discussed the fact that youth with disabilities have far less control over their actions than typically developing youth who self-harm. They reported that youth with disabilities did not tend to engage in self-harm with a sense of intent or purpose due to the fact that self-harm was a part of the youth's disability. This lack of intent or purpose made it very difficult for youth care workers to know how to intervene in order to help the youth with disabilities in minimizing their self-harming behaviours.

One youth care worker bemoaned the fact that there are no real standard interventions that can be used [for youth with disabilities].

“I find that youth with disabilities don’t have any interventions really that would be in place, standard.”

Throughout the responses, the participants noted far more purpose and a conscious effort to self-harm on the part of typically developing youth. In contrast, youth with special needs were not viewed as intentionally self-harming.

“It is more of a conscious effort for youth that are not intellectually disabled.”

Other participants reported that the act of self-harm was for attention seeking. Part of the sense of purpose for self-harm was an acute need to seek attention from youth care workers and others. Words such as ‘desperate for attention’ were used in describing this situation.

“How much was for attention... She put herself in desperate situations for the attention.”

“They did it [self-harm] because they were attention seeking.”

Yet the responses of the research indicated that workers were uncertain about the real reason for the self-abuse.

“I don’t know if it was a cry for help....a release of pain.”

“I don’t know...I think that all individuals do it for their own reason.”

Overall, participants were unsure why youth self-harm but felt they needed help from outside resources. The general sense was that all of the youth, regardless of their abilities, self-harm for individual reasons. Yet many youth are in places in which workers

do not know how to effectively deal with this behaviour and workers feel that there is a lack of available resources.

“Everybody’s different and that’s the problem and why these treatment plans don’t work because everybody is supposed to fit in that box...and either you fit or you don’t.”

Research Question #3: What interventions do youth workers report they use to address issues of self-harm and which interventions do they perceive as successful?

The participants utilized a number of interventions generally observed from co-workers and based on their experience in the field. However, of the eight participants none mentioned that they have worked directly with a therapist, despite the fact that many felt a therapist should be an integral part of intervention. Techniques that a therapist would apply included guided imagery, “no-harm contracts,” and journal writing, which were not mentioned by any of the participants. The following statement characterizes their lack of confidence and ability in how to deal with self-harm:

“You know what I don’t even find myself being on that level that I as a professional could even deal with that, I am not a psychologist and I personally feel that the only people that could adequately deal with people that are self-mutilators are psychologists.”

The acute need for outside professional help was focussed specifically on psychologists and doctors.

“We really have to push them to see psychologists.”

“It is better to work with their doctor and stuff to get outside help on how to deal with that.”

The participants view of medication varied but there was a general consensus that medication can help youth who self-harm. The youth care workers attested to the value of medication in cases of mental illness, chemical imbalance, and hypersensitivity. However, the participants reported that medication alone does not work. Rather, medication needs to be supplemented by emotional support.

“I think if there is a mental illness that is in fact what is causing it, maybe it is not a mental illness maybe it is a emotional issue...if it is a internal issue and it is a mental illness then for some reason there is a chemical imbalance and there is not quite something right, then medication can definitely help.”

“People who are hypersensitive and can’t stand to be in their body, medication is crucial, we need to give them something that helps them feel comfortable, relaxed, and calm.”

Despite the fact that the youth care workers could see the value of medication in treating youth who self-harm, they were sceptical about the negative side-effects caused by such medication. One participant stated, “Medication is a two sided good and evil. It calms self-abuse but you see all the side effects.” Another participant stated “I am not a fan of medication...but if it is a chemical thing meds can help.” A theme that emerged

from this is one of confusion as to how effective medication really is for youth who engage in self-harm.

The participants generally utilized some of the paratherapeutic interventions discussed in the literature review. Staff are the main source of support for the youth living in the group homes, so they were continually called upon to engage in supportive interventions. Some of the interventions that the participants used were placing the youth in a safe area, talking with them to find an alternate way to deal with the situation and find new strategies, taking away objects that the youth used to self-harm and to self-stimulate to the point of self-harm, and providing both verbal and physical redirection. Other participants mentioned confidence boosting and positive reinforcement as effective strategies wherein they would make a focused effort to enhance the youths' self-esteem in a variety of ways.

One youth care worker described the need to place youth with special needs who self-harm in a safe place where they are unable to harm themselves. Staff felt that directing a youth to a safe room with objects removed was the safest option for youth with disabilities.

“You can only put them in a safe place and limit the access they have to any objects that they can self-mutilate with.”

Another youth care worker who is currently working with special needs youth felt that allowing the youth to get his or her sense of irritability out in a safe place is the most effective method. A safe place would be a secure area where the youth could not engage in self-harm.

“...the approach that is better is to allow her to be in a safe area such as her bedroom to outburst and get it out of her system so that she is not feeling irritable or edgy for the remainder of the day.”

This same youth care worker utilized a different approach with typically developing youth. Rather than isolating the youth in a safe place, she felt that the typically developing youth needed to discuss the act of self-harm with the youth care worker in order to deal with their emotions and to find alternative strategies to self-harming behaviours.

“As far as working with youth at risk [typically developing] my experience has been to have an open conversation about it and come up with strategies to deal with the situation. After the fact, if they feel like cutting to find an alternative way to deal with those emotions.”

One youth care worker reported both adding objects to reduce self-harm and taking away objects causing self-harm. Gloves were added and a shirt was taken away in these instances. This youth care worker put gloves on a youth to get him to temporarily stop himself from rubbing himself raw. An additional method that the participant utilized was to take the shirt from a young man living in the home. The youth used the shirt to stimulate and this would keep him motivated to do things like bang his head on the wall and punch himself.

“If he doesn't have the stimulation of his shirt then maybe he will start biting the blanket, he can bang his head on the bed...it will not hurt like if he banged himself on the wall.”

Redirection was used as an intervention strategy extensively. This strategy differed depending on whether the youth had disabilities or not. Physical redirection was found to be very effective for youth with disabilities. One participant used redirection for a young girl who was autistic, and had her wash the walls as an alternative to head banging.

“I would make her wash the walls down to get the anxiety out...she didn't like to but it helped. Her arms would be sore but at least it was better then banging her head against the wall and cutting her head open. ...she caught on real quickly....she was physically exhausted and she would come right out of it.”

Some participants discussed the fact that they felt that they have a better chance of verbally redirecting a typically developing youth than a youth with special needs. Whereas physical redirection worked best for youth with special needs, verbal redirection was more effective for typically developing youth. They utilized emotional support to help redirect the self-harming behaviour by talking with the youth and helping them deal with their self-harm, stress and anxieties.

“I can support them [typically developing youth] and talk to them and be open with them...make them feel comfortable, sympathize with them, and just being there and show them that I care.”

“You could sit and talk with them [typically developing youth], hear them and that makes them feel better.....a lot of confidence boosting.”

Although general emotional support was believed to be helpful, youth care workers also directly discussed the self-harming behaviours with the youth in order to help the youth deal with this behaviour more effectively. One youth care worker felt that

it was important to be with the youth when they were self-harming. As well, he stated; “I have to stay calm, if I get upset this is no good.”

Overall, the youth care workers were open in discussing their views on intervention within the context of causes for the self-harming behaviours. They acknowledged the importance of interventions, although they recognized that they also should be placing emphasis on finding the root causes of the behaviour so more lasting and meaningful interventions could be generated.

“It is not something that we like to talk about and there is not a lot of information out there and we tend to think of self-harming as behaviours, instead we try to find something to stop that behaviour instead of looking for the root cause of it.”

Research Question #4: How do youth care workers perceive that they have progressed over the years in their understanding and treatment of youth who self-harm?

Participants were asked about their first experience wherein they witnessed a youth engaged in self-harm. The youth care workers responded to this question by discussing both their feelings and their behaviours in the actions that they took to deal with the youths' self-harm.

Most of the participants did not have knowledge about self-harm prior to their experiencing it at their place of employment, and much of their experience was gained from their work environment. The youth care workers had received only limited training

on self-harm and participants used words such as “gross”, “amazement”, “shock”, “intrigued” to describe their initial reaction to seeing an individual self-harm . They were curious and intrigued to actually see someone in the process of self-harming. While at the same time, the severity of the act was both disturbing and difficult to watch. Comments regarding the participants’ feelings toward their initial reaction to seeing a youth self-harm included such statements as;

“The first time I saw someone self-harm I was a bit in amazement and curious....intrigued as well as shocked.”

“Shock...the first time was when I saw a person try to break their finger in a wheelchair. Why would someone want to do that to themselves?”

“Shocked, couldn’t believe they were hurting themselves, it looked painful...I wasn’t prepared.”

Other participants demonstrated their empathy for persons who self-harm. Their initial feelings in first seeing someone self-harm were that of “sadness” and “pity.” The youth care workers felt sad because they did not understand why someone would intentionally hurt oneself. As one participant stated;

“Yes it [self-harm] is sad and one of those things that is hard to understand.”

The same participant felt “pity, actual pity” for the youth that she had seen self-harm.

The majority of the participants expressed a lack of understanding regarding self-harm. They felt that workers have to understand the topic in order to be most effective.

“I have always been interested in self-harm...there is very little information out there. You can’t work with a diabetic if you don’t understand it and here we are

working with youth that self-injure, we should understand why they are doing this and yet to change that behaviour that makes it hard to do.”

The majority of participants had stood back and observed what their co-workers did the first time they saw a youth self-harm. This is a result of not knowing that self-harm existed as well as, not having the skills to deal with self-harm effectively.

“I was orientating that shift [when a youth attempted to break their finger in a wheelchair] so I watched what everyone else did.”

Participants struggled to deal with self-harm and how to help youth when they were beginning youth care workers. All participants were trained in crisis prevention and intervention and they noted that this training was helpful. However, the lack of any explicit written policies on self-harm and intervention contributed to their confusion and uncertainty. All the participants said that there were not specific written policies in their current place of employment pertaining to self-harm. There were unwritten policies that staff utilized such as providing prescribed medication, placing the youth in a safe area, and following individual program plans. The participants described methods that they utilize to help a youth who self-harms despite the fact that there is no concrete policy in place.

“I support the use of medication [to help with the anxiety]....PRN’S.”

“....we [staff] use CPI [non-violent crisis intervention], all the staff are trained in CPI.”

Another participant described the ‘only policy’ that was protocol for youth who engaged in self-harm was their individual program plan. When asked about policy, one

youth care worker described an unwritten policy in place for a youth she was currently working with, but did not describe any policies for the other youth.

“The policy is for one lady to get her in a safe area and we use different techniques to de-escalate any behaviour at the time.”

There were expressions of hesitation on whether there were any specific policies that were in place that were utilized when dealing with self-harm. None of the youth care workers were able to provide any explicit examples of written policies for the three residential facilities.

“There are probably policies....most of the policies have probably been changed.”

“I know for certain houses I have worked at most of the policies are just let it [self-harm] run its course as long as there is no real life threatening self abusive state.”

The youth care workers discussed the lack of formal training specific to self-harm. None of the participants had taken courses specifically geared toward self-harm and effective interventions before starting their careers as youth care workers. Their post secondary training institutions and universities did not address the topic of self-harm in any detail. Much of their training had come once they gained employment in a residential facility. Collaborative teamwork, reading about self-harm, using their intuition and advice from outside sources were mentioned as helping them learn about self-harm. Only a few mentioned attending conferences or workshops and none of the participants provided any detail about such experiences. It was apparent that much of the participant's experience with self-harm came from their work environment and watching their co-

workers dealing with youth who self-harm. One participant explicated stated that the majority of her experience came from her practice;

“Most [experience] is from the people who work in this field with the particular individuals and gave us ideas of what may work or worked in the past.”

The youth care workers were also asked to describe their progression over the years in practice for both understanding and treating self-harm. They responded to this question by discussing the changes in their knowledge of self-harm. Changes in knowledge had more of an impact on practice for some participants than for others. One participant described how desensitization helped her deal with self-harm more effectively. As she encountered more experiences with youth who self-harm she became less alarmed and more able to deal with new experiences more objectively and effectively.

“I think I have built upon past experiences but I think as you go in this field you get desensitized so it [self-harm] does become easier to deal with.”

Some youth care workers readily expressed that they had gained more experience in understanding and dealing with self-harm in their years of practice. Another participant who had been unaware of self-harm when she started in the field felt that she has made progression from her years of experience. She has dealt with self-harm by using the common sense and knowledge she has acquired over the years. This participant stated;

“When I was in my twenties [just starting] I probably would not have been able to come up with something [effective strategies to deal with self-harm] so it is all that knowledge and experience over the years [that resulted in growth of her knowledge on how to deal with self-harm].”

Another youth care worker felt that she was gaining valuable experience despite the fact she was not initially prepared to deal with self-harm. With each experience encountered, her understanding of self-harm grew.

“As I get older and working in different areas you learn from each experience, each experience is different....experience will make things change.”

Another participant felt that she has gained professional competence in dealing with self-harm through experience and by speaking with other professionals to gain new ideas.

Other participants did not feel that there had been any substantive change in their knowledge of self-harm or of the strategies they used in treating self-harm as they progressed in the youth care profession over the years. Still other participants felt that although they had changed over the years through practice, that they were still uncertain how to effectively deal with self-harm. The following statement exemplifies her uncertainty pertaining to her progression of understanding self-harm. She explained that she had learned for each experience with self-harm;

“Yes....as I get older and working in different areas you learn from each experience.....not sure if I can answer that”

Yet when she was asked how her approaches had changed over the years, she displayed uncertainty.... “not sure”.

Although some of the youth care workers reported professional growth in dealing with self-harm, all the participants demonstrated that despite their years of experience they were still not entirely comfortable with the topic of self-harm. They were still uncertain why youth self-harm and how to help them stop the harmful behaviours.

E. Summary

In summary, the youth care workers reported three distinct types of self-injurious behaviour encountered in their practice in residential group homes; 1) stereotypic self-injurious behaviour, 2) compulsive self-injurious behaviour, and 3) impulsive self-injurious behaviour. The participants reported self-harm, such as head banging, self-biting and punching, to be the most common form of self-harm for youth who had disabilities. These behaviours were recognized by youth care workers as part of the youths' disabilities. Self-injurious behaviour, such as hair pulling and skin picking was evident in both youth with disabilities and those who were typically developing. Impulsive self-injurious, such as cutting and burning, was attributed most often to typically developing youth. Within these categories of self-injury, youth care workers described different varieties of self-harm, many of which had been described in the literature. However, several types of self-harm described by the youth care workers were different varieties of self-harm than those discussed in the literature. There was no discussion in the literature of carving tattoos, cutting off oxygen with a belt, ingesting batteries, and sticking fingers in the wheels of a wheel chair.

The youth care workers were asked to describe the youths' behaviour in regards to the differences between typically developing youth and youth with disabilities, and differences in interventions utilized. The participants had identified an inner turmoil as the main characteristic for both youth with disability and typically developing youth. The youth care workers identified both internal and external factors that contributed to the youth self-harming. Internal factors such as low self-esteem, emotional pain, and inner conflict were recognized and factors such as childhood abuse and low-income families

were acknowledged for the external factors. Both groups of youth were identified as having disorders which contributed to their self-harm. Cognitive disorders pertained to the youth with disabilities, psychological disorders to typically developing youth, and behavioural disorders for both groups. Participants noted that all youth harm for their own reason. However, they did feel that youth with disabilities self-harm as a part of the disability, and that other factors such as limited verbal skills, loneliness, and a hypersensitive to their environment also contributed to the self-harm. Other reasons stated for the self-harm for youth with disabilities were such things as attention craving and the need for physical touch. Youth care workers felt the best intervention for youth who have a disability is to place the youth in a safe environment to release the sensitivity. One participant directed a youth to wash the walls when they were upset to take the focus off hurting herself. The participants spoke about typically developing youth as high-risk youth who have had difficulties in their family and with the law. As well, they felt typically developing youth self-harmed due to anxiety, stress, and inner conflict and turmoil. The participants felt that typically developing youth had a purpose to their self-harm such as displacing their emotional pain by physical acute pain. The youth care workers felt that there were no real standard interventions in place to deal with the self-harm of typically developing youth.

Participants were asked to describe the interventions they use in further detail. They mentioned that getting outside help was important but none of the participants had actually worked in consultation with a psychologist or psychiatrist. The participants were asked about medication as an intervention. The youth care workers said that medication could help youth who self-harm when such self-harm was connected to a mental illness,

chemical balance, or hypersensitivity to the environment. The participants said that the medication should be used in collaboration with emotional support. However, some youth care workers felt medication could cause negative side effects. The participants used some of the paratherapeutic interventions described in the literature review. Some of the interventions listed were placing a youth in a safe place, talking with them to find alternate solutions, taking away objects used to self-harm, providing verbal and physical redirection, confidence boosting, and positive reinforcement. Participants felt that it was especially important to place youth with disabilities in a safe area to decrease the extent of the self-harm. Another example of decreasing the stimuli associated with self-harm included putting rubber gloves on youth who scratch themselves raw. Redirection was the most used intervention by all participants for both groups of youth.

Finally, youth care workers were asked how they have progressed over their years of experience. The youth care workers spoke about their first experience witnessing the act of self-harm. The participants used such words as “gross”, “amazement”, “shock” and “intrigued” to describe how they felt that first time. They were curious yet disturbed by the act. As well, they felt pity and sadness during their first experience. Generally, the participants watched their co-workers during that first occurrence. The youth care workers were not specifically trained to deal with self-harm but they did have training in crisis prevention and intervention. All of the participants said there were no specific policies in the organization that they had to follow but they used unwritten policies such as medication and individual program plans. The participants had learned about self-harm mostly from their team members, reading material, intuition, and outside resources. However, the best of their experience came from working as a youth care worker in

group homes. Participants felt they have changed through practice in dealing with self-harm yet they continued to express uncertainty as to the most effective methods.

Overall, the interviews indicated that staff have a level of uncertainty as to the reasons for self-harm and the most effective interventions. It appears further research should be completed to uncover the most effective interventions when dealing with youth who self-harm.

Chapter V

SUMMARY, DISCUSSIONS AND RECOMMENDATIONS

A. Summary

There is research on self-harm and the types of self-harm, yet there is limited research on effective interventions when dealing with the youth who engage in self-injurious behaviour. This research investigated youth care workers' perceptions pertaining to many aspects of self-harm, including the causes of self-harm and the interventions used by youth care workers when dealing with self-harm in the residential facilities where they work. Differing perceptions held by youth care workers pertaining to the causes and interventions used in treating self-harm when working with both youth with disabilities and typically developing youth were addressed. The youth care workers reflected on their progression over their years of practice working in youth care facilities in order to explore effective interventions that staff have utilized with the youth and to determine if their methods have changed over their careers.

Interview questions were developed that sought to discover interventions that staff found helpful in diminishing or stopping youths' self-harm in order to find out the types of self-harm that staff have witnessed. The types of self-harm found in the research included compulsive self-injurious behaviour, stereotypic self-injurious behaviour, and impulsive self-injurious behaviour. Three forms of self-harm emerged that were difficult to classify as they had not been previously discussed in the literature; 1) tattooing, 2) cutting off oxygen with a belt (strangulation), and placing fingers in the wheels of a wheelchair (breaking bones).

Low self-esteem, emotional pain, sadness, and inner turmoil were identified as characteristics common to both youth with disabilities and those who are typically developing. Behavioural disorders were also identified for both groups of youth. Differences between youth who self-harm according to whether they are typically developing or have special needs were as follows. Typically developing youth were perceived to have psychological disorders, while youth with special needs were believed to have cognitive disorders. The participants perceived the actual disability to be the root cause of self-harm for the youth with special needs. Hypersensitivity to the environment, limited verbal skills with a concomitant inability to express themselves, loneliness, and craving attention were also attributed to youth with disabilities. In contrast, typically developing youth were perceived as engaging in self-harm due to a specific intent or explicit purpose. This purpose was to release stress, to displace their emotional stress, and to replace their emotional stress by acute pain. Typically developing youth were also perceived as engaging in self-harm for acute attention seeking.

The youth care workers reported a number of supportive interventions that they used with young who self-harm. These included medication supplemented by emotional support, using "safe areas", taking objects away used in self-harm, confidence boosting, and positive reinforcement. Verbal redirection and extensive discussion regarding self-harm was found to be effective with typically developing youth, while physical redirection was used more extensively for youth with special needs.

Youth care workers had received limited training in self-harm prior to their employment. They described the dichotomous feelings of being intrigued and shocked, while also having feelings of sadness and pity, when they first encountered self-harm.

Due to both their lack of training in self-harm and lack of agency policy, the participants felt confusion and uncertainty in how to deal with self-harm.

B. Discussion

i. Uncertainty and Confusion

One major theme that emerged throughout the research questions during each interview was that of uncertainty and confusion. Youth care workers revealed this uncertainty when they were asked about causes of self-harm, when they were requested to describe the types of self-harm and when they were asked to discuss the interventions that they used when treating youth who engaged in self-harm.

One aspect of uncertainty and confusion that was reported by the participants pertained to the causes of self-harm. For youth with special needs, the youth care workers had a difficult time differentiating characteristics of the disability from the characteristics of self-harm. They reflected on whether self-harm was actually part of the disability or whether it was separate from the disability and most concluded that, the act of self-harm was a part of the disability. The literature review covered the most effective types of interventions for youth who have a disability. These interventions included redirecting inappropriate behaviours, decreasing stimulation, giving choices, and maintaining non-threatening tone of voice and body language (Fouse & Wheeler, 1997). The participants had used such methods but expressed uncertainty as to the effectiveness of the interventions. The consensus from the participants was that they used these interventions but questioned the true effectiveness and questioned if there were interventions that might be more effective.

A second source of confusion and uncertainty pertaining to the causes of self-harm in youth, was the dichotomy of whether self-harm was a cry for help or whether it was a secretive act that they did not want others to know about. The participants felt that for typically developing youth the act of self-harm was more an attention-seeking act than it was for youth with disabilities. The horrendous nature of the act causes great attention and concern on the part of caring youth care workers. It engages their attention immediately. Yet self-harm is also a secret act. Youth often cut, burn, ingest, and pick themselves in places that cannot be noticed. The youth care workers questioned how self-harm could be attention seeking, yet secretive. One participant stated that a group of youth she worked with cut for attention, but she also experienced youth hiding such things as their wounds and therefore questioned the need for the youth to receive attention for the act of self-harm. As well, sticking needles in the vagina and rectum was a form of self-harm that was mentioned. The rectum and vagina are surely secretive parts of the body that cannot be readily observed. Yet again, the youth care workers expressed confusion as to the attention seeking versus the hiding of the act and then questioned the real reason for self-harming.

The participants listed many forms of self-harm that were consistent with the research. A variety of stereotypic, impulsive, and compulsive forms of self-harm were described in detail (Fritz, 2004, Strong, 1998). However, more forms of self-harm were uncovered from this research and the youth care workers were challenged to understand the new forms of self-harm they had experienced. Specifically, group tattooing, cutting off oxygen with a belt (strangulation), and placing fingers in the wheels of a wheelchair (breaking bones) were found. One participant had worked in an organization that dealt

with youth who were typically developing. During her time, she worked with young girls who purposely carved tattoos in their arm. This resulted in her questioning the reasons for this act, again an uncertainty as to why people would do this to their bodies. She wondered if it was a way for the girls to bond as a group or whether they were self-harming as a group. The participant wondered as well if the tattooing was done for a fashion statement. Another youth care worker described a male who cut off his oxygen with a belt. Again, this led to the ambiguity if this was done as a form of self-harm or whether it was a form of sexual gratification. Another participant worked with a young female who would place her fingers in the wheel of her chair to harm herself. The youth care worker could not envision the pain of such an act and as such, the pain she believed the youth experienced disturbed her. Despite the years of experience of each participant, their uncertainty as to the new types of self-harm was evident and they struggled to find answers.

ii. **Effective Interventions**

The participants discussed a variety of interventions that they have utilized thus far in their careers as youth care workers. These interventions included specific techniques, such as providing youth with a safe place where they cannot engage in further self-harm and where they will be free from further injury. An important component of placing youth in a safe place includes the elimination of any objects that they use to self-harm. Fouse and Wheeler (1997) noted decreasing stimuli as important to the intervention process. A safe place should therefore be as free from stimuli as possible.

The youth care workers reported taking youth to their rooms and removing potentially harmful objects.

Although providing a safe place and removing potentially harmful objects were interventions used for all youth who self-harm, the participants discussed the fact that these interventions were particularly important for youth with special needs. When youth have special needs, the youth care workers considered safety and decreased stimulation as the most important considerations (Fouse & Wheeler, 1997). Research has shown that youth with disabilities self-harm in order to block out excessive stimulation or to increase arousal during periods of under-stimulation (Ristic, 2005). The participants articulated the belief that the best intervention when youth with disabilities were over-stimulated and attempting self-harm was to direct such youth to their rooms. Their rooms provided a safe environment where they could release the agitation from their systems in an area that was not over-stimulating.

According to Ristic (2005), interventions for youth with disabilities should be individualized and match the specific function of self-harm, i.e. sensory stimulation, attention, escape, and so on. Some such individualized interventions were described by the participants. One youth care worker describe putting gloves on a youth who self-harmed by rubbing himself raw. The gloves provided protection for his skin. Another participant worked with a youth who would self-stimulate by twirling a shirt, and this led him to bang his head against a wall and punch himself. This participant would remove the shirt so the youth would then bang his head on his mattress, a much safer method than using the wall.

The participants felt that physical redirection for youth with disabilities was the most effective intervention method. One youth care worker described engaging a youth in washing all the walls in a room thoroughly when she was about to engage in self-harm. In doing so, she physically redirected the self-harming behaviour into an acceptable physical activity. The youth would eventually tire from this physical activity and would refocus her energy on the physical task of wall-washing, rather than self-harming behaviours. Through mutual verbal discussion the participant and the youth were able to verbally redirect the youth's thoughts to activities other than harming herself.

In contrast to physical redirection as a primary intervention method when working with youth with disabilities, the youth care workers believed that verbal redirection and in-depth conversations were the most effective intervention strategies for typically developing youth. The youth care workers felt that the staff should discuss self-harm with the typically developing youth to find alternate strategies when dealing with their angst. Such conversations could assist the youth care workers in determining what could be done to stop the act of self-harm or at least to reduce the instances. Getting to the "root" of self-harm appeared to be the primary objective when working with typically developing youth, and conversations with such youth helped the youth care workers better understand the causes or reasons for this self-harm.

In addition to using specific techniques, youth care workers utilized some general interventions, such as praise, confidence boosting and raising self-esteem, and relaxation. The participants praised the youths' efforts when decreases in self-harm occurred, such as when self-harm occurred only once a week rather than three times in a week. This specific praise acknowledged substantive progress, and consequently helped raise the

youths' self-esteem. Other ways in which youth care workers assisted in raising youths' self-esteem were having the youth write down positive qualities about themselves and engaging them in activities in which they could excel. If youth were athletic, they would engage them in sports, and if they were creative, they would engage them in art or music.

Medication was one therapeutic intervention discussed as important to treatment of youth who self-harm. However, the participants had conflicting feelings pertaining to medication in that they felt it could reduce anxiety, but there can be negative side effects resulting from such medication. The youth care workers felt that medication should always be used with emotional support.

With the exception of medication, a number of therapeutic intervention techniques generally initiated by psychologists, doctors or psychiatrists were not mentioned by the youth care workers. Specific techniques such as guided imagery, journal writing, behavioural reframing, and no-harm contracts were not mentioned by any of the participants. In my seven years of experience in working with youth who self-harm I have seen a number of intervention techniques used in residential group homes. I have used contracts that include realistic alternatives to self-harming in collaborating with youth and I have engaged in the journal writing process with youth to assist them in dealing with their behaviours. I have also focused on encouraging the youth to engage in a variety of relaxing activities, such as going for walks, listening to music, engaging in yoga, participating in art activities or taking bubble baths. Additionally, I have helped youth experience a cathartic release by providing them a place to scream and yell in order to release pent up emotions. These techniques were not only used by me, but also by other youth care workers in the residential youth care facilities in which I have worked. It

may well be an oversight, that the youth care workers did not mention some of these effective intervention techniques.

One explanation for this omission might be the fact that none of the youth care workers in this research had worked directly in consulting with professional from other disciplines, although most of the youth care workers expressed the desire to work collaboratively with them. A second explanation might be that the youth care workers simply forgot to mention the intervention techniques that they use, and in the interviews, I did not supply prompts of any kind.

iii. Lack in Training and Policy for Self-Harm

It was apparent from the study that the youth care workers were not prepared to effectively deal with self-harm during their first experience in their career. The study revealed that despite the frequency of self-harm in residential youth care facilities, none of the participants had received effective formal training in their university or diploma courses in youth care. In fact, some of the participants had not even heard of self-harm before they began their careers in the youth care profession. All youth care workers agreed that the most substantive and effective training that they had received on self-harm was by observing the interventions used by experienced staff in the workplace, and by modeling such interventions. This modelling was supplemented by independent reading on the topic. Some workshops and in-services attended by the participants touched on the topic of self-harm, although self-harm was not the major focus of these sessions.

In addition to the lack of training on self-harm at the pre-service and in-service levels, none of the three residential facilities had developed specific policies on self-harm that could be used in guiding the youth care workers in understanding of self-harm and concomitant interventions. Some youth had Individual Program Plans that were followed and these plans did address self-harm. The youth care workers reported that such plans were helpful, but it would have been even more helpful to have overall policy developed that pertained to all the youth in the facility.

Overall, the lack of training and specific agency policy made it doubly difficult for the youth care workers to understand self-harm and to know how to intervene effectively. This lack in training contributed to their dichotomous feelings of being intrigued, shocked, and yet at the same time having pity for the youth who engaged in the act. These feelings are consistent with those of teachers (Best, 2004) who felt curiosity and shock when they first encountered youth in schools who engaged in self-harm. More training prior to entry into the youth care and teaching professions could potentially contribute to assisting both groups of professional in dealing with overwhelming feelings pertaining to youth's self-injuring behaviours. Therefore, this supports the idea that there needs to be formal training at both the pre-service and in-service levels for those working with youth who self-harm.

Youth care workers rarely talk together about self-harm, mostly due to a lack of understanding of the act of self-injury and how to react and deal with self-harm effectively. One participant discussed the importance of intervention relative to understanding the causes of self-harm.

“It is not something we [staff] like to talk about and there is not a lot of information out there and we tend to think of self-harming as behaviours, instead we should try to find something to stop that behaviour instead of looking for the root cause.”

This difficulty in discussing self-harm and appropriate interventions is not found only in the youth care profession. Leverkusen’s (1998) research found that therapists knew relatively little about self-mutilation and were reluctant to discuss interventions due to their lack of knowledge. It is ironic that the youth care workers in this research perceived therapists as experts who could provide guidance to them on self-harm, because if therapists are reluctant to discuss self-harm amongst themselves, they may be unable to provide guidance to youth care workers in developing and using effective interventions.

iv. Summary

Currently there is little research on self-harm and interventions in residential youth care facilities. Research that does exist focuses on the differing types of self-harm but there is limited research on effective interventions. This research project was completed to determine residential youth care workers perceptions of self-harm and the interventions they find to be successful. It is important to explore the perspectives of the residential youth care workers because they are the individuals who have to deal with self-harm on a daily basis in a youths home environment. Youth care workers are often the only support that a youth has and it is important that staff know how to deal most efficiently with the youth issues.

The research determined that youth care workers require more training during their educational endeavours and they should be provided with continuous workshops and courses on self-harm during their career. As well, the research determined that staff did not have the level of confidence to deal with self-harm that they believe they should have attained from their studies. Therefore, it is apparent that further research must be completed on finding the most beneficial interventions.

Limitations

1. Limitations exist for this study due to the choice of qualitative research.

Interviews were determined to be the most appropriate method for gaining in-depth information on the sensitive and complex topic of self-harm. Due to the interview format, there were a somewhat limited number of participants.

Therefore, the results may not necessarily be sufficient to generalize to the larger population.

2. Participants had one interview only wherein they were asked to describe interventions that they used. A more structured, follow-up interview or focus group might have uncovered more specific interventions that are routinely used in youth care facilities.

3. Self-harm can be a sensitive topic for discussion and participants could have difficulty reliving their experiences, which could potentially limit their discussions. Since youth care workers volunteered to be interviewed on self-harm, they were willing to discuss the topic, however.

4. Audio taping may cause discomfort for some participants and limit responses and participation. However, the participants to feel as comfortable as possible.
5. Staff who have more experience with interventions on self-harm may be the ones who agreed to participate in the research. Therefore, there is the possibility that the interviews may not reflect the feelings of other youth care workers and caution must be exercised when interpreting results.

C. Recommendations

Due to the low number of interviews conducted, the results should be interpreted with caution. It is complicated when establishing conclusive outcomes due to the limited amount of data available. The hope is that the study will lead to further research and it may answer some of uncertainties that the participants struggled to answer.

Recommendations for future research:

1. The sample size for this research was small. Future research could allow for more participants to be interviewed. Such interviews could be more comprehensive, allowing for a more in-depth analysis of interventions that staff have used.
2. Research methodology other than interviews could be used. Survey research would encompass a far larger sample, case study methodology would engender a more an in-depth analysis, and focus group research would provide opportunities for group discussion.

3. Future research could be carried out in different youth care settings. Facilities such as day treatment programs, and programs within the juvenile justice systems could be included in such research in order to examine a wider range of youth.
4. The research could be carried out with the youth themselves, and allowing the youth with opportunities to share the interventions that they have found to be effective and to discuss the reasons that they engage in self-harm.

For Practice:

1. Youth care organizations should require their group homes to develop policies and procedures pertaining to self-harm. Such policies and procedures should be included in the policies and procedures manual for each home.
2. Youth care organizations should offer more professional development in-service opportunities to enable the staff to learn more about the causes and interventions for self-harm.
3. Youth care workers organizations could promote networking between youth care workers and other professionals such as therapist, psychologists, psychiatrists, and doctors, outside the group home environment. The purpose of such networking would be discussions pertaining to self-harm, and the expectations for both youth care workers and the other professionals.
4. Post-secondary training institutions should develop extensive curriculum on self-harm. Universities and colleges that educate youth care workers could

either develop courses on self-harm, or integrate course content on self-harm into pre-existing communication or behavioural courses.

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Appendices

Appendix A

Letter to Directors of Residential Youth Care Facilities

Dear (Director of Residential Youth Care Facility):

My name is Tanya O'Rielly and I am currently enrolled in the graduate Child and Youth Study program at Mount Saint Vincent University. I recently spoke to you on the phone regarding my research on interventions that staff utilize when dealing with youth who self-harm. Thank you for agreeing to meet with me to discuss this research.

The purpose of this study is to provide youth care workers with a better understanding of self-harm and interventions that may be effective to stop or diminish this behavior. The proposed research will involve gathering qualitative data through interviews with youth care workers employed in three residential youth care facilities in the Halifax Regional Municipality. Approximately eight youth care workers will be interviewed. Interviews will last between thirty and sixty minutes and will be arranged with youth care workers at a time convenient for them. All data gathered during this study will be confidential.

Thank you for agreeing to participate in this research. I am further requesting that you distribute the staff envelopes that I have brought with me today. Each package includes a letter to the youth care worker providing details of the research study and describing the rights of the participants, an informed consent form, a demographic questionnaire, and a return envelope. Staff will be asked to read the material given to them and to fill out the consent form and demographic questionnaire, to place them in the enclosed envelope, and to place their sealed envelope in the large collection envelope in your office. Copies of all materials are attached for your information.

Thank you for agreeing to participate in this research and for your time and support. If you have any questions or concerns you may contact me at (902) 456-4504 (email: torielly97@hotmail.com) or my thesis supervisor Professor Harriet Field at (902) 457-6548 (email: harriet.field@msvu.ca). If you wish to speak to someone who is not directly involved in the study, you may contact the Chair of the University Research Ethics Board, Dr. Genevieve Boulet at (902) 457-6305 (email: genevieve.boulet@msvu.ca).

Sincerely,

Tanya O'Rielly
Master of Arts in Child and Youth Study Student
Mount Saint Vincent University

Appendix B

Letter of Permission to Residential Staff

Dear (Residential Youth Care Worker),

My name is Tanya O'Rielly and I am currently enrolled in the Master of Arts (Child and Youth Study) degree at Mount Saint Vincent University. I have worked as a Youth Care practitioner for the past six years. The purpose of this research is to investigate youth care workers' perceptions of self-harm and interventions used to diminish the self-harming behaviours of youth in residential facilities.

You are invited to participate in this research. This will involve participating in an interview focusing on your perceptions of self-harm, your experiences with youth who engage in self-harm behaviours, and the strategies you use when dealing with these situations. For example, you will be asked to tell me about the types of self-harming behaviours you have witnessed when working with youth, and why you think that youth engage in self-harm. Approximately eight youth care workers employed in four residential youth care facilities in the Halifax Regional Municipality will be interviewed. Interviews will last between thirty and sixty minutes and will be arranged with youth care workers at a time that is convenient for them. Interview sessions will be audio-taped and transcribed. There are no right or wrong responses as all discussion is relevant to this research. A small number of respondents will be randomly selected for a follow-up interview.

If you are interested and willing to participate, please read the material provided and fill out the consent form and demographic questionnaire that are attached, place them in an envelope, and return them to the pick up box in the director's office. Interview questions will focus on your experience with youth that engage in self-harm, the interventions you utilize, and your perceptions of self-harm.

All data gathered during this study will be kept strictly confidential whenever possible. Demographic questionnaires, informed consent forms and interview transcripts will be numerically coded for confidentiality purposes. The electronic files are password protected. Transcripts, questionnaires, notes and audiotapes will be stored securely in a locked filing cabinet in the researcher's office. Once the tapes have been transcribed, they will be destroyed. Information pertaining to legal infractions that affect the safety and well-being of youth, such as child abuse of minors, cannot be kept confidential and must be reported by the researcher and her thesis supervisor to the appropriate agency or authority.

Your participation is voluntary and you have the rights to withdraw from this research at any time without consequences, to request that the tape recorder be turned off, and to refuse to answer questions. Every effort will be made to ensure that you are comfortable during the interview. While participating in the interview process should not cause concern, someone will be available for consultation and support if need be.

This topic is of importance to me and I would like to thank you for your time and knowledge. If you have, any questions please feel free to contact my supervisor, Professor Harriet Field at (902) 457-6548, (email: harriet.field@msvu.ca) or me at (902)

456-4504, (email: torielly97@hotmail.com). If you wish to speak to someone who is not directly involved in the study, you may contact the Chair of the University Research Ethics Board, Dr. Genevieve Boulet at (902) 457-6305, (email: Genevieve.boulet@msvu.ca).

Sincerely,

Tanya O'Rielly
Master of Arts in Child and Youth Study Student
Mount Saint Vincent University

Appendix C
Interview Consent Form

Interview Consent Form

I, _____, hereby agree to participate in a study entitled
 (Please Print)
 “Residential Youth Care Workers Perceptions of Self-Harm and Interventions,”
 being conducted by Tanya O’Rielly.

I agree to participate in one interview for this research. Sample questions will include telling the researcher about the types of self-harming behaviours I have witnessed and discussing why I think that youth engage in self-harm. The benefits of this research include the discovery of effective and successful interventions valuable in dealing with youth who engage in self-harm.

I understand that my participation is voluntary, that I can request the stopping of the audiotape, that I have the right to refuse answering questions, and that I can withdraw from the study at any time without consequence. While participating in the interview process should not cause concern, I realize that someone will be available for consultation and support if need be.

I understand that confidentiality will be maintained whenever possible. I further recognize that any information I provide pertaining to legal infractions that affect the safety and well-being of youth, such as child abuse of minors, must be reported by the researcher and her thesis supervisor to the appropriate agency or authority.

I have been assured on the proper storage of data in a locked filing cabinet in the office of the researcher for the duration of the research and of the proper disposal of such data at the termination of the study. I have been informed that the duration of the session will be approximately thirty to sixty minutes

If you have questions about this research, please contact me, Tanya O’Rielly at (902) 456-4504, (email: torielly97@hotmail.com), or my thesis supervisor, Professor Harriet Field, (902) 457-6548, (harriet.field@msvu.ca). If you have any questions or concerns about this research and would like to speak with someone not directly involved with this study, you may contact the Chair of the University Ethics Board, Dr. Genevieve Boulet at (902) 457-6305, (email: Genevieve.boulet@msvu.ca).

Participant _____ (please print) Researcher _____

Signature _____ Signature _____

Phone number where I can be reached to set up an interview: _____
 The best time to call me is _____

If you wish to receive the results upon completion of this research project, please provide your mailing address:

Appendix D
Demographic Information

Demographic Information

Please place check marks in the appropriate blank spaces

1. Age: 20's _____
 30's _____
 40's _____
 50's _____

2. Gender: Male _____
 Female _____

3. Education: High school: _____
 College: (1, 2 or 3 year program) _____
 University Degree: _____
 Other: _____
 If "other", please specify the education: _____

4. How many years have you worked with youth?
 Less than two _____
 2-4 _____
 5-7 _____
 9-11 _____
 12 or more _____

5. Check the types of youth residential facilities in which you have worked.
 Facilities with disabled youth only _____
 Facilities with typically developing youth only _____
 Facilities with both disabled and typically developing youth _____

6. Write the number of youth care facilities in which you have worked. _____

7. Approximately how many years have you worked with youth who self-harm?
 Less than two _____
 2-4 _____
 5-7 _____
 9-11 _____
 12 or more _____

8. Approximately how many of the youth you worked with have engaged in self-harming behaviours?

Less than five _____

20-25 _____

5-10 _____

30 or more _____

10-15 _____

15-20 _____

9. Indicate the age range of the youth who self-harm with whom you have worked.

10. Estimate how common you feel that the problem of self-harm is.

Extremely common _____

Very Common _____

Common _____

Somewhat common _____

Rare _____

Never Occurs _____

Appendix E
Interview Questions

Interview Questions

1. a) Please describe the type of youth care facilities you have worked in and the approximate amount of time you have been employed in such facilities.
b) Have any of the youth in these facilities engaged in self-harm?
2. Tell me about the types of self-harming behaviours you have witnessed when working with youth.
3. a) Based on your experience, what are the characteristics of youth who self-harm?
b) If you have worked with youth disabilities and typically developing youth, please describe the characteristics of youth who self-harm from each group. Are there differences between the two groups?
4. Why do you think that youth self-harm?
5. a) Please share with me your reaction the first time you saw someone self-harm.
b) How did you respond to this situation?
c) Were you prepared?
d) Did you have prior knowledge and training to deal with this situation?
6. a) Please share with me the approaches you find helpful when working with people who self-harm.
b) Which approach or approaches do you find most effective?
c) Which interventions do you find most effective with typically developing youth and with developmentally delayed youth?
d) Please describe the sources you have used in developing your strategies.
7. There are many approaches used when working with youth who self-harm. What role do you think medication plays in treatment of individuals who self-harm?

8. Have your reactions to self-harm and the approaches that you have used changed over the years?
9. Are there any policies regarding self-harm in the youth care facility where you are currently employed? Could you please describe the policies?
10. Is there anything else that you would like to add about your experience with youth that self-harm?