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Self-injurious behaviour among adolescent girls in residential treatment.

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SELF-INJURIOUS BEHAVIOUR AMONG ADOLESCENT GIRLS IN RESIDENTIAL TREATMENT

by

Kathleen Florence Irwin

A Thesis
submitted to the Faculty of Graduate Studies
through the School of
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of the requirements for the Degree
of Master of Social Work at
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Windsor, Ontario, Canada

1979

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ABSTRACT

The purpose of this study was to report on related literature and to examine the phenomena of self-injurious behaviour at a residential treatment centre, Maryvale in Windsor. The project was intended to explore the occurrence of self-injury, the reported motivations and the apparent impact of this behaviour upon others. The theoretical interpretations of self-injurious behaviour, particularly among non-psychotic, non-retarded individuals were reviewed. In addition, data was collected regarding selected factors in social histories, sociometric status of sampled residents, the observations and opinions of the staff and girls regarding their experience with self-injury, and the general adjustment of the girls to residential treatment.

The research design was exploratory descriptive. Data was collected through the use of a checklist applied to case records, and three questionnaires, sociometric, girls and staff, all of which were developed by the researcher. In order to direct the examination of the phenomena of self-injuring at this centre, an hypothesis and six research questions were developed.

Review of the case files revealed that some factors appeared to be associated with the etiology of self-injurious behaviour, including family suicidal histories; frequent unresolved separations and health history, among others. The identified self-injurers were found to be least popular as a group; however the hypothesis, that those girls who are least preferred by their peers have exhibited a predisposition towards participation in self-injurious activities, was not supported by the ap-

parent status and self-injurious involvement of other residents. Attention-seeking was the motive most frequently attributed by all groups, with the exception of the identified self-injurers who tended not to respond. Staff and peer relationships were reported to have changed towards the negative, following incidents which identified a girl as a self-injurer.

Among the significant findings were the discovery of a significant group who, though not identified as self-injurers, declared themselves to be self-injurers and indicated an extensive repertoire of self-injury with an apparent greater determination and an obvious secretiveness. Despite the public, repetitive injury by the identified self-injurers, both groups of self-injurers almost unanimously denied attention-seeking motives. The found group tended to have injured less frequently and doubted future participation, whereas the identified self-injurers anticipated future self-injury.

Further assistance was felt to be useful by all staff respondents regarding appropriate handling of a self-injurer. Child care training programs failed to discuss this phenomena and professional consultants had not been sufficiently accessible nor were they experts in the field.

Self-injury was found to be a frequent occurrence, whether covert or overt, among these emotionally disturbed adolescents in treatment. Recommendations for the treatment centre and similar programs and considerations for further research also were suggested.

DEDICATION

To all those people, young and not so young, for whom houses are not homes, satisfactions are illusive; and life is without purpose, direction or joy.

And, with thanksgiving to those who are reached: "When I leave I know deep down inside that I will really miss this place -- staff, girls, social workers -- I can come and visit a lot". (Maryvale resident)

I went into a house, and it wasn't a house,
It has big steps and a great big hall;
But it hasn't got a garden,
A garden,
A garden,
It isn't like a house at all.

I went into a house, and it wasn't a house,
It has a big garden and great high wall;
But it hasn't got a may-tree,
A may-tree,
A may-tree,
It isn't like a house at all.

I went into a house and it wasn't a house -
Slow white petals from the may-tree fall;
But it hasn't got a blackbird,
A blackbird,
A blackbird,
It isn't like a house at all.

I went into a house, and I thought it was a house,
I could hear from the may-tree the blackbird call --
But nobody listened to it
Nobody
Liked it,
Nobody wanted it at all.

A. A. Milne, The World of Christopher Robin *

* from the book When We Were Very Young by A. A. Milne, Copyright, 1924, by E. P. Dutton and Co., Inc., Renewal, 1952, by A. A. Milne

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This research project was dependent upon the individual contributions of many people, both young and not so young, most of whom must remain anonymous. It is my wish that each one could be made aware of my continuing appreciation for their assistance.

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I would like to extend my appreciation to Mr. Arthur Vossen, Executive Director and Mr. Arthur Drummond, Treatment Co-ordinator at the Maryvale treatment centre for permitting this study. Thanks are owing to the staff and girls of Maryvale for their interest and co-operative participation in this research project. I was grateful for the opportunity to meet with the girls whose delightful candor and expressions of pleasure as participants were a special joy which has been treasured.

The personal contributions of interest and encouragement by my Maryvale friends, my classmates and my newfound friends and colleagues at St. Thomas Psychiatric Hospital have been greatly appreciated during the experience of the various trials of being a novice researcher.

Special thanks is given to Mrs. Sally Dolphin who so patiently gave of her time and talents to type this thesis, and to her husband and children who so generously shared her with me.

Finally, I wish to thank my family for the quiet encouragement and careful restraint shown by them during the protracted completion of this research component of the Master of Social Work program. Their confident assurances that goals are attainable have been present throughout my life; for this and the quality of their very being, I am greatly blessed.

To my committe, family and many faithful mentor-friends, especially Robert, I extend my prayerful gratitude and wish for awareness of God's blessings.

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CHAPTER I

INTRODUCTION

Eager to enjoy the attractions of adult status yet comforted by the familiarity and security of childhood, adolescents simultaneously are drawn to and repelled by both life stages. Individually they struggle to understand and accept themselves during this period of dramatic physical development and heightened emotional and psychological responsiveness. The researcher concurs with the description of adolescence as "a period when the inner world of personality is in particularly intense movement, and when it is simultaneously extremely sensitive to outer influence" (Hemming, 1967, p. 81). The environment therefore becomes a significant factor during this confusing, often lonely, stage of development.

Youngsters who are exhibiting emotional disturbances beyond those generally accepted as the normal range, and as a result are transferred from family units to treatment settings face additional stressful adjustments. They must separate from established patterns and relationships and adapt to a new setting with a multiple of adults and peers. Adolescents increasingly depend upon peers for affirmation, identification and direction. When the members of their reference group are experiencing emotional disturbances, the support given is largely unconstructive and inadequate, and with their striving for independence often it becomes awkward and embarrassing for adolescents to seek or

accept adult guidance.

Adolescents who come to the attention of social services frequently have histories characterized by the loss or absence of persons significant in their lives. They are hesitant to risk new relationships, particularly with adults, and often they approach the challenge of adulthood with ambivalence as well as fear.

Fantasy is an active component of adolescent thinking and when reality is too disappointing or threatening, this flight from reality can provide an alternative through which the adolescent can deal with the complexities of life. Withdrawal from relationships and over-investment in fantasy inhibit constructive emotional development so necessary to maturity.

For several years the researcher, in a position as social worker at Maryvale Vocational School, in Windsor, was exposed to and fascinated by the complexities of adolescents. This residential treatment centre has been selected as the setting for this study. The facility offers an open cottage, group living style treatment milieu for adolescent girls diagnosed as being emotionally disturbed. It became evident to the researcher, based upon her experience in the setting, that because of their emotional difficulties the residents are likely to act out their disappointments and internal dilemmas rather than deal with them through verbal means.

The researcher had an interest in and concern for this treatment setting both from the perspective of the needs of the residents and the desire of the staff to maximize a therapeutic environment. It

was her belief that it was incumbent upon the personnel comprising the treatment milieu that they make every effort to anticipate the girls' behaviour, understand their motivation and needs, and then provide for constructive therapeutic responses.

When incidents of self-injury began to occur with increasing frequency, the treatment personnel as well as a Windsor physician, who treated the residents, became concerned as to how to curb the apparent contagion factor and handle the individual self-injurers in an appropriate manner. The life-threatening potential of many of the self-injuries augmented the degree of tension and sense of urgency within the treatment milieu. Time and manpower demands and the pervasiveness of the anxieties and frustration which the self-injuries evoked, deterred the centre staff from the examination of this phenomena themselves.

The situation was brought to the attention of the researcher, and as a result it stimulated her interest and curiosity. She had concern for the comprehensiveness of the treatment offered at this centre, as well as being motivated by her own anticipated future work with adolescents. Several general questions arose. Were there predisposing factors which could be identified among individuals who self-injured? Were there environmental stimulants which triggered this behaviour? What motivation was attributed to this behaviour, both by identified self-injurers and observers?

The Study

Following from the occurrence of self-injurious behaviour at this treatment centre and the practice concerns with which the researcher could identify, the purpose of this study is to report on related literature and to examine the phenomena specific to this setting. The available literature is reviewed for previous studies and theoretical interpretations of self-injurious behaviour, particularly among non-psychotic, non-retarded individuals and specifically among female adolescent populations. It is assumed by this researcher that adolescence is characterized as a period of transition involving personal disruption, reassessment and change, but that self-injury is an extreme behavioural manifestation requiring special consideration and prescribed intervention. In addition, an assessment is made of the self-injurers including the apparent impact of their behaviour upon the other residents and the treatment personnel at this treatment centre.

Chapter II provides a background to the study including a discussion of residential treatment and the characteristics generally found among their adolescent populations, followed by an historical review of the study setting and its program. Early and middle adolescence are presented with attention given to ego development, the dependence-to-independence growth process including separation anxieties, and the increasing orientation towards peers for identity and direction. In conclusion, this chapter outlines the phenomena of self-injury as it has occurred in this study setting.

Chapter III reviews the available literature with a two-part focus. First, the chapter discusses suicidal behaviour, particularly among child and adolescent populations. The phenomenon of self-injurious behaviour then is reviewed in terms of motivational hypotheses and the findings of studies conducted among institutionalized and adolescent populations, especially those who exhibited behaviour similar to that noted in this study. The impact of self-injurious behaviour upon observers also is discussed briefly.

In Chapter IV the researcher presents the research design, questions and methodology utilized in this study of self-injurious behaviour. Chapter V provides analysis and interpretation of the information received through a Sociometric Questionnaire administered to a drawn sample of residents, as well as the data collected from these girls by an Interview Questionnaire and from the Staff Questionnaire distributed to the treatment staff. In addition, information obtained through the application of a Checklist to the treatment centre's resident master files is utilized to describe the drawn sample.

The recommendations and conclusions of this study are presented in Chapter VI. In addition, criticisms of the study and considerations for future study also are discussed.

CHAPTER II

BACKGROUND OF STUDY

In order to provide the context for the study of adolescent self-injurious behaviour, a residential treatment centre which operates to meet the needs of adolescent girls diagnosed as being emotionally disturbed has been chosen. This chapter presents a discussion of residential treatment and a review of the founding and program development of Maryvale Vocational School, more commonly referred to as Maryvale, in Windsor. Early and middle adolescent development is discussed and the behavioural phenomena of self-injury as they occurred at this centre also are presented. The chapter attempts to provide for the reader, a meaningful background to the study of self-injurious behaviour among the residents of this treatment setting.

Residential Treatment

Contemporary residential treatment facilities have evolved from the almshouses and orphan asylums of the nineteenth century which were founded and operated by religious organizations. Child care institutions vary in approach and purpose from a substitute family living experience to a custodial, correctional emphasis. Treatment centres, such as Maryvale, intend to provide a therapeutic setting within which individual needs, as they concur with the limits and expectations of the culture, are met through corrective treatment experiences. This treatment form is a type of psychiatric therapy providing the "maximum amount of external support and external direction for the disturbed patient" (Easson, 1969, p. 1). Implicit to the treatment of children,

whether they remain in the family or are removed to special settings, is the principle that a child "must learn how to initiate and reciprocate exchanges (interactions) with his environment that are adaptive for him, acceptable to others, and which, over time, he can learn to enjoy" (Kozloff, 1973, p. vi). The children referred to residential treatment are emotionally disturbed and, because of their own difficulties and their disturbed relationships, they need more control and therapeutic interactions than the natural family setting can provide.

Residential treatment facilities comparable to the one in this study are open and largely autonomous in that they accommodate educational and recreational activities as well as provide group living, usually of a cottage style milieu. Concepts basic to the treatment of disturbed children in residential facilities have been defined by Adler (1968). These concepts include that residential treatment is planned and controlled living; authority is present implicitly if not explicitly; the emphasis is upon the healthy rather than the pathological aspects of the personality; group living and necessary individualization are intermingled; identification child-staff interactions; community; and, integration beyond the world contained in the treatment centre.

Most youngsters admitted to residential treatment facilities for the emotionally disturbed are diagnosed as exhibiting a "weak ego syndrome" (Rinsley, 1968). An individual's identification with a group can provide interpersonal support of the joint ego which can develop into intrapersonal support, as needed by the individual (Mayer, 1972,

p. 483). Those youngsters who exhibit an underdeveloped superego can be buttressed by the security of the authority, regularity and predictability of the residential setting. Planned individual treatment programs are developed by the clinical staff of the residential centre, usually including psychiatrists, psychologists and social workers, with varying degrees of collaboration with child care staff. It is widely accepted that development of a treatment plan, including post-discharge planning, is desirable prior to an admission to a residential program. The pressure of admissions, confounded by the fact that residential treatment tends to be the final step taken in a despairing series of interventions, often results in this goal rarely being attained without the support of a strictly enforced policy statement. Treatment plans require ongoing evaluation and revision as the individual residents develop within the program. Without the assurance and security of discharge plans, each resident may suffer reasonable doubts as to the transiency of their resident status and may lose hope and confidence in their ability to help themselves towards future goals.

Treatment Approaches

Treatment approaches utilized in residential settings can be classified into four general categories, including: a systems or milieu orientation which intends to create a supportive, understanding environment combining residential experiences with community involvement as the individual can be reintegrated successfully (Redl, 1957; Redl and Wineman, 1951); a reality orientation which emphasizes a present focus and the importance of holding the individual responsible for his actions

(Easson, 1969, pp 76-77; Maultsby, 1975); a goal-directed relationship orientation which intends to enable the development of a more positive self-concept; and, a social opportunities orientation which attempts to develop the capacity and potential of each resident through individualized treatment programs which encourage the development of strengths and talents and the correction of weaknesses.

Adjustment Concerns for the Resident

The structure and size of residential centres can be an intimidating, if not an overwhelming experience for each new resident, and admission to a residential centre, representing a separation, can be a symbolic death or a rebirth for the youngster. Individual and family balances are upset, compensations and substitutions become necessary and there are "potentially enormously regressive effects on both parties (parent and child)" (Rinsley, 1965, p. 414). The new resident may exhibit a brief period of submissive cooperation before resisting by rebelling against the regulations and constraints. A similar pattern has been observed by this researcher among the parents of residents and leads her to the conclusion that consideration of parental needs should be given throughout the treatment process: intake through discharge and follow-up. The parental resistances reflect fear of the inferred criticism or the inadequacies of their parenting, whereas the children and adolescents seem to resist because of underlying fears of change and abandonment, fears which are defenses against depression and aggression (Rinsley, 1965).

Difficulties in the family of origin may have led to psychopathology and the failure to develop adequate impulse control in the youngster. As a result, behavioural outbursts tend to be aggressive and often are expressed in association with other adolescents. Incidents of acting-out increase the tension and emotional distance in the family and has the same impact upon treatment staff, subsequently turning the adolescent towards the peer group for closeness and thereby escalating the process which resulted in the assessment that she was difficult to manage. Regardless of the origin of the acting-out behaviour, Alt concludes that the primary need is for the child to experience "protection against his own impulses and for the sense of control which the structure of the institution and the routines of orderly living can give him". (Alt, 1960, p. 54). The resident frequently fears the use of authority and also may speculate against aggressive outbursts because of concerns that the staff or the peer group might respond with counter-aggression (Mayer, 1972).

Provision of a Therapeutic Milieu

The provision of a therapeutic milieu for emotionally disturbed children and adolescents is based upon the philosophy that daily living experiences involving peers and caretaking adults can be as significant for emotional growth as clinical therapy hours (Hylton, 1964, p. 15). The children who are referred to residential treatment settings often are unable to enter into structured therapy to any significant degree, thereby making the environment particularly important, for both

positive and negative influence. Emotional need and developmental sensitivity to peer influence demands careful consideration of cottage and classroom assignments as well as astute interventions by staff when peer pressures perpetuate destructive dynamics between residents (Adler, 1971, p. 214).

A high ratio of staff, particularly those with child care training, is characteristic of residential treatment facilities (Hylton, 1964, p. 14). Post-secondary training in child care increasingly has become prerequisite for treatment centre staff, however this is not an adequate qualification on its own for staff to succeed in significant relationships with emotionally disturbed adolescents. Trained staff genuinely must be interested in adolescents, be warm, open and capable of responsible firmness without rigidity, be free of adolescent developmental hangups, and, be willing to devote regular blocks of time for staff communication and ongoing supervision (Lewis, 1970). The treatment team as a whole must seek to understand adolescent behaviour and individual intricacies. This understanding must be in the sense of learning what motivates the behaviour and trying to modify it, and not in the sense of assuming a tolerant and sympathetic attitude and allowing it to proceed (Beckett, 1965, p. 15).

Stable and confidently reassuring staff are vital for the adolescent residents who collectively lack sufficient ego strength to cope with emotion laden incidents such as self-injuring. If the staff react with anger or obvious fearfulness then their unified treatment approach is likely to be disrupted. If the disruption occurs, the

adolescents will experience increased anxiety and tension which will predispose them to further disruptive acting-out, thereby heightening the anxiety among both staff and girls (Easson, 1969, pp. 69-70). Without anticipatory education of team members about possible behaviours among the residents and appropriate treatment responses, consistent constructive staff responses would be unlikely.

Same sex staff can provide residents with appropriate models while opposite sex staff allow for safe, constructive experiences in heterosexual relating at a time when sexual identification and a resurgence of libidinal drives are developmental concerns. Transference and counter-transference frequently are present in staff-child relationships, as well as among staff who may become caught up in their identifications with a child against the authority of other staff or a rivalry for control within the treatment team. It has been cautioned that adolescent girls may develop sexual feelings towards a staff member who is the major identification model, such as a team leader, if that person is male. Although these emotions are natural, these inner drives may be experienced as unacceptable, provoking anxious feelings to the degree that sexual or self-destructive acting-out may be exhibited by the girl (Easson, 1969, p. 32).

The Setting

Maryvale Vocational School in Windsor, Ontario (hereafter referred to as Maryvale) was the setting chosen for this study of self-injurious behaviour. As a residential treatment centre for emotionally

disturbed adolescent girls, it evolved from a project begun in 1929 under the auspices of the Sisters of the Good Shepherd. Originally the Sisters worked from a large, former family residence providing assistance to transient women and women without means of financial support. In 1930, the Sisters borrowed money from the Bishop of London in order to purchase the 17 acres of property comprising the present location. This acreage had been the site of the Essex Country Club and for several years after the purchase, the club buildings served as residences. The Provincial Department of Public Welfare recognized the project at this time and began granting assistance under the Female Refuge Act of Ontario.

With the impact of the Second World War, jobs became plentiful and there was less need for a shelter for women, therefore younger girls referred by clergy and juvenile authorities were accepted. The Director of the province's Association of Children's Aid Societies and a social worker from Toronto met with the Sisters to review the facilities and possible program changes. Recognizing that the Department of Public Health wished to expand the services available to children, a program review was conducted by the Sisters. In 1949, following the program review, treatment facilities for girls ages 12 to 16 years were developed, and as a result the program became eligible for operating grants under the Charitable Institutions Act of Ontario (Maryvale brochure). Under this Act, they received $0.05 per day per child under 16 and $0.10 per day per child over 16 years of age.

The first professional social worker, the late James McIsaac, was hired in 1950 and a program for the treatment of emotionally disturbed girls was begun. With the initiation of a planned treatment program, $1.50 became the per diem rate. This institution was recognized as the first Ontario residential treatment facility for emotionally disturbed adolescent girls.

The present facilities were completed in 1965 after several years of planning and administrative changes. The present building facilities consist of six cottage units and one large building containing the administrative offices, a school, gymnasium and an indoor swimming pool. This complex is linked to a Sisters' residence and chapel which were built at the same time. Also located on the property are the original convent residence and one built in 1948, containing maintenance facilities and a laundry which operated into the 1940's helping to finance the program.

In 1969 the Department of Health granted Maryvale partial coverage by crediting 100% funding for non-ward residents. In April of 1971, Maryvale was licensed under the Children's Mental Health Division of the Ministry of Health. Operating under this Act, Maryvale was a private, non-profit institution governed by the Sisters of the Good Shepherd and an elected Citizen Advisory Board. The Sisters of the Good Shepherd employed an Executive Director who, with the assistance of the Treatment Co-ordinator, administered the Maryvale program (Appendix C). Confronted with a $100,000 budgetary cutback, the Maryvale Administration closed two cottage units during the summer of

1971. One cottage was reopened in 1972, so that at the time of this study there were five functioning units, one Receiving and Assessment and four treatment, each being able to accommodate 10 girls. Although Maryvale was open to girls throughout the province, with the trend towards regionalization, preference was given to applicants from the Essex, Kent and Lambton tri-county area.

The Program

Maryvale operates as an open cottage residential program for girls of any race or creed who are residents of the Province of Ontario. The program is designed for girls between the approximate ages of 12 and 16 who are experiencing emotional problems not originating from retardation, psychosis or severe physical handicaps (Appendix C). Candidates should be in need of an open institutional treatment program rather than a closed setting such as a training school or hospital ward.

The treatment goal of Maryvale is to return to the community, as soon as possible, a girl who is functioning at a more age-appropriate, socially acceptable and personally satisfying level than when she was admitted. The Maryvale treatment philosophy, although not clearly defined at the time of research, seemed to be described best as eclectic, encompassing aspects of the various treatment approaches. It was apparent that Maryvale regarded all staff to be part of the therapeutic milieu of its adolescent residents. All staff were not therapists, however, as stated by Adler (1971), each employee in the treatment environment must supply a therapeutic personality for the residents. Generally the

kitchen, maintenance and office staff were not encouraged to have contact with the girls, however, it had been accepted that it was important to keep them informed in a general way as to the problems of the girls and the importance of their attitudes towards them.

Once approved by the Intake Committee, a new candidate was admitted, at the time of this study, to a Receiving and Assessment unit where she remained for approximately 3 weeks while being familiarized with the Maryvale program routines and goals as well as the individualized expectations for her. Visiting by referral sources and family members generally was encouraged, being arranged on an individual basis. The average stay for the first half of 1976 was somewhat less than 7 months.

While a girl is at Maryvale, four major departments, social service, child care, teaching and recreation, work in conjunction to provide corrective experiences in a programmed environment. During this study, the social service department, comprised of five professional social workers, M.S.W. graduates, and a psychiatric consultant available 1 day a week, acted as therapists to the girls and as consultants to the child care, teaching, recreational and medical staff. The child care department consisted of a Cottage Life Co-ordinator, an Assistant and 47 cottage staff including two part-time staff and Co-ordinators for each unit. Their task was to provide corrective relationship opportunities for the girls. The seven cottage staff assigned to each unit rotate through three shifts, with two staff covering the morning, three for the evening and one for the overnight

shift. At the time of this study, the social work staff predominantly were male, whereas the teaching and child care staff predominantly were female, with only one of the cottage Co-ordinators being male.

The Maryvale school, which came under contract with the Windsor Board of Education, May 29, 1976, employed nine teachers and a treatment program liaison worker who was previously the Head teacher. The school was able to accommodate 42 girls and attempted to fill learning gaps in order to ready the girls for a return to community schools or job training programs. A recreation director and an assistant co-ordinated overall recreational programming including daily activities, special outings, camping and special occasion parties and dances. A full time nurse was responsible for the institution's medical health services. As needed, referrals were made to a community physician who had agreed to act as a consultant and to treat Maryvale residents.

At the time of this research, there were 48 girls involved with the Maryvale program. Forty-one girls were residents, several of whom attended community high schools. One girl, a previous resident, had Day Care status, attending the Maryvale school and continuing to be seen with her family by a social worker. Six girls held After Care status and were seen by their social workers with varying frequency as each one adjusted to her community living responsibilities.

In 1971, Maryvale sought Ministry of Health approval of an intensive care facility which would provide adequate, 24 hour closed treatment for girls who require such a secure, intensive therapeutic

environment on a short-term basis before moving into an open unit or on occasion for critical periods during their placement. The proposal was submitted again in 1975, however, it was not approved. The program was expanded to meet the needs of certain Maryvale graduates, 16 years of age or older. In March 1975, the founding members of the James A. McIsaac Apartment board obtained a charter as a step toward planning for a community living experience for certain older girls. A facility which accommodates four girls was opened in July 1976, on a lease basis to work-referred girls, and is known as the James A. McIsaac Apartment.

Early and Middle Adolescence

Adolescence is the period of physiologic and emotional growth between the relative calm of the latency period and mature adulthood. Despite the similarity between adolescent symptomatology and neurotic or psychotic symptoms, this researcher agrees with Erikson's statement that "adolescence is not an affliction but a normative crisis, i.e., a normal phase of increased conflict characterized by a seeming fluctuation in ego strength, and yet also by a high growth potential" (Erikson, 1959, p. 116). Because it is marked by so many dynamics, the period of adolescence has been subdivided into early, middle and late stages, to assist in clarifying the developments. For the purpose of this study, early and middle stages of adolescent development are of relevance.

Early Adolescence

Blos defines young or early adolescence as the period between aged 10+ to 14^{+} (Blos, 1970, p. xii), which coincides with the

boundaries of the prepubertal phase and the onset of puberty as defined by Lidz (Lidz, 1968, p. 303). During this period, youngsters remain closely tied to home and family and characteristically prefer to continue with monosexual group associations. A study by Simmons, Rosenbert and Rosenberg (1973) showed early adolescents exhibited heightened self-consciousness, greater instability of their self-image, slightly lower self-esteem, and a less favourable view of the opinions held of them by significant others. Their study suggested that the environment may have a stronger effect than age in producing such changes, noting that youngsters entering junior high school appeared more disturbed than age-peers still in the elementary system.

Middle Adolescence

Middle adolescence is considered to begin 12 to 18 months after pubescence (Lidz, 1968, pp. 321-322), and is characterized by a broadening of activity as the youngster separates increasingly from parents, reworks oedipal attachments so that the new experience of libidinal drives may be allowed expression through affectional and sexual attachments outside the family, and attempts to respond to the societal expectation that she become a productive and therefore valued member (Lidz, 1968, pp. 322-342). This is a period of normative emotional lability and apparent fickle or transient interests as the adolescent experiments with the multitude of activities, ideals, associations and career options in an attempt to find a place in life.

Middle and late adolescence are marked by an increasing need

to establish a self-identity or in Erikson's terms, an ego-identity (Erikson, 1952; 1968). During the separation from family and parental definition of her self, the adolescent becomes more dependent upon peer groups and heterosexual relationships for acceptance, affirmation and a sense of belonging. It has been noted that many adolescent relationships "are rather exploitative, in that they are used more to enhance self-esteem than to establish a genuine interpersonal experience" (Clayton, 1973, p. 404). This is as much a reflection of the developmental stage of the ego identity as in childhood narcissism, in that a clear, satisfying sense of self must be present before the adolescent can share that self in depth with someone else. During this growth period, the adolescent is pressured by the dilemma of wanting to act contrary to parental advice and yet be a recipient of it, as it was from parents and parental models that support was derived in the past (Offer and Offer, 1968).

During middle adolescence the youngster tends to be confused as to her self-identity; feel unworthy, unloved and isolated; be overly resentful of parents; and, be overtly rebellious; yet in reality, she is overly-dependent on her parents and experiences the separation as a loss of love and support despite the desirability of independence (Kalogerakis, 1973, p. 58). It is especially important during this stage that parents take a firm stand, providing something to fight against and a loving tolerant focus for the rebelliousness (Froese, 1975, p. 10). Adolescent girls seek direct identification with their mothers, however this presents a conflict with their desire to become independent, and as a result they become frequently disagreeable and contrary.

Further Considerations

Adolescents grow intellectually as well as physiologically and emotionally. They become "capable of conceptual thinking, or in Piaget's terms, enter into the stage of formal operations" (Lidz, 1968, p. 300), skills which are utilized in coping with the ideological issues, developing sense of self and the images others are considered to have of them. The struggle of the ego to master the tensions and pressures from drive derivatives normally leads to character development, however a pathological outcome results in the formation of neurotic symptoms when the adolescent is unable to cope with anxiety created (A. Freud, 1958). As noted later in the Review of Literature on self-injurious behaviour, identification and introjection take place in the formation of a super-ego. With this development, hostility previously directed towards parents is directed towards their introjects within the child and provokes feelings of depression (Toolan, February 1962). Toolan also notes that running away is the most common expression of depression among children and adolescents. When this response is not possible, behaviours may become more angrily expressive, possibly including self-injury. Because adolescent affect is more easily aroused and labile and because emotions are experienced more poignantly, extreme behavioural expressions are not unusual (Sklansky, Silverman and Rabichow, 1969). Separation, loss, abandonment, feelings of self-doubt, worthlessness, hopelessness and helplessness are common among early and middle adolescents. These sensations of being inferior render the adolescent susceptible to depressive feelings which frequently are masked as boredom,

restlessness and constant seeking of stimulation.

Acceptance is very important for all adolescents, especially for those who sense failure in their community social field and rejection within their families as a result of their behaviour being labelled as unacceptable. Schneider has stated that "social approval is the external counterpart of personal status" (Schneider, 1965, p. 59), withdrawal of which has a devastating effect upon the struggling ego. Most adolescents come to the attention of social services because their acting-up has gone beyond the normative limits to become acting-up at socially unacceptable, anxiety producing levels. Adolescents exhibiting the other behavioural extreme, that of an unobtrusive recluse, on occasion are referred, however, by their very withdrawal they have been overlooked more frequently.

As a caution to parents and caretakers, Schneider has stated that "the first and most important thing to learn about adolescent wants is that more often than not they are rooted in basic needs of the personality" (Schneider, 1965, p. 51). In Erikson's words, adolescence is a period of "psychosocial moratorium" during which time most adolescents are allowed the privilege, albeit confusing, of experimenting with the world with the goal of establishing a place for themselves (Erikson, 1968, pp. 156-158). According to Erikson's stages of the life cycle, the crucial psychosocial crisis for adolescence is the fifth: Identity versus Identity (or Role) Diffusion, preceded by the Trust versus Mistrust of infancy; Autonomy versus Shame, Doubt of early Childhood; Initiative versus Guilt of the play age; and Industry versus

Inferiority of school age children (Erikson, 1959). The ease or difficulty with which the adolescent has passed through the normative crisis will affect the adolescent's ability to cope with the critical questioning of past certainties. Confidence acquired through mastery of childhood tasks contributes to the development of a sense of ego identity in adolescence (Erikson, 1959, p. 89). Sincere praise and genuine accomplishments are the foundation of this ego identity and for many of the adolescents admitted to residential treatment these necessary successes have been lacking. For these adolescents dependency needs are prolonged, whether masked as strict conformity to clique or gang norms, or a more overt dependence upon treatment staff for permission and direction or as a target for displacing responsibility for acting-out behaviour.

Observations Specific to Adolescent Girls

In his chapter "The Body and the Body-Image in Adolescents", Schonfeld concludes that the behavioural aberrations exhibited by adolescents frequently are caused by disturbed body-image or perceived functioning, whereby they perceive themselves as being different and subsequently inferior (Caplan and Lebovice, 1969, p. 48). The growth spurt and bodily changes, both visible development of secondary sexual characteristics and the mysterious maturational implications of menarche, present particular difficulties for adolescent girls. The fact that adolescent girls during the early and middle stages often are bigger than pubertal boys places additional stress and subsequent anxiety upon them with regard to their female identification and sense

of desirability and acceptance.

In our Western culture, girls more than boys are allowed to prolong their dependency upon parents. In this position of relative comfort and security, adolescent girls seem to develop skills in reorganizing and reassessing their world and their position in it, becoming particularly introspective and self-critical. Assets such as attractiveness or intelligence may be perceived as liabilities, and the reconciliation of the demand for gratification made by instinctive urges, particularly developing sexuality thereby provokes frustrations and anxieties. Self-injury by an attractive young female has been interpreted as a punishment for real or imagined sexuality and as an expression of the hope that if disfigured, then she would be assured that people were attracted to her inner self worth (Clayton, 1973, p. 399).

Anna Freud has noted that all too frequently youngsters are placed in foster care, residential centres or hospital facilities as they are available without being matched sufficiently with the type of disorder presented, which also may be inadequately determined (A. Freud, 1970, p. 30). Female adolescents who act-out tend to be reacted to sooner than their male peers because of societal differential tolerance based on sex norms. In a study of male and female adolescents in a residential treatment program, the females were found to have had significantly poorer social and family histories and yet had less severe symptoms at admission and discharge in comparison with the males. The females also were found to be significantly different in that they had fewer suicide attempts, a shorter duration of their illness prior to

admission, and stayed longer in residential treatment, though their response to treatment was not significantly different (Young, 1977). In the opinion of Konopka, "societal institutions, established to help girls, frequently added to their depression by offering no basic security and by separating them from their friends" (Konopka, 1976, p. 99). Removed from their natural field of social support, the adolescent girl in residential treatment may regress developmentally as the placement serves to prolong dependence upon others and to sustain her lack of autonomy. If the adolescent resident senses that she has been divested of personal responsibility, then her treatment status may be abused to excuse and justify unacceptable behaviour (Kovar, 1968).

Sociological studies indicate that adolescent girls feel most secure and therefore are more relaxed, receptive and responsive when they are participant in small groups or one-to-one relationships, yet most residential treatment settings have cottage or ward groupings of 10 or more adolescents. As Hemming notes, a "girl is related to the group of her fellows as a whole only through the one or two girls with whom she has managed to establish a friendly relationship, however tenuous" (Hemming, 1967, p. 57). A girl newly admitted to a residential treatment facility must enter a fluid, but nevertheless formed, group within which she is likely not to know anyone and whose members are limited in their relationship skills by their own emotional disturbances. Emotionally disturbed groups have shown significantly more fluctuations than groups of normals in their choice of friends (Kaplan, 1977, p. 345), therefore each girl is likely to be made anxious and

frequently distressed by the instability and changeableness of her co-residents' friendships. Unless treatment staff succeed in establishing significant one-to-one relationships with each girl, the loss, abandonment and sense of isolation aggravated by her placement will contribute to the adolescent's emotional disturbance and pathology.

Girls in the early or middle adolescent stages are a target group for whom placement outside the family has been found to be detrimental. Steele (1971) found that placed adolescent girls had difficulty in achieving a positive ego identity and an appropriate sexual stance which led Steele to plea for careful evaluation and consideration of other treatment approaches rather than interrupting the constancy of the mother-daughter relationship. If placement of adolescent girls is deemed necessary, then active involvement of the parent and family group seems advisable even in dysfunctional family systems.

Recognizing that the majority of youngsters seem to grow through the adolescent period without serious distress, conflict or acting-out, it seems reasonable to assume that these youngsters have entered adolescence with a more solid, reality based sense of confidence and ego integrity than the adolescents who come to the attention of social services. The process of placement outside the family contributes further potentially negative crises with which these emotionally sensitive adolescents must attempt to cope. Such were the young adolescent girls resident at Maryvale at the time of this study.

The Self-Injurious Behaviour

Threats of self-injury are not uncommon among children and adolescents in treatment, however commitment to action is far less frequent. For many of the treatment staff, the incidents of self-injury, which began with marked frequency in the fall of 1975, were the first of such behavioural manifestations with which they had to work.

Adolescent girls have been noted to act out through self-injurious gestures more than their male counterparts, however, the degree of severity and the frequency of the occurrence at Maryvale was felt to be an extreme. The range of self-injury included facial scratching; hand, arm, wrist and thigh scratching, cutting and puncturing which frequently resulted in scarring; and, the ingestion of foreign objects, such as tacks, pins, needles, crushed glass and buttons. During this period of frequent self-injuring, there was one incident of retaining medication by one of the older girls who then, upon request, gave it to another girl in an apparent bid for friendship. Several girls claimed to have swallowed toxins such as shoe and nail polish. Several of the girls required hospital observation. One girl who had ingested tacks several times without apparent harm, though considerable risk, required major surgery to remove a needle that lodged in her digestive tract.

During this period, the residents themselves were concerned, expressing anxieties and questioning the motivation for the behaviour when a peer participated in self-injurious activities. Their reactions seemed to reflect genuine concern, but more significantly, a fear that

they too might find themselves engaged in self-injury. On occasion they articulated that they feared being considered to be "crazy" as many of them judged the self-injurers to be. Though there was a status attributed to the self-injuries, by the residents, their response seemed unpredictable and subject to change ranging from attentive concern to imitation to ostracism.

Summary

This chapter has outlined a descriptive background for this study. It has presented a discussion of residential treatment and a review of the history and program development of Maryvale, the study setting. Characteristics of early and middle adolescent development also have been discussed, with observations specific to adolescent girls.

Self-injurious behaviour as it occurred in this setting was reviewed in order to complete the description of the context and boundaries of this study.

CHAPTER III

REVIEW OF THE LITERATURE

It is the intent of the researcher to review the available literature relevant to the study of the phenomena of self-injury. It should be noted that the adolescent residents of the treatment centre selected as the setting for this research are female, almost all between the ages of 13 and 16 years. The incidents of self-injury, therefore, have been experienced in relation to the first two phases of adolescence: early adolescence and middle adolescence. Early adolescence identifies "the period of puberty, which lasts three years or more, from about 11 or 12 until 14 or 15" (Miller, 1974, p. 6). Developmentally, midadolescence follows as "the period of identification, 'This is what I am', and self-realization", lasting from 14 or 15 to 17 or 18 (Miller, 1974).

Self-injurious behaviour, because of the varied operational definitions, presents a topic which could not be reviewed completely within the limits of this study. Extensive readings were done, however, not all the literature has been included in the bibliography. The researcher has elected to limit the review to that literature relevant to the forms of self-injury which were reported at the Maryvale. These include external bodily abuse by severe scratching, cutting and puncturing of skin tissue, and internal abuse by ingestion of foreign objects and toxins. The literature first was reviewed during the period of research preparation and data collection, then again 2 years later

in 1978 at the time of the completion of the research project.

In order to provide clarity in the discussion of the various aspects of this study, the review of the literature has been subdivided. Studies of suicide attempts will be presented first as suicidal gestures and self-injurious behaviour are conceptually difficult to differentiate and appear to be used synonymously in much of the literature. The review of self-injurious behaviour includes presentation of the various motivational hypotheses posited for this behavioural phenomenon. Relevant studies and the impact self-injurious activity has upon observers also are discussed.

Studies of Suicide Attempters

In Canada, only accidents and cancer take more lives than reported suicides among the 15 to 24 year old age group, with suicide more than doubling between 1960 and 1969 (Pollack, 1971) and having increased by one-third since 1971 (Lee, 1979). Twelve per cent of all reported suicide attempts are by adolescents, with estimates of the ratio of attempts to successful suicides ranging from 7:1 to 50:1 (Corder, Shorr and Corder, 1974). Although females of all ages make more life-threatening gestures, adolescent girls represent the group with the highest frequency of attempted suicide and self-injury (Jarvis, Ferrance, Johnson and Whitehead, 1976). Males are significantly more successful in that they tend to use more active and potentially lethal methods. It has been postulated that in Western cultures males find it easier to be aggressive either towards themselves or others, and that, as a re-

sult, when contemplating suicide are more successful in their attempts (Lester, 1972; Toolan, 1962).

Four causal categories of adolescent suicide attempts have been identified, including: anger for another which is internalized in the form of guilt and depression; an attempt to manipulate another to gain love and affection, possibly by punishing someone; a signal communication of distress; and,a reaction to feelings of inner disintegration (Toolen, 1962). Gould (1965) has expanded these basic categories to include: a wish to gain support and strength through joining with a powerful loved object lost either by separation or death; death as a retaliation for abandonment or threatened abandonment; manipulation or blackmail to obtain love and attention, and to punish others; atonement for one's sins by dying; self-murder; disintegration of the personality; and,as a last cry for help. Basic to intropunitive behaviours which have been observed to escalate towards serious suicide attempts, are feelings of loneliness, unworthiness, hopelessness and depression. Depression frequently has been discounted as a psychological state in children and adolescents because its manifestations have not been clinically clear, however, the following behaviours have been identified as indicators of camouflaged depression: boredom, restlessness, temper tantrums, rebelliousness and defiance, somatic and hypochondriacal preoccupation, "accidental" injuries, running away, drug and alcohol abuse, sexual promiscuity, truancy, poor school performance, and conflict with authorities (Burks and Harrison, 1962; Gould, 1965; Teicher, 1966; Toolan, 1962).

Summarizing these categories, suicidal attempts may represent a symptomatic act as an outgrowth of earlier conflicts or as an adaptational act intended to effect a change either in the suicidal actor or his environment. Aspects of these interpretive types may apply to incidents of self-injury, however it seems appropriate to regard self-injury as "deliriums in action" expressing inadequate attempts at defensive organization (Haim, 1970). As noted by Menninger (1935), in contrast to the intent of a suicide attempter, the goal of self-injuring appears to be to enable the individual to continue to live with herself after the incident.

The conceptional analysis of suicide which was presented by Breed (1972) has been most useful to the researcher in the examination of self-injury, in that the individual, the situation and the response to the situation were considered. Durkheim (1951) originally discussed the notion of social structural events which serve to isolate individuals from meaningful social relationships and thereby restrict their social integration. This social structure focus was a departure from the intrapsychic interpretations which have been developed by Freud.

Several authors have observed that self-esteem seems necessary to survival and that without it suicidal thoughts may develop (Breed, 1972; Clifton and Lee, 1976; Kaplan, 1975; Neuringer, 1974). Freud initiated the interpretation of self-injury as a compromise act reflecting the struggle between the life and death instincts, or as Menninger (1935) regarded it, as a bad bargain made by a neurotic between a demanding, strict, tyrannical ego and an over-riding id. There appeared

to be a universal acceptance among the various authors reviewed that suicide attempts and self-injury were acts of aggression against the self, whether the self was the intended target, as in the cases of guilt, atonement or joining with a lost loved object, or as a safe substitute.

Suicidal persons have been noted to have a characteristic dependency upon one or more persons or types of persons and to be dependent for social reasons, based upon their desire to share nearness and mutuality (Breed, 1972). This desire for associations seems to develop into an acute need which, when continually unmet, provokes suicidal thoughts. Adolescent attempters have been found to have histories of chaotic, excessively mobile families with inadequacies in intrafamilial communication frequently noted, irreconcilable isolation among family members, and with parental communications that the attempter was an unwanted child (Shrut and Nichols, 1969; Glaser, 1965; Jacobs and Teicher, 1967). Studies frequently have found no distinctive differences between hospitalized or high risk adolescents who displayed suicidal tendencies and those who did not (Kennedy and Kreitman, 1973). Incidents of parent loss, although similar in frequency, were experienced at a younger age, generally preadolescence, among the suicidal group (Stanley and Barter, 1970). Types of parental discord were found to be significant in that there was a higher incidence of threats of divorce and separation among the families of hospitalized attempters.

Studies of the sex, sibling position and family constellation

of suicide attempters, summarized by Cantor (1972), have noted that firstborn females and only children tend to learn to associate pain reduction with the presence of others and therefore tend to seek help and companionship more than later born siblings. Firstborn females and only children appeared to be developmentally predisposed to needing adult attention and recognition, and being fearful of expressing antagonistic or aggressive feelings toward parental figures. These characteristics have been noted repeatedly among individuals who exhibit life-threatening behaviour. Cantor also found an overrepresentation of firstborn females who had younger brothers as their next closest sibling, at a statistically significant frequency at the .001 level. Extremely high incidence of family disorganization and loss again were noted, particularly with regard to paternal deprivation.

In more recent studies (Cantor, 1976; Glaser, 1965; Kaslow, 1975), it has been stressed that the type of verbal warning or the nature of the act should not be used as an indicator of the attempter's psychological condition, neither should the likelihood of reoccurrence attempt to be predicted from this basis. Although less than 10% of known attempters have taken their lives later, it has been recognized that most successful suicides are committed on the first try. Cantor has noted in her study of females that suicide attempters thought about suicide more frequently, at an earlier age and had repertoires of more self-destructive behaviours than non-suicide attempter groups. Individuals who admitted to having thought of suicide frequently without attempting it, were found to be more like attempters than the

group who only infrequently thought of suicide. Glaser advises that regardless of whether there is a verbal warning, a gesture or an actual suicide attempt, the degree of seriousness requires assessment along four criteria: the depth of the conflict; the youth's inner resources for coping with conflicts, citing physical and emotional health, emotional maturity as compared to chronological age, intelligence, and ability to communicate; accessibility of outer resources, and their availability and willingness to be of help; and a realistic appraisal of the stressful situation to which the individual is reacting.

Self-Injurious Behaviour

With regard to the focus of this study, the term self-injurious has been adopted by the researcher to categorize the phenomena being explored. Self-injurious is less connotative and more accurate descriptively for the study than the alternative terms of self-destruction; self-punitive; self-mutilative or masochistic behaviour; self-directed aggression; or suicidal or parasuicidal gestures, all of which appear throughout the relevant literature. Malingering or factitious illness also are terms which have been used to identify self-injurious behaviour. The term malingering is indicative of "a wilful, purposeful and deliberate effort to simulate disease or injury"(Victor, 1972, p. 425), as opposed to hysterical or actual functional ailments, and appears to be motivated by anticipated secondary gains (Herzberg, 1977, p. 321; Lester, 1972, p. 119).

Self-injurious behaviour has been described as "any overt,

painful or destructive act committed by an individual upon his own body" (Shodell and Reiter, 1968, p. 453). This behaviour involves a seemingly sadomasochistic intent of suffering as well as punishment through exposure of the self to potential harm (Bychowski,1959). Because evidence of ingestion self-injury is not apparent in every instance, it is the opinion of the researcher that self-injurious behaviour cannot be limited to overt acts. Incidents of ingestion self-injury have occurred without bodily harm, therefore it is important to interpret the description as including acts with the potential to do physical damage and cause pain, whether or not this actually does occur.

Consideration of the phenomena of self-injury encompasses the dilemma of what is normal and what is abnormal in human behaviour. From the review of the literature it appears that frequent incidents of behaviour defined as psychopathological, when occurring in normal children, may be indicative of developmental stress, while such incidents may be regarded as symptomatic behaviour when evidenced during critical life stages, such as that of adolescence (A. Freud, 1970, p. 21). Self-directed and aggressive behaviours are subject to cultural interpretations as to their acceptability. African societies have numerous rituals and techniques for aggressive expression which would be considered self-injurious and undesirable in Western cultures. Societies which lack sanctioned channels through which aggressive feelings may be expressed, are characterized by incidents of rage directed toward the self, whether the intent is suicidal, less intense, self-injury, or the symbolic meeting of psychological needs

with a minimum of reality consequences, such as alcohol ingestion, tatooing, nailbiting or haircutting (Steiner, 1974; Cowie, Cowie and Slater, 1968; McCandless, 1968; Menninger, 1935).

Ferrance and Johnson (1974, in their 1971 survey of the known cases of self-injury occurring among London, Ontario residents, aged 6 years and over, established a rate of 730 incidents per 100,000 of the population per annum. Further evidence suggests that the rates may be as high as 1,400 per 100,000 population per annum (Whitehead, Johnson and Ferrance, 1973). A study conducted by Bancroft et al., (1975) found that incidents of self-poisoning and self-injury necessitating admission to a general hospital in Oxford, England, had increased approximately 45% during the 3-1/2 years studied. Among the people who harmed themselves, 75% of the men and 67% of the women were between the ages of 16 and 35. Rates were found to be exceptionally high for teenage wives and among single, widowed and divorced women aged 24 to 35. In addition, repetitive self-injuring also was found to be increasing.

These various statistics indicated a consistent increase in the number of incidents of self-injury and suicide attempts, with some studies also indicating a particular upward trend among young females (Jarvis, et al., 1976). The implications of our culture's sex-role socialization have been reviewed by Clifton and Lee (1976) who found women more than men were self-destructive in their self-attitudes, personal habits, and everyday life responses. It was suggested, in this study, that females are raised to experience negative, introverted feelings which, in combination with a strong pattern of passive social-

ization and a relatively powerless position, disposes women towards self-destructive behaviour. While gestures may not represent suicidal intent, miscalculations can occur, and for this reason authors repeatedly have stressed that every threat and attempt warrants serious consideration.

Hypotheses Regarding Motivation for Self-Injury

Self-injurious behaviour has been observed across a continuum of human conditions including apparent "normals", those suffering from mental retardation, organic deficits or brain damage, and those dictated to by various psychoses. Incarcerated adults and institutionalized children have been studied, in addition to non-human life forms which were the subjects of experimental manipulation for the purpose of testing the hypotheses. These independent studies can be grouped under five motivational hypotheses with self-injurious behaviour as: a means of providing self-stimulation; a product of physiological deviations; a learned operant maintained by positive reinforcement; a learned operant maintained by the termination of negative stimulation; and, an attempt to relieve psychodynamic tensions, whether to reduce guilt or to establish a sense of self in relation to the world (Carr, 1977). It is noted by the researcher that many of the research publications reviewed for this study have been evaluated recently in an excellent article by Carr (1977). This researcher concurs with the conclusion made by Carr that effective treatment would seem to depend upon recognition of the different sources of self-injuring motivation and an accurate assessment of the

interrelationship which appear to exist between the sources.

Self-Stimulation Hypothesis

This hypothesis holds that living organisms require tactile and kinesthetic stimulation, which, if available at insufficient levels, will be compensated for by repetitive, stereotyped behaviours, including self-injury. Lemke (1974) proposed that self-injury is an abnormal, self-stimulating behaviour which, as adopted by retardates, reflects an attempt to communicate. He accepted the hypothesis that kinesthetic needs are distinct, and equally important as oral, anal and phallic drives and are significantly influenced by the nature of early mother-child interactions. If the passive motions of the mother or attending adult have not been internalized as an integrated inner object by the child, then stereotyped, active movements, rather than purposive motions, may be substituted. This self-stimulating kinesthesis as seen in rocking, head banging, and facial scratching and slapping, has been regarded as an attempt to ward off loneliness and to protect the formative ego from sensations of abandonment (Solomon, 1959).

Self-injurious behaviour which is self-stimulation has been attributed largely to populations of children suffering from mental retardation and psychoses, however this hypothesis also has been utilized in the analysis of self-injuring among incarcerated adults who characteristically complained of boredom (Cookson, 1977; McKerracher, Loughnane and Watson, 1968), and institutionalized adolescents whose acting-out included escape attempts, disobedience and fighting, in addition to self-injuring (Farley and Farley, 1972). In

a comparative study between self-poisoners and wrist-slashers (Horn, 1976), the cutters were found to be less determined with regard to the lethality of their actions. Typically their behaviour was in response to a loss, abandonment or threatened separation which stirred emotional reactions ranging from anger, anxiety and tension to depression. The ability to communicate the feeling level adequately is blocked and the individual retreats to solitude where loss of feeling becomes acute, described as "numb", "empty", "frankly unreal" (Horn, 1976). The bloodletting triggers a return to reality and the process was likened to a sexual, orgasmic relief of tension, which in itself was rewarding and therefore reinforcing for repetition.

The self-stimulation hypothesis frequently has been discussed in conjunction with the psychodynamic hypothesis which will be considered later. As noted by Carr (1977) this hypothesis appears plausible but inadequately tested. Animal analogies were initiated by studies conducted by Harlow and his associates and have led to the conclusion that barren, unstimulating environments are conducive to the continuance of repetitive, frequently self-abusive behaviours. This finding should be considered in developing treatment approaches for the vulnerable populations.

Hypothesis of Physiological Deviations

As this hypothesis did not appear to have specific relevance for the target population of this study, evidence supporting it was not reviewed in depth. In his evaluation Carr (1977) noted that physiologic ailments such as the Lesch-Nykan syndrome (Lesch and Nykan, 1964),

characteristically have self-injurious behaviours associated with them but that this is a correlation only as self-injury does not occur in every case. Head-banging has been observed among children suffering from painful middle ear infections (otitis media) and in a study by Lissovoy (1963) it was concluded that head-banging was a form of pain relief. Further testing of the hypothesis was recommended as not all head-bangers suffered from the painful infection, neither did all those afflicted resort to head-banging.

Studies of self-injurious behaviour and other problem conditions have not been conclusive. In one study of schizophrenic children who showed abnormal non-response to apparently painful circumstances (Goldfarb, 1958), there was no evidence that the children had an elevated pain threshold in that their individual response to pin prick testing were normal. It would appear that organic conditions may contribute to the occurrence of self-injurious behaviour. Social reinforcement whether positive or negative, withdrawal or reduction of negative stimulation or psychodynamic conditions would seem to contribute to the continuation of this behavioural expression.

Positive Reinforcement Hypothesis

This hypothesis regards self-injurious behaviour as a learned, operant or instrumental social behaviour which is maintained by the positive social reinforcement given in response to the occurrence of the behaviour (Lovaas, Freitag, Gold and Kassorla, 1965). The behaviour of an acting-up child is difficult to ignore, so much more so is the behaviour of someone who is observed to be self-injuring (or who is

discovered or reveals this kind of behaviour has occurred). As this behaviour tends to command attention, especially when accompanied by surpise, it is very difficult to refrain from providing for secondary gains through expressions of care, concern and reassurance. Self-injuring can be adopted by individuals who are unable to acknowledge their own inadequacies, as a means to have personal failures excused and to secure pity and compensation (Drinker, Knorr and Edgerton, 1972). Herzberg (1977) studied a contrasting population of female self-injurers characterized by verbal, active, athletic successes who derived secondary gain through infirmity and inactivity. In many cases infirmity provided temporary relief from the responsibilties of caring for a dependent parent or spouse. It has been suggested that the positive reinforcement hypothesis be broadened to include activity and material reinforcers as additional sources of motivation for self-injurious behaviour (Carr, 1977).

In support of this hypothesis it has been observed that self-injurious behaviour can be reduced or eliminated with the removal of social consequences, as tested among institutionalized retarded populations for whom time-out procedures were applied (Hamilton, Stephens and Allen, 1967). Because measures of social reinforcement have not been made systematically before, during, and after treatment interventions, there has not been conclusive evidence that the reduction of self-injurious behaviour is the result of withdrawn social reinforcement exclusively. The confining environments may have acted as a punishment, thereby contributing to the reduction of the fre-

quency of the behaviour. As with other behaviours being examined for behaviour modification treatment programming, it has been speculated that self-injurious behaviours may receive intermittent attention. Noncontingent time-out procedures at fixed interval schedules therefore have been investigated, in addition to differential reinforcement of behaviour other than self-injuring and low rates of self-injury, with results reporting gradual reduction of self-injurious behaviour (Carr, 1977; Lovaas, et al., 1965).

Much of the testing of the effects of withdrawal of reinforcement for previously rewarded behaviour, done among non-human subjects because of ethical considerations, have indicated heightened frustration, an initial increase of self-injurious behaviour, and a frequently noted by-product of extinction, aggression (Carr, 1977). It has been cautioned that after deprivation of social reinforcement, reinstatement of social reinforcement has resulted in the highest rates of self-injury incidents, indicating therefore that the reinforcement has increased in potency.

In summary, considerable support has been given to the Positive Reinforcement hypothesis which seems to account for much of the self-injurious behaviour observed. Studies have demonstrated that: self-injurious behaviour rates can be reduced when social reinforcers are withdrawn; rates can be increased when positive reinforcement is made contingent upon the behaviour; and self-injuring can come under the control of stimuli in whose presence self-injury is positively reinforced (Carr, 1977).

Negative Reinforcement Hypothesis

This hypothesis states that self-injurious behaviour is maintained by the termination or avoidance of an aversive stimulus following an incident of self-injury (Carr, Newsom and Binkoff, 1976). The hypothesis has not been extensively tested however Carr, et al. (1976) demonstrated that self-injurious behaviours were high in demand, aversive or noxious situations, and low in demand-free circumstances. The subjects responded with gradually increased rates of self-injury during consecutive demands sessions, in what has been labelled as a scalloped pattern of increase. This phenomenon was attributed to the fact that at the end of the fixed length demand session, the self-injurious behaviour which occurred was negatively reinforced because it would be correlated with the cessation of demands.

Covert stimuli such as aversive dreams, hallucinations and compulsive thoughts have been attributed a role in the self-injurious behaviour which appears to have escape motivation. Counterconditioning and desensitization procedures have been introduced to neutralize aversive stimuli and the desired results have indicated that further investigation of the approach could lead to improved management techniques (Carr et al.,1976; Carr, 1977). It has been noted that children who self-injure often are placed in physical restraints and allowed to sit alone or lie down in low demand circumstances. When restraints have been removed and demands have been made such as dressing or toileting, incidents of self-injury reoccur. Although social reinforcement is removed under restraint conditions, it has

been speculated that the isolation and absence of demands become associated with safety and therefore what outwardly appears to be a noxious circumstance becomes desirable for the child who resorts to self-injuring to secure this reassurance. Carr (1977) suggests that if the safety environment associated with restraints could become associated also with high demands and unrestrained circumstances with free time, then the frequently necessary restraints should lose their positive reinforcement value. This principle would seem to have implications for treatment approaches which utilize isolation, closed units or exclusion from designated tasks and activities in response to self-injurious behaviour. The individual self-injurer should be assessed in order to determine if the consequences seem to be perceived as more desirable than the pre-injury environment, however temporary this relief by escape may be.

Psychodynamic Hypotheses

Various hypotheses proposed regarding the motivation for self-injury are based upon psychoanalytic theory as it appears to apply to self-injurious behaviour (Cain, 1961). It has been suggested that self-injuring is an adaptive behaviour adopted to trace the "ego boundaries" (Bychowski, 1954, p. 67) or to establish "body reality" (Greenacre, 1954, p. 38), each of which may be attempts to distinguish the self from the external world (Hartman, Kris and Loewenstein, 1949).

Freud's theories on aggression have provided a cornerstone for the interpretations of self-injurious behaviour. In his early hypothesis (1917), Freud considered that aggressive instincts were a

basic component of human existence. He associated aggression with the destructive instincts and attributed its origins to deprivations and subsequent frustrations (Freud, 1935). Frustration occurs when pleasure-seeking or pain-avoidance are prevented. In normal development, aggressive impulses once provoked are directed away from the body towards those objects or persons perceived as being the source of the frustration. When expression of these aggressive urges is restricted or prohibited, then an individual's behaviour tends to become less adaptive and rational. The deprivation may be coped with by sublimation and redirection whereby the aggression is internalized and the self becomes the substitute target (Hartmann et al.,1949). Threat of punishment initially may curb any aggressive expression, however such interference is likely to increase frustration with the aggravated aggressive feelings being directed towards the restricting, punitive agent. When the self is the inhibiting agent then the inhibited aggressive impulses have a greater tendency to be directed towards the self. Self-aggressiveness, however by virtue of the threat to the self, is felt to occur only when alternative forms of expression are more strongly prohibited (Dollard, et al., 1939, p. 48).

Psychoanalytic theory describes the fusion of aggressive urges with libidinal urges. Internalized aggression is regarded as essential in the formation of the superego, however when the fusion of libidinal and aggressive urges is inadequate, when boundaries are poorly defined or the ego is weakened, the aggressive urges may be diverted to the self without the mitigating influence of the superego,

thereby threatening the individual's safety (Cain, 1961; A. Freud, 1949). The fusion process is thought to be inhibited by adverse external or internal conditions such as the absence of love objects, breaking of emotional ties as soon as they are formed, lack of emotional response from the adult environment, or deficiencies in emotional development for innate reasons (A. Freud, 1949, pp. 41-42). Psychoanalytic interpretations regard self-injurious behaviour as displaced genital damage while suicide is considered to be an attack upon the whole body as the source of sexual urges (Freidman, et al., 1972, p. 182).

Geleerd (1956) and Freidman, et al., (1972) consider the developmental process, particularly the mother-child relationship to be a decisive factor in the occurrence of self-injury. An inability to detach libidinal ties from original objects is presumed to be the provocation for the melancholia observed in adolescents who self-injured. Disappointment, or a sense of loss or abandonment at the hands of the mother or love object upon whom the child was totally dependent can become re-activated in adult life when serious losses or fear of abandonment or rejection are experienced (Walzer, 1968). Adolescents who self-injure have been observed to have ambivalent relationships with their mothers, severe and primitive superegos, and low self-esteem with excess guilt and self-criticism. As the child matures, the hostility which originally was directed towards the parent figures is directed towards their introjects within the child. With the anger turned inward upon the self, the child or ado-

lescent may become subject to depression.

Dollard, et al.. (1939) built upon the frustration-aggression hypothesis by applying a learning theory interpretation. In addition, Miller, et al. (1941) expanded upon the direct causal relationship to include that frustration may provoke several types of responses, one of which may be a form of aggression. The original hypothesis has been reviewed and challenged by Berkowitz (1978) who tentatively has concluded that pain rather than frustration is the primary source of angry aggression. Burks and Harrison (1962) in their study of aggressive children regarded their aggressive acts as a defensive reaction adopted to ward off depression. Runaway behaviour frequently is considered an indicator of child and adolescent depression from which they are trying to divert their attention (Finch and Pozaanski, 1971, p. 56). Individuals, as children, may have learned that "leaving" is a means of hurting others, therefore running away, suicidal gestures and various forms of self-injury may be adopted for manipulative and vengeful reasons.

Children typically respond to unresolved frustration with aggressive, infantile dependency apparently feeling inadequate to cope alone with their aggressive impulses. They may become passively withdrawn or may seek to appease the perceived opponent through submissive behaviour rather than resort to the previously cited active, defensive behaviour. "Accidental" self-injuries are common among children who feel overwhelmed by the frustrated expression of their aggressive impulses. Burks and Harrison (1962) found that physically adept, "motor

minded" children tended to cope with stresses and depression by using alloplastic means, or adaptations intended to alter their environment, rather than the self. Building upon this hypothesis, self-injurers and suicidal individuals either would have experienced frustration and failure of their alloplastic means of coping, or initially, by basic personality, were predisposed towards autoplastic means of adaptation, whereby the total personality rather than the environment is the target for affective expression and change. The self-directed affect in response to what is perceived as an ineffectual ego would tend to be aggressive and therefore could place the individual in jeopardy of depression or self-injury (Kaplan, 1975). Redl and Wineman, (1951) noted in their observations of aggressive children that depression was suspected because the children characteristically seemed unable to have fun and rarely seemed to experience joy.

The concepts of transactional analysis suggest another psychodynamic hypothesis for the motivation of self-injurious behaviour (Berne, 1964; Steiner, 1971). It would appear that the self-injurer has decided upon a script or life plan on which her own needs and expectations accommodate the injunctions applied to her since infancy by her family. Consistent with psychoanalytic interpretations, it has been noted that the most potent injunctions are transmitted from the opposite sex parent to the child, fathers therefore being most significant in their communications with their daughters. It would be expected that the injunctions would largely be negative, including "don't show anger", "don't be happy" and possibly "don't be". Counterscripting,

the accommodation of social and cultural demands, could not support suicide attempts, therefore self-injurious behaviour may be the only acceptable compromise between the demands of the script and counter-script injunctions.

The psychodynamic hypotheses have been found to be extremely difficult to test empirically because the basic constructs such as "guilt", "body reality", and "ego boundaries" defy operationalizing. Psychoanalytic theory from which the hypotheses are drawn has been fundamental in the interpretation of human behaviour and therefore efforts should continue to be made to define test constructs. Given that these hypotheses have been inadequately tested, the researcher has accepted them as a valuable contribution in the understanding of the motivations for self-injurious behaviour.

Further Study Considerations

Self-Cutting

There was a dearth of literature regarding non-drug ingestion self-injury, although this method was cited in several of the studies of parasuicide. Swallowing of foreign objects was considered to be a cruel or bizarre method of self-injury "usually found only in those youngsters who are seriously disturbed" (Finch and Pozaanski, 1971, p. 58). Self-cutting has been widely discussed with a differentiation between coarse and delicate cutters. Coarse cutters utilized deep, often singular incisions near vital areas while delicate cutters exhibited light, multiple and carefully designated incisions which usually require no sutures and leave no scars. Delicate cutters,

because of the repetitive nature of their activity, have been considered to have the potential to adopt coarse patterns and thereby increase the suicidal potential (Ping-nie, 1969). Cutters have been conceptualized as being in an altered ego state to be compared with depersonalization and derealization immediately prior to their self-injuring (Ping-nie, 1969; Rosenthal, et al., 1972). Various studies found the phenomena of depersonalization equally among controls and cutters and therefore challenged that depersonalization could not be considered to be the essential factor preceding self-injurious behaviour (Gardner and Gardner, 1975).

Siomopoulos (1974) regarded repeated cutters as being caught in a psychosexual fixation with a fusion of instinctual impulses which they found irresistible. He supported the classification of self-cutting as an impulse neurosis similar to such forms of abnormal behaviour as kleptomania and pyromania (Siomopoulos, 1974, p. 94). He found that the cutters might report depressed or hopeless feelings but characteristically they denied suicidal intent. They would cut after a period of mounting tension of various origins, and they reported an autoerotic release of tension immediately upon cutting. Narcissism and obsessional patterns built upon the reinforcing reward of tension release have been noted, particularly among superficial cutters (Gardner and Gardner, 1975, p. 131). Rosenthal, et al., (1972) concluded that self-cutting serves an important defensive or reintegrative function, being "a primitive way of combatting the feelings of unreality and emptiness" (Rosenthal, et al., 1972, p. 1367). Feelings of numbness, (Battle and

Pollett, 1964) emptiness or sense of isolation and aloneness may be factors among persons who self-injure.

Influence of Menstruation

A study by Rosenthal, et al., (1972) supported previous observations of a definite relationship between menstruation and wrist-cutting, with wrist cutters having far more negative feelings towards menstruation, and reporting greater incidence of irregular menses than did the controls. Sixty per cent of the cutting incidents occurred during menses, particularly on the first and last days of the period, and none of the subjects had cut themselves prior to menarche although they often had histories of self-injuring. Menstrual conflict, denial of sexual drives and identification problems may be significant factors in the study of self-injury, particularly cutting methods. These factors require further research however as various studies have found that, although menstrual data was difficult to obtain because of irregular menses or recall difficulties, there appeared to be no relationship between self-injuring and menstruation (Cookson, 1977; McKerracher, et al., 1968). Case study analyses have led to speculation that these problems are redirected towards the self in such a way that the body surface becomes a constant source of erotic fascination (Uemura, 1975). Early immobilization and skin diseases also may contribute to the cutting syndrome (Kafka, 1969).

Impact of Separation and Controls

The study conducted by Offer and Barglow (1960) suggested that self-injury was a learned behaviour which could be propagated in highly structured settings where incidents create widespread repercus-

sions and where program controls restrict aggressive acting out. Self-injury frequently was found to be related to a conscious wish for attention, prestige among peers, or the release of tension in addition to having a contagious quality which prompted widespread imitation and identification. They observed that neither relaxed nor strict controls were significant deterrents of further self-injury. When anticipated secondary gains of self-injury failed to occur, a reduction in defensiveness and the denial of psychological and emotional problems have been noted as factors contributing to increased depressive feelings and further self-injuring. Offer and Barglow (1960) also noted in their study that sexual acting-out seemed to replace self-injurious behaviour, particularly during the summer season.

Studies of self-injurious behaviour among incarcerated populations have discovered that the self-injurers had histories of habitual violence including cruelty to animals and fire setting as children and physical aggressiveness as adults (Bach-Y-Rita and Veno, 1974). Containment in an environment which restricted the individual's customary aggressive actions seemed to result in the aggression-turned-inward phenomena of self-injuring (Bach-Y-Rita, 1974). An uncertain sentence or the beginning of a long sentence engendering hopelessness correlated with more frequent incidents of self-injury in a study by Cookson (1977). Rosenthal, et al., (1972) suggested that self-injuring may be a reaction against a felt hostility or aggression either of a family or an institution. For adolescents admitted to foster care, group homes or, as in this study, residential treatment, this

researcher feels the separation from family may be experienced as the culmination of an ultimate threat, verification of their unacceptability and rejection by their family.

Within the natural family, an adolescent must work through the frustration and doubt of the normal adolescent separation-individuation identity crisis. Within foreign environment, where rules are imposed and often perceived as being arbitrary and constricting, the infantile developmental stage of separation-individuation may be re-experienced as an acute sense of self-doubt, inadequacy and anger. The adolescent may feel unable to grow, separate and become successfully independent (Taylor and Siegel, 1978). It is common among children seen by special treatment services that a firm sense of personal identity was not achieved as a child. The separating family and the controlling institutions may be perceived as threatening oppressors. Self-injury may be adopted as an attempt to appease the oppressors and perhaps to divert them from enforcing a more severe, upsetting punishment, as suggested by Cookson (1977). Hopelessness with regard to their post-treatment futures may aggravate feelings of depression which, as previously stated, may lead the adolescent in treatment to self-injurious behaviour.

Psychological Instruments

Although there were no significant differences noted on scores from the Minnesota Multiphasic Inventory scale as applied to a state prison population (Panton, 1962), the self-injurers were found to be more psychotic in their attempts to defend against stress and frustration and were more inclined toward compulsive outbursts of

hostility with more bizarre forms of resistance to the attempts made to control their aggressiveness. Because of their unacceptable behaviour, these prisoners often were isolated during which time they would engage in self-injuring. A manipulative function was attributed to some cases, however all the self-injurers in the study by Bach-Y-Rita (1974) described the pattern of feeling low, isolated, tense and needing to do something with relief following their self-injurious actions. Kovacs, Beck and Weissman (1975) responded to the need for a tool to provide a prompt assessment of suicidal risk by designing a Hopelessness Scale, which proved to be a significantly better indicator of suicidal risk than a depression inventory which had been used traditionally. Hopelessness was found important in the prediction of the intent to commit suicide and as a predictor of future successful attempts. The rapid screening process proved valuable in delineating target symptoms which might respond to treatment, such as extreme negativism and misconceptions about life choices.

Impact Upon Observers

In a study of Emergency Room hospital staff responses towards suicide attempters it was observed that when the situation was not acute and the attempters were not terminally ill then the responses were of a hostile nature. In self reports, the nurses identified feelings of anger, fear, anxiety, frustration, contempt and concern (Welu, 1972). The range of these responses could prove to be comparable with those of child care and other treatment staff who are exposed to self-

injurious behaviour. Ansel and McGee (1971) found the hypothesis that the less the perceived degree of intention to die in an attempt, the more negative the attitudes toward the attempter was verified in their study.

As previously noted the occurrence of self-injurious behaviour typically commands an active staff or parental response and therefore the behaviour frequently is described as "attention seeking" (Chance, 1974; Cookson, 1977; Herzberg, 1977; Jarvis, et al., 1976; Notvotny, 1972; Offer and Barglow, 1960; Simpson and Hawke, 1970). Observation of the transaction of attention given and received may be perceived as a positive consequence of self-injurious behaviour and thereby provide "vicarious reinforcement" (Muus, 1975, pp. 243-244). The contagion effect, particularly evident in institutional settings when self-injurious behaviour occurs may be indicative of behaviour being modelled because of the positive consequences, whether it is peer prestige, staff attention or familial concern (Cookson, 1977).

A case study of ocular auto-enucleation by Carson and Lewis (1971) presented a significant aspect of the impact of self-injurious behaviour. They found that fears and fantasies were aroused in staff and other patients as to their own aggressive potential and the anticipatory threat which the self-injurers represent to them. Although this self-injury was more apparent and more severe than the acts upon which this study focuses, their recommendation of open discussion of possible fears among staff and patients through group meetings could have transfer value.

Summary

Among the Canadian population aged 15 to 24, suicide ranks third as the cause of death. Suicide attempts appear to be motivated by: angry aggression turned inward, forming guilt and depression; a desire to manipulate love, attention and support, possibly with the additional intent of punishment; a signal of distress or a cry for help; or a feeling of inner disintegration. Self-criticism, self-rejection and low self-esteem seem characteristic of suicide attempters who also exhibit feelings of helplessness, hopelessness, unworthiness and acute loneliness and isolation. These traits are not abnormal occurrences in adolescence, however the lability of the age group can subject adolescents to acute emotional crises leading to suicide attempts.

Marital and family discord, sex and sibling position, availability of willing, capable supporters, legitimate outlets for the expression of frustration and aggressive impulses are cited as various factors influencing the decision to suicide. Although the intent of a self-injurer seems to be to survive the act with the apparent hope that subsequently the psychosocial environment would be improved, the psychodynamic and situational factors cited for adolescent suicides are applicable in the exploration of the phenomena of adolescent self-injury.

The act of self-injury is confounding as to its intent and motivation. Explanations vary from sociological interpretations whereby the root cause is considered to rest with the institution or environment rather than in individual pathology, to moral judgements such as

an individual's antisocial manipulation of his life space (Bach-Y-Rita, 1974). Hypotheses regarding the motivation for self-injury reviewed in this chapter have included self-injurious behaviour as: self-stimulation; a product of physiological deviations; a learned operant maintained by positive reinforcement; a learned operant maintained by the termination of negative stimulation; and an attempt to relieve psychodynamic tensions, whether to reduce guilt or to establish a sense of self.

Various studies suggest that the restrictions of treatment or correctional settings and the separation from family are experienced as rejection and are disruptive to an individual's sense of identity and autonomy. Attention-seeking, tension release, change of setting or circumstances, brief control over the environment and, in cases of acute hopelessness, death wishes are some of the motivational factors which could be relevant for the adolescent self-injurers who are the focus of this study. Conclusive direction for the management and reduction of the types of self-injurious behaviour among the population of this study has been found to be lacking in the literature reviewed.

CHAPTER IV

RESEARCH DESIGN AND METHODOLOGY

Through her contacts with treatment personnel from various departments at Maryvale, the researcher became aware of a sense of inadequate information and understanding of the phenomena of self-injury. Incidents of self-injurious behaviour had occurred with unprecedented frequency involving girls in each treatment cottage during the period of September 1975 to May 1976. The staff were concerned about the impact and meaning of this behaviour, as well as the life-threatening potential of many of the modes of self-injury chosen by the girls. Not only were staff concerned with the effective treatment of the residents who self-injured, but they also sought means to handle the group within which what appeared to be a contagion effect frequently was noted.

Self-injury, the focus of this study, was assumed by the researcher to be indicative of a felt need on the part of individuals who engaged in this type of behaviour. A more detailed understanding of the resident who self-injures and the nature of the psychosocial environment in which she behaves in this manner would constitute a preliminary step towards further understanding and hopefully, as a result, more effective treatment. This study was addressed to an exploration of the perceptions of three groups of people: those known to be self-injurers; their resident peer group; and the treatment personnel who had direct involvement with the residents. It was intended

to examine the motivation for and purpose and consequences of the various incidents of self-injury as perceived by the three groups. Of related interest was the general adjustment patterns used by the known self-injurers as compared to those of their peers while resident at Maryvale. It was hoped that the data might make evident or clarify why only some of the residents became involved in what seemed to be imitation of the self-injurious activities.

Following from the preceeding discussion of problem identification and problem formulation, this chapter focuses upon the nature of the design and methodology which directed the research. Included are: classification of the research, concepts, operational definitions, an hypothesis and research questions. A description of the population is followed by assumptions made, limitations of the study and its design, data instruments, pretest procedures, methods of data collection, means of data analysis and attempts which will be made for the dissemination of the research findings. The researcher's contacts with the Maryvale administrators in relation to obtaining permission and reviewing data collection procedures also are presented.

Classification of the Research

Of the three types of research, namely: experimental, quantitative-descriptive, and exploratory, this research was classified as exploratory. The apparent lack of previous research in the area of self-injury made an exploratory design necessary. Exploratory studies are:

> ...empirical research investigations which have as their purpose the formulation of a problem or a set of questions, developing hypotheses, or increasing the investigator's familiarity with a phenomena or a setting to lay the basis for further research.... Relatively systematic procedures for obtaining empirical observations and/or for the analysis of data may be used.... A variety of data collection procedures may be employed in the relatively intensive study of a small number of behavioural units. (Fellin, Tripodi, and Meyer, 1969, pp. 255-256)

The exploratory research design sometimes is regarded as being quite unscientific in its approach. It does, however, fulfill the purpose of this study in that it lends itself to the examination of a broad issue which should generate specific questions and provide direction for further research.

The design employed could be sub-typed as being exploratory-descriptive. As Kahn notes, "exploratory and descriptive studies are frequently two categories logically on the same level" (Kahn, 1960, p. 53). The purpose of exploratory-descriptive studies is to develop a thorough description of a particular phenomena from which ideas and theoretical generalizations can be drawn (Fellin et al., 1969, p. 256). The study was considered to be descriptive in that it sought to investigate for relationships between certain variables including sociometric status, social history and demographic data, psychological assessments, patterns of coping with frustration, anger and disappointment, perceptions of alternative actions, and responsiveness to peer influence, and the occurrence of self-injury.

Concepts and Operational Definitions

The following are concepts which are relevant to the study and which are defined here to assist adequate understanding.

Aggression, refers to "a sequence of behaviour, the goal-response to which is the injury of the person toward whom it is directed" (Dollard, Doob, Mowrer and Sears, 1939, p. 9). This behaviour is not necessarily overt. It may exist in fantasy or be directed towards the person perceived as causing the frustration, or it may be displaced or even undirected in its expression.

Frustration, refers to an "interference with the occurrence of an instigated goal-response at its proper time in the behaviour sequence" (Dollard et al., 1939, p. 7).

Perception, is "the process of becoming aware of objects, qualities, or relations via the sense organs; (including) such activities as observing, recognizing, discriminating, and grasping meaning" (Goldenson, 2, p. 93).

Self-concept, refers to how an individual views herself, the pattern of attitudes entertained or assumed concerning her values, goals, abilities and personal worth.

Sociometric status, refers to an individual's relationship within a group, based on choices generally made by a group of peers directly involved with each other and who actually determine these relationships (Goldenson, 1, p. 1235).

The following working or operational definitions are provided for the purpose of enabling the reader to conceptualize

clearly the meaning intended by the use of certain terms in this research.

Crown Ward, refers to a girl in need of protection who has been placed in permanent care as a ward of the Crown, and for whom the Children's Aid Society is delegated to provide care. Rarely does the girl reside with or return to the care of her family, therefore group and foster home placements and possibly adoption are the usual experiences of a Crown Ward.

Day Care; refers to the status of a girl who lives with her family in the community and returns for the 5 day school program and noonhours at a cottage, as well as periodic weekend activities.

Identified Self-Injurers, refers to the girls who were known to have participated in self-injury, as identified by the Unit Co-ordinators.

Non-Self-Injurers, refers to the girls residing in cottages where self-injuring had occurred as of June 14, 1976, but excluding the residents who had been identified as self-injurers.

Non-Ward, refers to a girl with whom social agencies, particularly the Children's Aid Society, has been involved but over whom the maximum influence and responsibility would be granted through a supervision order.

Private, refers to a girl who was referred to Maryvale by her family or physician, or was a self-referral.

Resident, as used in this research, refers to the population of girls at Maryvale from October 1, 1975 through June 16, 1976.

At that time, the girls were between the approximate ages of 13 and 16 years.

Self-Declared Self-Injurers, refers to the residents who had been regarded as non-self-injurers, but who had identified themselves in the Interview Questionnaire (Question 39, Appendix F) as having participated in self-injurious behaviour.

Self-Injury or Self-Injurious Behaviour, refers to self-induced, self-directed activity which resulted in external or internal bodily harm. Self-injurious behaviour as experienced by the subjects in this research included scratching, cutting and puncturing of skin tissue, as well as ingestion of toxins, pins, needles, tacks, glass and other foreign materials.

Temporary Ward, refers to a girl in need of protection who has been placed in temporary care as a ward of the Children's Aid Society. With Society approval, the girl may live with her family, otherwise she experiences foster or group home placements. A child may continue in this status to a maximum of 2 years at which time the case must be evaluated and the child returned to the original guardians or made a ward of the Crown.

Research Questions and Hypothesis

The following research questions and hypothesis provided direction for the data collection.

> Hypothesis: Those girls who are least preferred by their peers have exhibited a predisposition towards participation in self-injurious activities.

Question 1: Are there etiological factors which may indicate a predisposition towards being a self-injurer?

Question 2: What is the status within the treatment environment, specifically within the cottage grouping, of the girls who are known to have self-injured while resident at Maryvale?

Question 3: Do the girls who indicate that they have self-injured also report more limited relationships with peers and staff than do the non-self-injuring residents?

Question 4: Do the residents regard self-injurious activities as a means of escaping situations which they perceive to be difficult or non-rewarding?

Question 5: In each of the three subject groups, is attention-seeking the purpose attributed most often to the use of self-injury?

Question 6: Do treatment personnel consider their education background to have prepared them adequately for working with individuals who self-injure?

Populations

The population of girls consisted of discharged identified self-injurers and all residents enrolled at Maryvale at the time of this study. In this research there were two distinct data collection processes occurring approximately 2 months apart. Because of the purpose of the data collection instruments and the limited access to certain potential subjects, one sample of girls was selected for the Sociometric Questionnaire, and a second sample for the Interview Questionnaire which focused upon self-injury.

The staff population consisted of all Maryvale employees at the time of this study. Because of the focus of this study, the Staff Questionnaire was distributed to a drawn sample.

Sample Groups

Sociometric Questionnaire

For the Sociometric Questionnaire it was necessary to select as subjects those girls who had been resident at Maryvale during the frequent occurrence of self-injuries. Attendance records were used for the month of January 1976 from which were drawn the names of only those girls who had been residents for at least 3 months. The researcher felt that this was a minimum period from which the respondents could be asked to consider friendship attractions among their cottage mates. Several of the girls who were known to have self-injured during their residency had been discharged during the early months of 1976. These identified self-injurers as well as all former residents discharged after October 1, 1975 were included in this drawn sample which totalled 29 subjects.

Interview Questionnaire

The drawn sample for the administration of this questionnaire consisted of those residents who had been participant in self-injury, as well as the girls residing in cottages where self-injuring had occurred as of June 14, 1976. The residents and staff of the Receiving and Assessment cottage were not included as there were no known self-injurers in this unit. In addition, identified self-injurers who had been discharged between October 1, 1975 and June 14, 1976 were included in the group of identified self-injurers. The group of identified self-injurers totalled 13 girls: 5 residents and 8 former residents, (1 had continued as a Day Care student). There were 32 girls in the group of

residents not identified as self-injurers, forming a drawn sample of 45 girls.

Staff Questionnaire

The teaching, child care, recreation, social work and medical staff were potential sources of information, however, only those staff who had direct, regularized involvement with or input into the treatment and handling plans of the identified self-injurers were selected for the staff sample. Included were the child care staff and Unit Co-ordinators for each of the four treatment cottages, the Cottage Life Co-ordinator and Assistant, and the Treatment Co-ordinator, social workers and the nurse. The drawn samples consisted of 44 staff.

Checklist

The case records of the 36 girls who completed the Interview Questionnaire, and the 6 non-participant, discharged identified self-injurers were reviewed with the aid of the 14-point checklist. In total, a sample of 42 master file records were examined.

Assumptions

An assumption is a proposition, similar to a hypothesis, however, it is not to be tested in the study; rather it is considered to be true or a "given" factor in the research. Assumptions are of three major types: those which express value goals of society, those concerning the organization of society, and those that concern the particular variables of the study (Ripple, 1960, p. 35).

The following are assumptions which are of particular concern to this study:

- Self-injury is neither desirable nor prestigious behaviour in our Western culture.
- There are similar patterns in self-injurious behaviour which can be classified.
- Increased knowledge about the phenomena of self-injurious behaviour would provide for more appropriate treatment planning.

Limitations

It was recognized that the nature of the study encompassed limitations.

By limiting the subjects of this study to the defined drawn samples a considerably narrow focus was adopted, thereby limiting the generalizability of the findings to a population of greater variation. While providing for a high degree of internal validity, external validity was significantly limited.

All cottages differed as to the number of girls in the subject groups. Because of these differences it was difficult to do comparisons among the sociometric responses. The validity of the comparisons made may have been questionable, recognizing that the units were largely autonomous, with staff and resident interrelationships unique to each.

As a result of planned discharged and recommendations for alternative placements for severely acting-out self-injuring residents, there was a substantial loss in the population of resident identified self-injurers between the study proposal and data collection stages.

The ex post facto examination of self-injury restricted the potential for accuracy and completeness in the responses of both the

staff and girls. The impact of this limitation was aggravated further because there were no records of a critical incident reporting style to which the researcher could refer for cross-reference and elaboration. The examination of daily notations on the residents was considered to be beyond the scope of this study.

Because of program scheduling and the discharges planned for late June, data collection was restricted by time and was done by larger groups than originally planned. These groups included the identified self-injurers for whom individual interviews had been proposed. As a result, the interview schedule became the Interview Questionnaire by virtue of the revision of its intended administration.

Some contamination of responses from the residents was possible since the data collection was conducted over a 3 day period. It was possible also that the staff discussed their responses prior to completing their individual questionnaires.

Because many of the staff and residents knew the researcher as a previous staff member, fears regarding anonymity and confidentiality may have inhibited their responses. It was not possible to determine if the response patterns reflected unwillingness or inability to respond.

Approval of the Study and Procedures

A letter (Appendix A) was sent to the Maryvale Executive Director, January 30, 1976, requesting permission to use Maryvale as the setting for the research study of self-injurious behaviour.

Approval was granted in a letter (Appendix B) of February 9, 1976.

Permission was received to conduct a taped interview with an identified self-injurer when it was learned that her discharge was to occur prior to the planned data collection date. This interview was conducted March 11, 1976.

Early in April, the Treatment Director and the Cottage Life Co-ordinator reviewed the Sociometric Questionnaire (Appendix E) and approved its administration to the proposed population of residents and former residents who had been discharged after October 1, 1975. A schedule for the administration of the Sociometric Questionnaire was arranged with the Unit Co-ordinators for April 14, 1976.

The researcher met with the Treatment Director in May 1976 to discuss further the research methodology. The girls' Interview Questionnaire (Appendix F) and the Staff Questionnaire (Appendix G) were reviewed in early June with the Treatment Director. The girls' Interview Questionnaire also was presented at this time to the Cottage Life Co-ordinator and the Unit Co-ordinators in order to acquaint them with the instrument and to respond to any questions or concerns which they had regarding the study and the instruments to be used. The mechanics of the administration of the questionnaires were discussed and a schedule for data collection was arranged for three consecutive days in mid-June. At this meeting the Unit Co-ordinators provided the researcher with the names of the residents who were known to have self-injured. It was accepted that the researcher would arrange through cottage unit staff to meet the identified self-injurers individually,

preferably the day prior to their unit's scheduled group interview. This meeting was intended to provide each identified self-injurer with an overview of the questions and to offer each girl the option of completing the scheduled interview privately with the researcher rather than with the cottage group as a whole.

It also was necessary to contact the social workers directly in order to obtain the addresses of the guardians of the former residents who were known to have self-injured and had been discharged after October 1, 1976.

The Executive Director permitted the researcher access to the master file case records for the collection of select social history material, utilizing the Checklist (Appendix D).

Data Instruments

The Sociometric Questionnaire (Appendix E) was used with both current and former residents. It was devised to assess the attractions and repulsions each girl had for the girls with whom she lived in her cottage unit.

The questionnaire was designed to fit the sociometric structure and to reflect the real nature of the group being examined. The second section of the questionnaire represented a modified version of the Ohio Social Acceptance Scale (Goode and Hatt, 1952, pp. 252-253), and contained the only negative statements, reflecting with whom the respondent would choose not to associate.

The former residents, all of whom knew the researcher, received a mailed Sociometric Questionnaire accompanied by an informal

hand written letter of introduction and instruction, and a stamped self-addressed return envelope.

With regard to the girls' questions on self-injury, an interview schedule format was chosen (Appendix F), hereafter referred to as the Interview Questionnaire. The researcher felt that the personal contact and the opportunity to prod, accompanied by the assurance of confidentiality, would facilitate more adequate responses. The interview was standardized, meaning that questions were to be "presented with exactly the same wording, and in the same order to all respondents...(ensuring) that all respondents are replying to the same questions" (Selltiz, Jahoda, Deutsch, and Cook, 1959, p. 255). There were 56 questions for all respondents. Four additional questions (Appendix E) were included in the interview schedule for the identified self-injurers. All respondents were requested to identify their birth month and year only, providing for anonymity.

A Staff Questionnaire (Appendix G) was devised to gather data from the direct treatment staff in relation to their work experience with self-injurers. Although educational background was requested, anonymity was intended.

A Checklist (Appendix D) was developed for use in the review of case records, with regard to variables which the researcher considered to be potentially significant in understanding the etiology of the self-injurer.

Pretest

Arrangements for a pretest utilizing a local Children's Aid Society group home in which there had been recent incidents of self-injury were intended. Residents and staff were to have been involved in the pretesting of the Interview Questionnaire and the Staff Questionnaire.

The researcher had not accounted for the discharging and vacationing of residents following the mid-June closure of their school classes. However, through the co-operation of a social worker of the Roman Catholic Children's Aid Society of Windsor, two female residents and a staff member of an area group home did review the data collection instruments. The residents were somewhat older than the Maryvale population. One of the girls had self-injured by wrist cutting while in a previous placement, and was able to respond openly and with authoritativeness to each of the questions. Recommendations for minor revisions, in terminology only, were made. The procedure took the form of examining each question in sequence, taking approximately 45 minutes to complete, with time spent in discussion afterwards. The girls seemed enthusiastic and uninhibited by the questions. As expected, their ability to recall and to describe emotional responses seemed to be the most difficult elements of the interview schedule.

During the June meeting with the Cottage Life Co-ordinator and Unit Co-ordinators, minor revisions were suggested which coincided with those recommended by the pretest participants. These changes were

made in the finalized Interview Questionnaire.

Collection of the Data

Sociometric Questionnaire

During the evening of April 14, 1976, a group meeting was held with the residents of three of the four treatment cottages. The girls in the Receiving and Assessment unit were excluded because as newly admitted residents these girls only stayed briefly in this unit, from which they were moved to one of the treatment cottages. The researcher was informed that there had been no incidents of self-injury in the treatment cottage which at that time was considered to be a senior cottage. For this reason, the girls in the senior unit as a group also were excluded. Three girls who had been transferred to the senior cottage attended the meeting held in their previous cottage. Because the Sociometric Questionnaire was based upon the cottage groupings as they had existed during the frequent incidents of self-injury, the researcher felt that having the three girls rejoin their respective cottage grouping would help to stimulate their recollections.

The girls were informed that the questions asked were about friendships which they might have developed with other girls in their cottage. The researcher explained that she had chosen to include only those girls who had come to Maryvale prior to January 1976. The explanation given was accepted by each group, however several of the girls who were excluded expressed disappointment in not being able to participate. No girl refused to complete the questionnaire.

The administration of the Sociometric Questionnaire in each unit required approximately 30 minutes. As expected, several requests for help and clarification arose with regard to certain questions in the second section of the questionnaire. This section required descriptive evaluations including negative categories. Conceptual problems and an unwillingness to categorize cottage mates, despite assurance of confidentiality, seemed to be significant factors. There were 16 residents who completed the questionnaire. Of the 13 former residents, addresses for 4 of the girls could not be obtained. There were five questionnaires returned (one being a refusal to participate) in response to the nine questionnaires which were mailed. From the drawn sample of 29 girls, there were 20 completed questionnaires.

Interview Questionnaire

Because of programming schedules and the imminency of the end of the school year, a maximum allotment of 1-1/2 hours per cottage unit for the interviewing process was offered by the Unit Co-ordinators during the meeting with them early in June. This time period coincided with the programmed Quiet Hour. It had been the intention of the researcher to interview at least the identified self-injurers on an individual basis. Recognizing the length of the Interview Questionnaire, the necessity that all the residents be interviewed within as brief a time period as possible, and within the blocks of time offered, the researcher decided to conduct one group interview for each cottage. The identified self-injurers were to be included if they were willing to participate in this format. The reduction of the time for data collec-

tion, necessitating the decision to conduct cottage group interviews, eliminated the planned small group interview with three or four residents and the preferred individual interviews with identified self-injurers.

The Interview Questionnaire was completed in the relaxed, air-conditioned atmosphere of the cottage living rooms, allowing for comfort, seating flexibility and sufficient space to provide privacy. The cottage setting was chosen also in anticipation that there might be girls who would not complete the task and that there would be a range of time and assistance required by the respondents. Being in their own cottage, the girls could circulate to other activities while being supervised by their staff who were excluded from the room where the Interview Questionnaire was being administered.

In this informal setting, the researcher identified her student status, her interest in Maryvale and her hope to work with girls in similar programs in the future. The researcher explained that she felt that the residents were not often asked for their opinions about the places in which they lived, and about some of the experiences they had while living in these places. She explained that she had interest in their experiences at Maryvale and particularly the self-injuring behaviour which had occurred in each unit. Each group was told that the Administrators were genuinely interested in being helpful to the girls and that they had given the researcher permission to meet with all the girls accepted into the Maryvale program.

The girls were assured that every effort to ensure confidentiality would be made, including the absence of their staff during the completion of the Interview Questionnaire. No request for names would be made and the collection of the questionnaires from each cottage would be made as a group. In view of the fact that the interviewing was conducted on 3 consecutive days, each group was asked not to discuss the content of the Interview Questionnaire with those girls still to meet with the researcher. Voluntary participation, the opinion nature of the responses requested, with no right or wrong answers, was stressed before the Interview Questionnaires were distributed.

The Interview Questionnaires were administered by the researcher and without the presence of other adults. The interview groups ranged in size from one to a maximum of nine respondents, depending upon the cottage composition at the time of the interviewing, and whether the girl was of Day Care status, discharged or about to be discharged. Thirty-three residents, one girl of Day Care status and two discharged self-injurers completed this questionnaire.

The researcher used one of two approaches. In one approach, each question was read orally by the researcher, who waited for the responses to be completed before proceeding to the next question. The second approach was to permit the respondents to complete the questions at their own rate, with the researcher being available to any respondent wishing to question her.

The first method was preferred by the researcher as she anticipated poor readers whose motivation could be maintained longer

with this kind of assistance. In the group interviews, and almost all of the individual interviews, the respondents were not receptive to having the questions read, perhaps being indicative of their sense of pride and need to be allowed to operate independently. With both methods, requests for clarification or other forms of help were encouraged and responded to. In each of the four group interviews, one respondent had reading or responding difficulties which prolonged her response time. In each instance the respondent readily accepted the researcher's offer to utilize the first method. There were 36 respondents to the Interview Questionnaire.

Distance, time and financial restrictions, as well as situational limitations specific to the girls, interfered with scheduled interviews, so that the researcher could not conduct an interview with five of the seven identified self-injurers discharged prior to the administration of the Interview Questionnaires. However, one of the five girls omitted had participated in a taped interview prior to her discharge so some data was available from her, although not obtained according to the Interview Questionnaire.

Staff Questionnaire

The Staff Questionnaire was deposited in the individual mail boxes of the selected non-Child Care treatment staff on June 16, 1976. At the same time, each Unit Co-ordinator was provided with sufficient questionnaires for distribution to each team member at their unit meeting. Attached to each Staff Questionnaire were a labelled return envelope, instructions for the completion of the questionnaire and the

request that the responses were to be sealed and deposited in a specially marked envelope at a convenient location in the Maryvale Administration building. A return deadline of June 25, 1976 was indicated which subsequently was extended for 2 weeks. Of the 44 Staff Questionnaires distributed, 24 were returned.

A notation that the staff was new to the program and unable to respond was indicated on one of the returns.

Checklist

Following the previously noted data collection procedures, the researcher conducted the checklist review of 42 master file records. Included in this sample were records of 34 residents and 8 discharged identified self-injurers, 2 of whom responded to the Interview Questionnaire.

The checklist data sheets were correlated with the Interview Questionnaires by means of the identifying birth month and year. With the discovery of the group of self-declared self-injurers, it was possible to categorize each girl's checklist according to her self-injury status. The remaining checklists were known to be those of discharged identified self-injurers.

Data Analysis

Beyond the literature review, this research consisted of four data collection procedures including: a Checklist applied to the master file records of the drawn sample; a Sociometric Questionnaire and an Interview Questionnaire for residents and discharged identified self-injurers; and a Staff Questionnaire. Responses of the resident and dis-

charged identified self-injurers were grouped for analysis. The taped responses of the identified self-injurer interviewed prior to the formulation of the Interview Questionnaire were not included in the statistical analysis, but when appropriate were included in the discussion.

Analysis of the data obtained through the Sociometric and Interview Questionnaires was made according to the originally identified groups and again with the recognition of the found group of self-declared self-injurers. Case record data from the master files were examined for differences among the three groups of girls.

Because of the nature of the data, which were frequency measures and descriptive comments, the Chi square test of significance was utilized. Where appropriate, Fisher's exact test of significance was applied to 2 x 2 contingency tables when the two independent sample frequencies were small, 15 or less. The level of statistical significance, $p \leq .05$, was accepted for this research.

Dissemination

The researcher has chosen a seminar presentation of the study rather than an oral defense. The seminar presentation was selected because it was the researcher's intent from the outset to share the results of the study with those persons who also were interested in the phenomena of self-injury. An invitation was sent to various residential settings whose staff might wish to know the findings of this study. A copy of the research project was offered for the Maryvale library.

Summary

The study has been classified as exploratory-descriptive. The area of focus, self-injurious behaviour among adolescent girls in the residential treatment centre, Maryvale in Windsor, was examined. A Sociometric Questionnaire was administered to 16 residents, and was mailed to 9 former residents, in an attempt to assess the sociometric status of the known self-injurers as perceived by their peers at Maryvale. An Interview Questionnaire was administered to 33 residents, 1 Day Care student, and 2 former residents who were known to have self-injured while living at Maryvale. Of the 36 respondents, 7 were identified self-injurers. Fifty-six research questions were formulated for the girls in relation to the area of focus and their overall adjustment to the treatment setting. Four additional questions were given to the identified self-injurers.

A questionnaire comprised of 26 questions was distributed among 44 treatment staff. This Staff Questionnaire focused upon their perceptions of the phenomena of self-injury and of the girls who engaged in such behaviour.

The master file social history records of 42 girls were examined utilizing a 14-point checklist. These case records included those of 33 residents, 1 Day Care student who had been a resident, and 8 discharged self-injurers.

It was anticipated that more data would be gathered than would be examined in detail in this research. It was hoped that the data presented could provide direction for further study.

CHAPTER V

DATA ANALYSIS

In this chapter the data collected by use of the study's four instruments is presented with discussion and statistical analysis. The drawn sample is described in terms of the data obtained by means of the Checklist applied to the master file records at Maryvale.

The response to Question 1 is based on this data. Cottage group peer preferences and perceptions obtained through the Sociometric Questionnaire and selections from the Interview Questionnaire follow and are applied to the hypothesis and Question associated with it. Responses to the girls' Interview Questionnaire and the Staff Questionnaire are discussed and applied to the study's questions.

The Interview Questionnaire was formulated with the expectation that comparisons would be made between the responses of the girls identified by the treatment staff as self-injurers and the responses of the girls not identified as self-injurers. The finding of a significant number of self-declared self-injurers, totalling 16 girls, prompted re-analysis of the data recognizing the existence of the three groups. The groups consisted of: 13 identified self-injurers (ISI), 16 self-declared self-injurers (SDSI), and 13 non-self-injurers (NSI).

Social History Findings

Demographics

The ages of the drawn sample for the social history review were calculated with June, 1976 as the base point (June 14, 15 and 16

being the period during which the Interview Questionnaire was administered). The ages ranged between 11 years 10 months and 17 years 4 months, with the mean age being 14 years 1 month. Based upon the definitions of early and middle adolescence, the subjects were classified as early up to the limit of 14 years 11 months and as middle for those aged 15 years and older.

A program study by the Cottage Life Co-ordinator determined the average length of placement to be 8 months, therefore 8 months or less was classified as a short placement and 9 months or more a long placement, with sample placements ranging from 1 to 23 months. No difference was found among early adolescents with regard to length of placement: 4 short to 3 long for the ISI, 4 to 5 for the SDSI, and 5 to 3 for the NSI. For the middle adolescents, there was a trend towards difference with the ISI having the highest frequency of lengthy placements: 1 short to 5 long for the ISI, as compared to 5 to 2 for the SDSI and 4 to 1 for the NSI.

Referrals almost entirely were made by social agencies. Involvement with social agencies did not prove to be discriminating among the groups as only a small proportion of each group had not been involved with various social services. It is recognized that the Checklist could have been more sensitive if it had investigated types and frequency of agency involvement, however the researcher notes that this information would not have been retrievable from only the Maryvale master files.

Legal Status

The ISI and SDSI tended not to differ in their frequency distribution among the legal status categories (Table 1), in that the majority were either temporary or Crown wards. Both groups of self-injurers differed from the NSI. The wardship status of the self-injurers was assumed to reflect their more frequent separation, loss and possibly rejection experiences, particularly relative to their families.

Table I

Legal Status Among the ISI, SDSI and NSI

	Status			
Group	Non-Ward	Temporary Ward	Crown Ward	Private
ISI **	2	4	5	2
SDSI *	0	6 [a]	5	5 [b]
NSI	4	2	0	7

[a] After placement at Maryvale, 1 became a Temporary Ward.

[b] A Private placement had been admitted as a Temporary Ward.

* $p < .02$. SDSI to NSI.

** $p < .05$. ISI to NSI.

Sibling Position and Parent/Family Characteristics

Sibling position and parents' marital relationship did not differ among the three groups. It appeared that marital breakdown, including separation and divorce, were more frequent than were stable relationships and marriages, particularly among the parents of both the

SDSI and ISI. The instability of parental relationships may provoke feelings of rejection and loss of love which, during the adolescent period characterized by heightened loneliness, may aggravate self-injurious or suicidal behaviour (Gould, 1965; Toolan, February 1962).

Family problems were spread without remarkable differences among the groups. Child abuse was blatant in two of the ISI case records, one of which related to a father-daughter incestuous relationship of 5 years duration. Parental violence was noted in two of the SDSI cases only, while alcoholism was cited infrequently for each group. The researcher concluded that the master file records were not sufficiently descriptive of family dynamics for informative interpretations and group comparisons.

Parental occupation had been of interest as a measure of social class and probable degree of financial security, however this information was not adequately documented. It was of interest to note that 3 of the ISI and 1 of the SDSI came from families supported by Mother's Allowance, thereby having absentee fathers, which has been considered to be a significant loss for adolescent girls (Berne, 1964; Steiner, 1971). It was apparent that the ISI experienced less familial and financial stability than the NSI, and to a somewhat lesser degree, the SDSI.

Placement and Separation Experience

As a group, fewer of the NSI had the experience of being placed outside their nuclear families prior to their Maryvale admission than the self-injuring groups. There was no difference between the

NSI and ISI, however, the SDSI and NSI did differ, with most of the SDSI having had previous placements (Table 2). In addition to placements by social agencies, this category included detention and lengthy periods of care with relatives, such as following parental separation. Frequency of placements ranged from 2 to 4 for the NSI, and 1 to 18 and 2 to 10 for the SDSI and ISI respectively.

Table 2
Previous Separation from Family
Among the Three Groups

	Separation	
Group	Yes	No
ISI	8	5
SDSI *	13	3
NSI	4	9

* $p < .01$. SDSI to NSI.

It was apparent that the self-injurers, who comprised the majority of the study sample, had a higher frequency of placement. The SDSI group had the highest frequency of placements and therefore had been exposed most often to the trauma of separation and meaningful losses. It may have been that these girls brought with them unresolved grief and feelings of personal rejection and failure. Unresolved separation experiences, social isolation and a sense of loss of control over their environment and futures may have been precursors of their self-injurious activity, as suggested by Corder et al. (1974). It would seem

advisable that the treatment centre recognize that their population is comprised of high-risk girls, with regard to self-injurious potential. Sensitive history taking which would explore separation experiences, and individual casework providing a forum for examination and working through of the impact of the separations would seem to be valuable components of the treatment planning.

Separations from the nuclear family were necessitated for similar reasons among the groups, including parental incarceration, hospitalization, desertion, and custody settlements following marital breakdown. The father's separation was cited as the precipitating factor in the deteriorated behaviour and suicidal threats of one of the ISI. Excessive truancy, obstreperous behaviour, poor family or peer relationships, running away, sexual acting-out, theft and drug or alcohol abuse frequently necessitated the involvement of Children's Aid Societies or the Court, and subsequently extra-family placement. Two cases will be cited as illustrations of the chaotic frequency of separation and placement among the self-injurers.

> Case 1: One member of the ISI was placed with a foster family within days of her birth, but at age 3 was separated from this family which moved out-of-country. She had experienced a 3 week adoptive placement and, in the 3 months prior to her Maryvale placement, had a series of 11 foster home placement failures.
>
> Case 2: One of the SDSI had 12 moves within the first 5 years of her life and at age 5-1/2 was moved into foster care because of her mother's physical and psychiatric illness and her father's abusive irresponsibility. She has continued in care.

Poor parent/adult models, including psychiatrically ill mothers and absentee or abusive fathers, blatant parental rejection, separation from siblings and frequent foster or group home placements seemed to be the pattern of experiences for self-injurers. The NSI pattern, though similar, was somewhat less severe and less frequent. A 1 month psychiatric hospitalization had been necessary for a 15 year old member of the NSI who was diagnosed as having had an acute schizophrenic episode, and was referred to Maryvale to secure her gains before returning to her home.

Other Factors

Psychiatric diagnoses, when given, did not provide a discriminating factor for the determination of potential for self-injury. Psychological and intellectual testing were not required for Maryvale admissions. From the limited data, a similar pattern of scoring higher on Performance than Verbal scales was noted, although the SDSI generally showed more consistency between the scores. The extreme low scores found among the self-injurers were not noted among the NSI. In most cases, academic functioning had been hampered by the pervasive influence of their emotional disturbances.

Unsatisfactory peer relationships were characteristic of the ISI without exception. The file records of the SDSI were less decisive, with nine unsatisfactory and six satisfactory ratings, with one girl's peer relationship skills being unclassifiable because of insufficient information. The NSI group was divided similarly with eight unsatisfactory and five satisfactory relationship ratings. It was apparent the ISI were least

equipped to develop and sustain constructive peer relationships and therefore would have the greatest need for staff direction and support as they attempted to be accepted within the cottage and centre's milieu. Staff support particularly in negotiations with the cottage group, would become particularly crucial for the ISI in the aftermath of incidents of self-injury.

Health

Among the ISI health generally was good. Abdominal distress and constipation were noted and two ISI had been given anti-anxiety and anti-depressant medications. Mellaril, a tranquilizer and anti-psychotic drug, had been prescribed for one of the ISI who tended to hoard the pills but was obstreperous when a liquid format was tried. Two of the ISI were diagnosed as having epilepsy which was controlled effectively by medication. One of the ISI by age 15 had two pregnancies terminated, and another girl, aged 13, had not reached menarche. Three of the ISI had required special medical attention atypical of the population.

> Case 3: A girl suffering from scoliosis had self-esteem and self-image problems associated with the curvature of her spine. At age 12 she had experienced a 3 week hospitalization followed by 3 months limited mobility in a body cast.
>
> Case 4: This girl had suffered a dislocated hip at birth and during the 8 month period in which she was in a cast she cried constantly, could not be comforted and was left alone in her crib by order of the physician because she would scream, not cry, when held or sat with. As a child and adolescent this girl exhibited rapid mood swings including episodic breath-holding and very demanding, attention-seeking behaviour as well as withdrawn states during which she preferred to be alone.

Case 5: One girl had suffered a period of unconsciousness as an infant following a shock from an electrical plug, and was diagnosed at age 5 as having a non-malignant brain tumor. The tumor was removed at age 6 following an excessive weight gain, fainting and seizure activity.

The health of the SDSI, although generally good, was marked by various somatic complaints including stomach tension, pre-menstrual distress correlated with behaviour/management problems (relieved in one case by a diuretic), sleep disturbances including insomnia, moaning and crying, chronic urinary tract infections, and one case of rheumatoid arthritis following rheumatic fever. One of the SDSI tended to feign abdominal pain, particularly following disciplinary restrictions, and on one occasion ran away from such a situation to a hospital.

Two members of the NSI had not yet reached menarche and two were considerably overweight, but otherwise the health history of this group was unremarkable. There was one incident of a pin being swallowed without negative effect, presumably accidentally, by a girl who neither was reported to be a self-injurer nor considered herself to be someone who self-injured. One of the NSI group was slow in reaching developmental milestones and as an infant frequently would wake screaming. This was the only case among the NSI in which medication was reported to have been prescribed. Mellaril had been given irregularly over a period of 1-1/2 years prior to her Maryvale admission.

Investigation of medical histories did not reveal predictors of self-injury. It did appear that an association may exist between physical ailments which negatively affect self-esteem and body image, such as epilepsy and deformities, and self-injurious behaviour if the ego is

not sufficiently strong to withstand the assault of the illness and its implications. Attention given to the patient status may serve to predispose these individuals to replicate the experience as noted by Chance (1974), Cookson (1977), Herzberg (1977) and Offer and Barglow (1960).

Presenting Problems

The initial impression of the presenting problems cited in the master files was that there could be no determination of a potential for self-injury. However, when the preadmission records were reviewed for reference to self-injury, suicidal threats or gestures by the girl or an immediate family member, in these cases parents, and for excessive sexual acting out, including terminated pregnancies, then these problem behaviours did appear to have an association with the occurrence of self-injurious behaviour. Differences were found when the number of intake case records containing reference to one or more of these problem behaviours were compared among the groups, with both self-injuring groups differing from the NSI (Table 3). The intake records of half of the ISI and SDSI group members contained reference to one or more of the three problem behaviours cited. The intake records of one NSI made reference to suicidal threats and infantile head banging during temper tantrums and that this behaviour, though less frequent, was present at the time of her admission to Maryvale.

Actual self-injurious behaviour by the referred girl was acknowledged in the intake records of only 5 of the 13 members of the ISI. The 8 remaining records were classified as "Unknown" because this behaviour was not specified, neither was this type of behaviour speci-

fically questioned for intake applications. Among the SDSI and NSI, the "Unknown" classification was necessary for 10 and 13 records respectively.

Table 3

Number of Intake Case Records Citing One or More of the Problem Behaviours

	Occurrence	
Group	Yes	No
ISI **	6	7
SDSI *	8	8
NSI	1	12

* $p < .01$. SDSI to NSI.

** $p < .05$. ISI to NSI.

Although the treatment personnel did not identify the group of SDSI, presumably because they had not experienced these girls to be self-injurious, the intake records did identify four girls in this group as self-injurers whose behaviour included prescription drug overdose, cutting, burning, ingestion of toxins and glue sniffing with a declared death wish. In addition, records of two members of the SDSI noted threats of self-injury including a threat of using a knife "to let the bad out" (as quoted in the case record). If intake records, rather than a list compiled by treatment staff, had been used to determine the ISI group,

then this group could have been expanded by four girls. Even after the review of the files, the researcher would not have been able to ascertain that there were an additional 12 girls who had self-injured, as confidentially acknowledged in the self-reports for Question 39 of the Interview Questionnaire (Appendix F).

Question I: Are there etiological factors which may indicate a predisposition towards being a self-injurer?

In response to the first research question, the checklist review of master files did not provide clarification of the etiology of self-injuring. Several factors did appear to be associated with such behaviours, including suicide or suicidal threats and gestures by family or significant others, and unresolved grief for relationship separations, particularly those experienced as a loss, such as a rejection or death. Ailments which were experienced as assaults upon the body image and sense of self-worth also seemed to be associated with the occurrence of self-injurious behaviour. Excessive sexual acting-out, which may be regarded as self-injurious and also may be indicative of or contribute to a poor self-image, was found among this sample, particularly if a resultant pregnancy was terminated by abortion, to have an association with self-injury.

It can be speculated that lengthy placement and wardship status are worthy of consideration in the identification of possible self-injurers. These status factors seem to connote for the girls a loss of self-determination and control over personal decisions as well as a sense of futility and failure with regard to their future, thereby predisposing them towards self-injury. It is recognized that the intake

material in the master files of this small sample was not necessarily complete and may have had information presumed to be detrimental to admission acceptance screened out by the referring sources. Etiological identification of self-injurers therefore was limited in this study.

Sociometric Findings

Because all other factors seemed equal among the cottages, the researcher assumed that the cottage environment, particularly girls to girls, staff to girls, and staff to staff relationships, was a significant factor. The girls' mutual relationships were examined through the Sociometric Questionnaire (Appendix E), which was devised to assess the attraction or repulsion each respondent felt for the girls with whom she lived, particularly those girls known to have self-injured at Maryvale. In addition, relevant comments from the Interview Questionnaire are considered. A research question directed towards this aspect of the exploratory study of self-injuries will be considered in the following discussion of the findings.

> Question 2: What is the status within the treatment environment, specifically within the cottage grouping, of the girls who are known to have self-injured while resident at Maryvale?

Because the second and third choice statistical probability of selection for members of each of the groups would vary in terms of non-responses and previous selections, the researcher elected to examine first choices only for the 13 questions in Part I regarding preferred companions in various situations. In order to determine the expected frequency of first choices for members of each group, it was necessary to assume that the pattern of choices among groups would be random. It

was not possible to determine if the self-injurious activity of the SDSI had been confided to peers, and therefore these girls may not have been known to be self-injurers.

Cottage Composition

The three participating cottages randomly were labelled as A, B, C, rather than their usual numerical identifications. In cottage A, the group of 10 subjects consisted of: 2 members of the ISI; 1 a non-participant; 2 members of the SDSI; and, 6 members of the NSI, of whom 3 did not participate. The group of 8 subjects in cottage B included: 3 members of the ISI; 1 member of the SDSI; and 4 members of the NSI, including 1 non-participant. In cottage C, the group of 11 subjects was composed of: 1 member of the ISI; 5 members of the SDSI; and, 5 members of the NSI, of whom only 1 participated. The obtained sample of sociometric responses therefore was from 20 girls.

Preferred Companions

First Choice Preferences

The sociometric data initially was analysed by cottage, recognizing the autonomy of each unit and the boundaries of the choices. The findings, however, have been presented according to the combined data drawn from the three participating cottages. This analysis minimized some of the individual relationships in the small samples, however the pattern of selection was retained. The expected and actual frequencies of first choices among the combined cottage groups have been presented in Tables 4, 5, 6, 7 and 8.

Table 4

Frequency of ISI as First Choice Selection by the Three Groups

Group	Frequency	
	Expected	Actual
ISI	12.3	21
SDSI	17.4	4
NSI	22.0	3

$p < .001$

As illustrated in Table 4, the ISI tended to be chosen by each other significantly more often than had been expected by random selection. It was not clear whether the underselection of the ISI by the NSI and SDSI reflected less attraction to the ISI initially because of personality or because self-injurious behaviours had detracted from possible friendship attractions. Question 49 (Appendix F) did not add clarification, however the responses indicated a tendency towards difference between the NSI and SDSI in that the NSI reported their relationships with the ISI to have changed negatively, towards dislike and fear, when the girls became known as self-injurers. Attention-seeking was the motive for self-injury attributed by the majority of the NSI and SDSI (Question 51, Appendix F) who seemed critical of the behaviour, particularly its public, disruptive nature.

Although attention-seeking may have been a motive in the self-injurious activity of the SDSI, it appeared that they kept these activities relatively unidentified and infrequent (Question 40, Appendix F). Their apparent ability to discriminate alternative coping mechanisms seemed to reflect an ability to examine consequences and a maturity recognized, though perhaps not appreciated, by their peers. These subtle differences may have been felt most acutely between the ISI and SDSI, with the SDSI being particularly critical of the public nature and repetitiveness of the self-injury by the ISI.

The pattern of selections by the ISI was examined further (Table 5) and revealed that the NSI were selected at the expected frequency but that the SDSI were underchosen. Social history data and self-reports of the SDSI indicated that they tended to have more experience of the trauma of separation and loss, and that the self-injurers, partjcularly the SDSI, differed from the NSI in having more frequently witnessed physical violence ($p < .01$), (Question 12, Appendix F). As a result, the SDSI may have been less responsive to the ISI relative to self-injurious activity because the SDSI may have developed a deliberateness in their own actions and detachment from noxious stimuli in their environment. The assumed closed nature developed by the SDSI as a defense against environmental pain may have made them particularly unappealing to the ISI. It was possible also that the SDSI were repelled by the similarities between themselves as self-injurers, albeit unknown, and the ISI, and thereby behaved so as not to attract the friendship of the ISI. It was noted in the sociometric

data that the ISI tended to select the more popular girls in addition to their own group members.

Table 5

First Choice Selections by the ISI

	Frequency	
Group	Expected	Actual
ISI	12.3	21
SDSI	14.8	8
NSI	36.9	35

$p < .01$

Although the SDSI shunned the ISI, they chose the NSI at the expected frequency and each other at a higher than expected frequency. The apparent rejection of the ISI therefore was not of a random pattern (Table 6). Personality qualities of the SDSI may have attracted them to each other, although it was possible also that they had confided in other members about their self-injury so that this led to bonding.

The NSI appeared to reject the ISI and seemed to discriminate somewhat against each other, perhaps reflecting the bully characteristics of some of the NSI. The undesirable characteristics of some of the NSI, as known to the researcher, may have affected all the sociometric re-

sults. With the exception of the degree to which they would recognize similarities between themselves and the ISI, it was assumed that the NSI were not attracted to the ISI for the same reasons as identified for the SDSI.

Table 6

First Choice Selections by the SDSI

	Frequency	
Group	Expected	Actual
ISI	17.4	4
SDSI	27.6	39
NSI	55.1	57

$p < .001$

Table 7

First Choice Selections by the NSI

	Frequency	
Group	Expected	Actual
ISI	22.0	3
SDSI	18.2	48
NSI	37.4	27

$p < .001$

Selection of the ISI

Categories for which the members of the ISI were first choices included being a companion at recess and outings, being most considerate and able to make friends most easily, perhaps reflecting the urgency of their need to form friendships with even a few girls. When selected as second and third choices, these same categories were most frequent, in addition to recognition of the individual abilities of the identified self-injurers. One of the older girls selected an age-mate who was a member of the ISI almost consistently as her second choice companion. Another older girl also selected this ISI member, possibly indicating that age affinity was more significant than concern for acceptable or understandable behaviour among peers.

Table 8

Selection of the ISI

by the Three Groups in Each Cottage

	Selection of ISI			
Cottage	By ISI	By SDSI	By NSI	Totals
A	1	1	13	15
B	31	0	4	35
C	0	9	0	9
Totals	32	10	17	59

Taken as a whole the responses to Part I of the Sociometric Questionnaire indicated that the members of the ISI were chosen 59 of the 663 possible selections (Table 8). If it was assumed that the members of the ISI had equal opportunity of being chosen, then they would have been expected to be chosen 137 times. The overall pattern of sociometric preferences indicated an underselection of the identified self-injurers.

Peer Ratings

Rating of Cottage Peers

Part II of the Sociometric Questionnaire (Appendix E) required the rating of cottage peers as to closeness and desirability as a friend. The following are abbreviations of these ratings: A, rating for a favourite girl with whom one would choose to spend a lot of time, would share and would want to be helpful; B, rating for a friend with whom one would choose to do things, both work and play; C, rating for one who was alright but not a friend; D, rating for someone not known as well and therefore not necessarily one with whom one would choose to be; E; rating for girl towards whom one is polite but with whom one would rather not be; and F, rating for girl with whom one would rather not talk or work. To be rated were 6 members of the ISI (5 of whom participated), 8 members of the SDSI and 15 members of the NSI (7 of whom participated).

> Hypothesis: Those girls who are least preferred by their peers have exhibited a predisposition towards participation in self-injurious activities.

Approximately one-third of possible ratings were not given by the respondents in Part II reflecting that the instructions were not followed consistently. The incomplete responses resulted in unknown ratings, however the pattern appeared to be random and therefore was not felt to detract significantly from the findings (Table 9).

Table 9

Distribution Frequency of Ratings

	Ratings					
Group	A	B	C	D	E	F
ISI	2	1	7	6	9	5
SDSI	12	11	6	2	5	1
NSI	12	13	8	12	5	10

As has been illustrated (Table 9), the ISI almost without exception were rated from "alright, but not a friend" to "one with whom one would rather not talk or work". The SDSI tended to be named in the initial three, more positive ratings, and evaluations of the NSI members were towards both extremes, although all ratings were utilized. When a dichotomy was made of the ratings, combining A, B and C rating frequencies and those of D, E and F, the ISI and SDSI ratings differed ($p < .001$), with the SDSI rated more positively. The ratings of the

ISI to NSI did not differ, however, as noted, the ISI tended to be rated more negatively. The NSI and SDSI ratings differed ($p < .02$) with the SDSI receiving positive ratings most frequently.

The hypothesis therefore was not supported by the data collected. Although the members of the ISI received least preferred ratings, the members of the SDSI were among the most positively evaluated girls, thereby contradicting the hypothesis. The evaluations of the members of the NSI also did not support the hypothesis in that preferential and least preferred ratings were distributed among them, none of whom had acknowledged self-injury.

Maryvale Peer Relationships

The category of whether respondents had friends at Maryvale who were helpful (Question 15, Appendix F), did not indicate group differences as, almost without exception, friends were found to be helpful. Helpful characteristics included "cheer me up when I'm down", "keeping me from running", being available so a girl could "talk out problems I couldn't talk about with my social worker" and, as stated by one of the NSI, "I don't know, I just feel that when I'm down kids help me better".

The alternate aspect of friendship, whether the girls perceived themselves as having been helpful to others, (Question 16, Appendix F), also proved to be an undifferentiating category. The majority of all respondents felt that they had been helpful. The responses of the SDSI were typical and stressed listening and prevention of running, however, as a group, they also reflected a greater sense of self-worth

and integrity, "teach them some skills I have", "try not to say things that won't be for their own good". Perception of the degree of staff encouragement of friendships was not a category indicating differences.

Perceived personal acceptance indicated no differences among the three groups (Question T8, Appendix F). When the responses of the NSI were compared to those of the SDSI, a tendency to differ was found. Among the NSI, four girls reported feeling less accepted as a person by the other girls. These reports may have been indicative of a greater degree of personal confidence and integrity thereby allowing them to be more realistic in their report of perceptions by others.

Given the sociometric data, the comments of the ISI seemed unrealistically complimentary and uncharacteristically optimistic, as if they were unable to perceive their interactions accurately or were defending against more honest accounting. The ISI comments included: "they accept me as I am and not as they want", "they make me at home and made me like their sister", and "I feel like a brand new person". The one member of the ISI group who indicated that she did not feel accepted by other girls refrained from elaborating. Except for one, all members of the SDSI reported feeling accepted, "I feel better about myself 'cause the girls accept me for what I am", and "they don't accept you for what you wear or if you smoke up". The responses of the NSI ranged from "they treat me differently from everyone else and I don't feel I belong" to "they are all nice to me - we have our own private groups". This latter comment supports Hemming's statement that a girl relates to a group of fellows only through one or two girls

(Hemming, 1967). Failure to be accepted by even a small group of peers would be a despairing experience for any adolescent, but so much more so for the emotionally disturbed adolescent girl placed away from familiar supports into residential treatment. This isolation would appear to have been the experience particularly for the ISI, despite their own reports, and may have been a significant factor in their self-injurious behaviour.

Adolescent Self-Reports

As previously stated, the responses given to Question 39 of the Interview Questionnaire (Appendix F) suggested that there were three rather than two groups of girls: non-self-injurers (NSI), self-declared self-injurers (SDSI), and identified self-injurers (ISI). The data, therefore, was analysed according to the original groups of NSI and ISI, as well as the group of SDSI drawn from the original group of NSI. Responses regarding the girls' initial adjustment and experiences at Maryvale are discussed prior to the presentation of their perceptions and reports of self-injuring.

The question number citations refer to the Interview Questionnaire, (Appendix F), unless otherwise indicated.

Exposure to Physical Aggression

Although infrequently noted in the case records, the experience of physical hurt at the hands of family members or others was acknowledged by the majority of each group (Questions 11 and 13). These categories were not discriminating among the three groups, however the self-injurers tended to report more physical hurt. With regard to observation

of physical violence within their families, the SDSI differed from the NSI (Table 10), with the SDSI most frequently reporting the observed occurrence of such violence (Question 12). For this reason, the reports of the SDSI tended to differ somewhat from those of the ISI, however it was apparent that the self-injurers as a group, more than the NSI, had witnessed deliberate physical violence.

Table 10

Observation of Physical Violence

	Occurrence	
Group	Yes	No
ISI	5	2
SDSI *	15	1
NSI	5	8

* $p < .01$. SDSI to NSI.

It appeared that, based upon their exposure to physical abuse, the SDSI were carrying more anxious, and possibly unresolved, feelings with them through their adolescence. If this aspect of their social histories had been included in the data collected for case records, then the individual treatment plans of the SDSI could have been developed to explore the impact and destructive residue of their exposure to physical violence. Incarcerated self-injurers had been found to have

histories of habitual violence (Bach-Y-Rita and Veno), in addition, Rosenthal et al., had suggested that self-injury may be a reaction against felt hostility or aggression, which would be supported by the social history data available for the self-injurers in this sample.

Adjustment to Maryvale

Hopes and expectations of the Maryvale placement were similar across the groups (Question 4). Included were avoidances, "get away from my stepmother", hopes of freedom to do what they wanted and to make new friends, "be spoiled", and "like home, but I wanted it to be like a real family", and expressions of fear, "hoped rumours weren't true, i.e. lesbians., cells, mean staff, gate, guards". One of the NSI responded philosophically, hoping "it would help me understand life itself", and only one girl, an ISI, acknowledged the treatment nature of the setting by her comment "that it would help me out".

Initial experiences at Maryvale were reported as similar (Question 5). Although the majority of each group indicated that the actual experiences were "little" or "not at all" like their expectations, the response pattern of the NSI was more along the continuum. Differences focused upon complaints of scheduled activities, charges (rotating assignment of household tasks), asking permission to go outside, and, as stated by one of the SDSI, "the staff follow you everywhere, no real good privileges". Among the ISI were reports of never before having been told what to do, objections to direction coming from non-parents, complaints about the numerous rules and frequent changes, and perceived isolation from the community. One of the SDSI reported "the girls doing things to their arms" (cutting) without

knowing that this type of behaviour was to be the actual focus of the questions.

The ease with which the respondents adjusted to Maryvale was not a differentiating factor for the groups (Question 7a). Members of each group frequently found it "very hard" to "okay", with few reporting it as "quite easy", with the category "really easy" never selected, (Question 7a). Again the quantity and quality of the rules, "had to just smoke 6 cigarettes a day", the frequency of moves, and the lack of privacy were cited. Separation from family, quiet hour, staff who stay in the office and "don't treat you like humans", and attempts to make friends were defined also as sources of difficulty in their adjustment.

Having to belong to a formal group, such as the cottage, appeared to be a similar "okay" experience for the majority of each group (Question 8a). The "easy" responses were explained by perceptions of themselves and others as being easy to get along with, and their enjoyment of the experience of meeting many people and learning how to accept them. Group experiences described as "hard" focused upon "not being used to a lot of girls", "being watched all the time", and feeling that "hardly any of the girls are considerate of others".

The combined group of self-injurers showed a pattern of running away more frequently which differed from the NSI (Question 9). Runaway activity while at Maryvale did not differ among the groups, although a trend was observed in the comparison of SDSI and ISI responses, with 6 of the 7 ISI and 10 of the 16 SDSI acknowledging such behaviour (Question 10).

Resident Problems and Behavioural Responses

The problems encountered at Maryvale, as described by the ISI, reflected loss, futility, failure and interpersonal difficulties (Question 29). They described their problems as "home problems and losing staff (favourites)", "getting along with people" and "being alive". Several of the SDSI felt also that they had worsened and had lost ground with their family relationships. Among the SDSI comments were "I feel like I'm trapped and can't get out", "trying not to fight or be mad", and "my anger, cutting my arms. Rules are hard!". The NSI identified similar problems and, in addition, a middle adolescent indicated "I need a guy to talk to every once in a while that's my own age". Uncertainty about their futures and their place within their families and circle of friends, as well as doubts about their ability to cope with the indeterminate length and conditions of their Maryvale placement, seemed to be common concerns across the groups. These concerns paralleled those defined by Kovacs (1975), for which clarification of future options and correction of misconceptions and personal negative evaluations were advised in order to reduce the sense of hopelessness and suicidal risk.

The groups reported that their most usual response in coping with problems was to try to work things out on their own (Question 30). The categories of talking with staff and other girls were chosen less than half as frequently. Several responses were multiple or had comments which indicated a progression or a variety of coping routines. Respondents who indicated "other" specified social workers, siblings and friends, both male and female, as advisors. Although self-direction and

a willingness to assume personal responsibility are valued qualities connoting maturity in our culture, this independence may represent a pseudo-maturity among the adolescents in this study. Because their case records indicated a lack of skill in adopting acceptable coping responses, it would seem to be advisable that adults make a special effort to be approachable, and initially directive, in their attempts to provide these girls with a repertoire of constructive coping responses.

Behaviours During Elected and Enforced Solitary Time

Solitary activities, similar across the groups, included reading, fantasizing, crafts, cleaning, listening to music, writing letters and retreating to sleep (Question 21a). Often the residents were required to be by themselves, whether during the Quiet Hour part of the early evening program or when segregated to their rooms as a form of reprimand, or for the reduction of environmental stimulation. One half of the respondents in each group indicated that their preferred solitary activities changed under these circumstances (Question 21b). The changed activities included expressions of hostility, "get mad, punch walls, kick chairs", and "think about some things to argue about", and of passive contemplation, "just sit and stare". It had been the researcher's experience that Quiet Hour, although disliked, did not elicit the anger and aggressive acting-out that disciplinary isolation tended to provoke.

Responses to Feelings of Frustration and Anger

The exploration of the frequency of frustrated plans resulting from withheld permission found no differences among the groups (Question 22). Perceived reasons for withholding permission were similar and in-

cluded complaints of neither being trusted nor having their needs understood, in addition to being constrained by programming.

With regard to feelings of anger, frustration or upset, the ISI reported behaviours reflecting their label of self-injurer, "cry", "put my foot through windows", and "ran and carved my hand and broke my glass in my room" (Question 34). The SDSI responses included "sleep", "see my social worker", "get mad and hit people", and "cut my arms, swear, slam doors, run away". The NSI responses were similar, though less destructive of property and with less risk to themselves, "end up in the Unit", (segregation to the Closed Unit), "tear paper into small pieces or scribble on paper", and "bitch at everyone". The self-reports of the girls regarding feelings of anger and frustration led the researcher to question whether treatment programs, as well as family units, genuinely accept anger as a legitimate emotion. Provision for the expression of frustration and anger without self-injury, safety risk or material damage, would seem advisable, particularly for adolescent populations recognized as being emotionally disturbed.

Given the responses to coping with frustration and anger, it was somewhat surprising that no differences were found among the groups regarding whether or not they had broken or damaged property at Maryvale (Question 35). The reported tendency was toward the negative. When damages had occurred, the girls' expectations of repercussions tended to be to pay or work off the equivalent of the damage. Some of the respondents were surprised by the use of the Closed Unit as a consequence. One of the ISI articulated that she did not care, citing con-

flict with a staff "who got on my nerves so it was better to kick a window instead of her head". It appeared, therefore, that damaging of property did not have an association with self-injurious activity. Based upon the responses of the girls, the researcher felt that the injunction against property damage had been more clearly and frequently stated than the injunction against self-injury. The consequences of property damage may have been less desirable than the assumed consequences of acting-out against themselves through self-injury and, therefore, self-injury may have been elected in lieu of property damage.

Aspect of Relationships with Adults

Preferred Qualities in Adults

Desirable qualities in adults typically were identified as "listens to me and does not jump to a solution", "sincerely care but not like your parents, spend more time with you instead of in the office with each other or in the john", "talk at our level of thinking, not over or under our standards", "for sure a sense of humour and honesty", and "to treat us more like friends not patients" (Question 27).

Availability of Adults

Responses were similar among the groups regarding adult availability generally, and at the times when the girls specifically had problems, in that all categories were utilized (Questions 28 and 32a). Although not statistically significant, it was of interest to note that the majority of the ISI and NSI indicated that adults were available, in contrast to the SDSI. Several of the comments indicated a preference not to talk with adults, however, the majority of the comments reflected

attempts to interact with adults and to receive reassurance of their support, paralleling interactions by adolescents with their parents (Kalogerakis, 1973). When adults were not available, the girls tended to respond by waiting, becoming depressed, diverting their attention, or finding someone else who could be trusted and helpful.

Degree of Staff Understanding

The groups of girls were similar regarding their evaluation of the staff's ability to understand their needs (Question 25). Responses ranged from "always, because they care about you", to "never, I want to be myself, but they want me to be like them". The "rarely" category elaboration included "I don't think they see me as a person, they see me as some kid at Maryvale that needs help", and "some staff are off in their own private affairs and won't change". The "never" category tended to be explained by responses which attacked age, "they're too old to understand or they don't care about kids", and "they don't need anybody as we do and they don't understand our needs".

Each group tended to find that, at Maryvale, adults had been helpful when problems had been discussed with them (Question 31). Several girls from the SDSI group seemed to recognize individual staff skills in that their responses discriminated problems and preferences for certain staff. The comments of the ISI were predominantly positive, "you can understand adults better", "my social worker listens and doesn't try to discourage", and specifically, "I felt calm again and I was right back in the group". The negative evaluations described adult responses as not helpful because adults "don't listen", "go overboard",

and "give you an answer that's going to hurt".

Friendships with Adults at Maryvale

The responses of the ISI differed in comparison with those of both the SDSI and NSI regarding the number of friendly relationships the girls had with adults at Maryvale (Question 19). The ISI most frequently indicated "lots" of friendships (Table 11). Two-thirds of the respondents indicated that their relationships with adults were "very meaningful", and only one girl, an SDSI, described these relationships as "not at all" meaningful (Question 20).

Table 11

Friendships with Adults at Maryvale

	Occurrence			
Group	Lots	Some	Few	None
ISI	4	1	1	0
SDSI *	1	6	6	1
NSI **	2	6	5	0

* $p \leq .02$. SDSI to ISI.

** $p \leq .05$. NSI to ISI.

It appeared that the ISI regarded their relationships with adults as significant and more accessible than peer friendships. This observation seemed to reflect the actual milieu, based upon the findings of the Sociometric Questionnaire, which indicated isolation of the

ISI by their peers and may have resulted in adult relationships becoming a more accepting forum for identification, support and comfort.

The overall impression given by the girls was that, despite their desire to be increasingly independent, they continued to be dependent upon adult affirmation and direction. Their responses indicated that adults, regardless of role, may provide significant associations, including friendships, for the emotionally disturbed adolescent. The responses seemed to indicate that several of the girls, particularly the members of the SDSI, were severely scarred as the result of negative experiences with adults and that these girls would be particularly resistant to, though nonetheless needy of, caring adult attention and support.

Satisfaction with Staff Relationships

The NSI and SDSI differed in the degree of satisfaction with their relationships with staff, with the SDSI indicating that they did not wish for changes. The responses of the SDSI may have been a reflection of their apparent preference to depend on their own resources and skepticism of adult trustworthiness (Question 26). It could be hypothesized that the NSI had higher expectations of staff and their mutual relationships and, therefore, wanted their relationships to improve.

Only two of the ISI offered comments as to how they would like their relationships with staff to change, stating "I would like to get closer to them" and "to just leave me alone when I would like to do things that get my anger out or cause trouble". The comments of the SDSI and NSI were similar and focused upon staff understanding and

approachability; "be a friend not a robot or a person who writes everything in the logs", and "be able to talk more with them about our problems and feelings".

Self-Injurious Behaviour

The responses of both the girls and staff are discussed in this section which deals with aspects of self-injurious behaviour considered in this study.

The Staff Questionnaire (Appendix G) was responded to by 23 staff and, although almost one half of the respondents had 12 months or less experience, their cumulative experience was over 59 years. Reported educational training among the staff included: 8 with completed and 3 with incomplete Child Care Worker training; 2 with Bachelor of Social Work degrees; and 6 with Master of Social Work degrees. Six of the respondents had participated in a 6 month in-service program at Maryvale. One staff had training in recreation leadership, one in family therapy, and one had been employed in a psychiatric hospital, group home and a boys' club.

Self-Determination

The right to self-determination was supported by more than three-quarters of the staff, with one respondent not answering any questions on this topic (Questions 3a and 3c, Appendix G). The staff qualified the generalization of the right to self-determination as follows: one-third included persons 12 years of age and under (4 staff did not respond); more than one-third included persons 13 to 16 years

of age; and almost three-quarters included persons 17 to 21 years of age. When asked whether self-determination included self-injurious behaviour, two-thirds of the staff felt it did not (Question 3b, Appendix G). Five staff felt self-injurious behaviour was included in the right to self-determination, however four of them did not generalize this to persons aged 12 years and under. For persons 13 to 16 years of age, only two staff supported the right to self-injure, whereas all five staff supported this right for persons 17 to 21 years of age.

Staff Exposure to Self-Injurious Behaviour

Conflicts between beliefs and practice in working with the ISI were denied by almost two-thirds of the respondents, reflecting that the majority of the staff were comfortable with the treatment centre's philosophy that self-injury should be prevented (Question 4, Appendix G). Almost all of the respondents had worked directly with members of the ISI, and almost two-thirds had been at work at the time of an incident (Question 5, Appendix G). First person contact with members of the ISI at the time of the incidents was reported by less than two-thirds of the staff, although inter-cottage discussion of self-injury was acknowledged by almost all of the staff. The number of incidents forming the base of the staff experience with self-injurious behaviour ranged from 1 to 300, of which a range of 1 to 30 had occurred at Maryvale.

Thoughts of Self-Injury

As expected, the SDSI and ISI acknowledged thoughts of self-injury and, in addition, almost half of the NSI admitted to these thoughts (Question 38). The researcher felt that there could be unde-

clared self-injurers in the NSI group, however this could not be determined from the responses given. It was interesting also to note that two of the ISI denied self-injurious thoughts (Table 12).

Table 12

Acknowledged Thoughts of Self-Injuring

Group	Yes	No
NSI	5	7
SDSI *	14	2
ISI	5	2

* $p < .02$. NSI to SDSI.

The denial of thoughts of self-injury may have been a reflection of an unwillingness to acknowledge this type of behaviour. The researcher felt, however, that this question possibly was perceived as asking about premeditation and that the denials were an indication that the self-injuring had been impulsive in nature. The two members of the SDSI who had denied thoughts about self-injury had reported one incident of self-injury, possibly supporting the speculation that impulsivity was a factor in at least some incidents of self-injury.

With regard to the kinds of self-injurious thoughts, two of the ISI did not comment and two were uninformative. The one responding ISI indicated thoughts of "carving my hand but I did not do it because

if I did I would hurt my mom and (staff named)". Although four of the SDSI did not elaborate upon their thoughts, the responses given were descriptive and indicated a situational sensitivity, a higher frequency of death wishes, and a knowledge of lethal means: "Well, my mom and dad were getting a divorce and my dad blamed it on me--also because my dad hit my mom with the car on purpose", "problems with family, friends, school, just everything seemed to 'gang-up' at once. I often thought of O.D. or hanging or getting into a hot, hot tub and slit my wrist, or put a radio in the tub too--but if ever I was to do it again I won't get stopped", and "angry and couldn't help myself, I had no self-control. I sniffed glue, cut my arms. These things are things that I thought I would get attention from". Among the NSI, four of the five girls indicated that they had thought of self-injuring: "they wouldn't let me go home and I said I was going to hurt myself--but then my dad wouldn't have liked scars all over my body", and "I thought of committing suicide, but I talked myself out of it. I felt as if no one cared about me, and my feelings. I wanted to get some attention".

Awareness of and Participation in Self-Injury

The range of exposure to and participation in self-injurious behaviour has been summarized in Table 13 (Question 37). Several of the respondents were unable or unwilling to follow the instructions and, as a result, did not indicate a category. In addition, many girls did not rank the cited behaviours as to the degree they found the behaviour upsetting.

Table 13

Self-Injurious Behaviours: Self and Others

Behaviours	Frequency Cited					
	ISI	Others by ISI	SDSI	Others by SDSI	NSI	Others by NSI
Suicide	1	1	1	2		2
Swallow pins/tacks	1	1	1	8		4
Cut/carve/slice flesh	3	2	6	10		6
Break hand/foot/arm	1	2		1		
Swallow alcohol	1		1	1		
Slash wrist		1	1	3		1
Glue			1			
Overdose of pills			3	7		1
Needles in wrist			1			
Drink poison	1		1	1		
Burns			1			
Speed/drugs		1				
Smoke pot				1		
Running		1		1	1	1
Bite/punch/beat self		1		2		
Radio in bathtub				1		
Swallow shampoo				2		
Swallow razors				2		
Attempt stabbing				1		
Shoot self				1		1
Break something/punch wall		2		1		
Run in front of car				1		
Contemplate suicide/sad things			1		1	

*Also mentioned without identification or rank: strangle, hang, suffocate, jump off high building, catch pneumonia and bang head against a wall.

The SDSI indicated a range of kinds of self-injury that was greater than that of the ISI; this may have been a reflection of their greater ease in talking about this aspect of their life, in comparison to the ISI and NSI who responded.

Frequency and Kinds of Acknowledged Self-Injury

There was a tendency to differ between the ISI and SDSI regarding the reported frequencies of self-injury (Question 40). The ISI indicated the frequency of two to five times most often, in contrast to the majority of the SDSI who reported the one time frequency. Several of the SDSI, however, did indicate a two to five time frequency and, unlike the ISI, the upper frequencies. The discrepancy in self-identification, 14 of the 29 members of the original NSI reported having done some form of self-injury, but 16 girls responded to subsequent questioning, may have represented an initial reluctance to admit to self-injurious thoughts or actions (Question 39). As it became apparent that self-injurious behaviour was an acceptable topic and the focus of subsequent questions, then more confidence may have been derived, prompting the additional girls' responses.

Pain Sensitivity

With regard to the kinds of self-injury and sensations felt, there were no differences between the ISI and SDSI although the ISI again were less informative than the SDSI (Question 41). Self-reports of pain sensitivity were similar among the groups (Question 36). Denials of pain or sensations were given by two ISI, one of whom had "split a wrist and ripped open an arm", while the other cited "complete numbness".

Among the SDSI, five acknowledged pain or other sensations resulting from their self-injuring, which included three slit wrists, one broken arm and one overdose consisting of undefined quantities of valium, sleeping and contraceptive pills. Pain or other sensations were denied by three of the SDSI who described two wrist cutting incidents and one pushing needles into a wrist. It seemed, therefore, that neither pain tolerance nor sensitivity were factors in the tendency to self-injure.

Cottage Environment Prior to Incidents of Self-Injury

Of the 13 staff who were able to recall the cottage environment prior to incidents of self-injury, the majority described the cottage as "somewhat tense", "somewhat argumentative", and "somewhat disruptive" (Question 7, Appendix G). Comments on significant conditions ranged from perceiving the self-injurers as the originators of these conditions to perceiving an ISI as being "unable to handle change in routines and other negative behaviour". It also was observed that there was "lots of anxiety of the child resulting in anger not depression in most cases", and that three self-injurers "operated individually, environment not a condition for self-injury".

On the days marked by self-injurious incidents, staff relationships were regarded predominantly as "average", with "somewhat tense" the next most frequent description (Question 8, Appendix G). Factors of devisiveness and disorganization also received "average" ratings. Among the comments were "(the ISI) seemed to need more staff attention, i.e. supervision, games, or one-to-one", "usually two staff were involved with group, other staff on landing (dorm corridor) keep-

ing a close check (on the ISI). Decisions have been team decided upon--close and supportive staff", and "the carving and scratching would occur on any day or everyday".

Antecedent Behaviours

There were few reports dealing with the behaviours of the ISI prior to self-injury (Question 47). Perceptions by the ISI of how the self-injurer felt prior to self-injuring included "bummed out", "unwanted and sad", and "upset and mad at the staff and girls". In addition to similar descriptions, the SDSI comments on specific incidents included "angry, afraid but happy that she would get attention", "she didn't get the attention she wanted to she scraped her arms up", and "she seemed proud she did it". The NSI cited anger, depression, sadness and loneliness.

Sixteen of the staff reported that the self-injurers were experiencing frustration, fears and concerns prior to their self-injury. In addition to previously cited indicators, the respondents commented "a low frustration level to anything new or to any unannounced change in routine. The carving and scratching was almost immediate--but the pin swallowing was on a run--or when the girl was away from the cottage--the pills were taken after a few weeks of hoarding", "frustration due to immediate restrictions of being in C.U. (Closed Unit)", "difficulty getting attention and dealing with peers several days prior to incidents", and "usually problems have been occurring 4 to 8 hours before". Other comments indicated that the self-injurers had experienced problems five minutes to one week prior to self-injuring, thereby reflecting the difficulty presented by the generalizations required in responding to the Staff Questionnaire.

In addition, the staff described pre-injury events as "seemed partly to be an angry reaction to situation (having been confronted about misbehaviour along with more restrictions) to 'get even' with staff", "variety of problems with seemingly no immediate resolution", "nothing...(girls) were always somewhat quiet, withdrawn and unreachable", "sometimes a hectic struggle with the girl--other times a very relaxed, comfortable time with her before an incident", and a specific account "woke up in a poor mood, had trouble doing routines and was argumentative. During recess telling girls that she had swallowed tacks and pins. Seemed relieved that she was going to hospital. Had a need for the kind of setting as there were no pressures or demands made of her".

Staff Perceptions of the ISI

The staff assessments of various characteristics of the ISI in relation to the other girls with whom they worked have been noted in Question 6, Appendix G. In summary, the staff evaluations of the ability of the ISI to maintain relationships were predominantly negative. The self-injurers' perceptions of self-worth were considered to be poor and their need for attention was evaluated by the majority of the staff as being much higher than their peers. The ability to operate independently was considered to be lacking among the ISI, with the evaluations of their ability to lead being more varied although tending to define the ISI as followers and easily influenced by others.

Thirteen of the staff respondents felt they could anticipate which girls would self-injure. A greater than usual preoccupation with

their bodies among self-injurers was noted by seven of the staff. These concerns were noted not always to be positive and were qualified as "not so much preoccupation but their dress, grooming and hygiene were often indicative of moods in poor--bad mood, good--good mood".

Concepts and attitudes about death as expressed by the self-injurers tended towards revenge, making others feel guilty and they "felt that when they died people would be sorry or they wouldn't even know that they were gone", reflecting a lack of self-worth and a sense of insignificance. Several of these girls had expressed death wishes as a means "to end it all", because there was "nothing to live for", but had not always impressed staff as being particularly suicidal.

Awareness of Self-Injurious Intent

The majority of the ISI and SDSI indicated that they felt others did not suspect their self-injurious intent and that they did not want others to know (Questions 44a and b). These responses again disclaimed the attention-seeking motivation, presuming that the self-injurers were capable of being open and honest about their perceptions of their intent.

Among the staff respondents, 14 claimed they were aware of clues regarding the intention to self-injure and 9 felt there were no such clues. Perceived indicators included "incidents with social worker or family, a need for attention, good feelings about hospitals and the attention given there", "removed from the group because of behaviour, girls injured themselves for attention", " a look on the girl's face--their mood, anger or depression", "rejection by family

or peers", "seeking attention--feeling very sorry for herself. Almost letting you know she intends to do something, almost asking you to console, stop them, but not really telling you what it is", "verbal acknowledgement, knowledge that this has happened on other occasions, frustration level high", "seeking a lot of physical attention", "continuously wants staff attention--negative or not", and, for one girl, "seemed to be connected to her period. And gave some indication of poor sexual identity". With the exception of self-injury in response to organic conditions, the staff responses reflected the various motivational hypotheses for self-injury as defined by Carr (1977).

Determination to Self-Injure

When asked if there was anything anyone could have done to change or interrupt the process of self-injury, the ISI reported an ability to be influenced whereas the SDSI indicated a greater degree of certitude and determination in their acts (Question 42).

Although not statistically significant, it was of interest to note that, when the self-injurers were asked specifically whether they hoped that people would do something different, unlike the ISI, the SDSI were more hopeful of different responses. Among the members of the SDSI who hoped something different would have occurred, explanations ranged from "let me alone or give me a sharper razor", "try to help change the situation", to "I wanted them to give me attention so I wouldn't feel so bad". Several girls in each group indicated that they really did not care if people would have done something different at the time of their self-injury.

The girls who indicated that their acts could not have been changed elaborated "no one was around", "pins were too hard to take away", and "if I decide to take my life no one has the right to stop me. It is my life, is it not?". One of the SDSI reported that "staff came in and I dropped the razor blade in the toilet and I flushed it, but not on purpose".

Death as a result of self-injuring was an expectation declared by four of the SDSI and one of the ISI. At the time, death may have been regarded as a relief from intolerable situations and feelings of inadequacy and impotence. The remaining respondents foresaw "punishment", such as being closely guarded by parents or being confined in the Closed Unit at Maryvale. As the forms of punishment were comprised of attention, albeit negative, the self-injurious behaviour may have been perceived as behaviour commanding a response, making it a means of obtaining a positive response of attention, and of potentially changing the upsetting aspects of the self-injurer's life.

Motivation for Self-Injury

> Question 4: Do the residents regard self-injurious activities as a means of escaping situations which they perceive to be difficult or non-rewarding?

The majority of the responses given by the members of the ISI regarding self-injurious motivation dealt with change and acting-out of frustration: "someone was bugging them", "to get things changed", and "to get out of Maryvale, to get away from everybody" (Question 51). In addition to the tendency to attribute attention-seeking as the motive for self-injury, one-third of the SDSI referred to futility and change

motives: "to get out of Maryvale", "sometimes when they are down they don't feel there is anything to live for", and "they need attention and can't seem to get it any other way". The NSI attributed similar motives to self-injury and specifically cited "one of the girls said that she wants people to take pity, to act cool".

It appeared therefore that escape from the actual physical setting or an attempt to move into a more comfortable and accepting status, characterized by attention and understanding within their current environment, were the motivations attributed to self-injury. The frequency of attributing physical escape as a motive for self-injury was highest among the opinions of the ISI and lowest for the NSI, whereas attention-seeking was cited with an inverse frequency distribution, the NSI showing the highest frequency and the ISI was the lowest.

Question 5: In each of the three subject groups is attention-seeking the purpose attributed most often to the use of self-injury?

Thirteen of the staff specifically cited attention-seeking, thereby making it their most frequently attributed purpose for self-injury. Many of their interpretations focused upon obtaining approval, acknowledgement, understanding and acceptance which also reflected attention-seeking intents "to get her family together, to know whether or not they cared, to escape problems and frustrations", "seeking negative attention consciously or unconsciously through a way of self-destruction, also could be a means of searching for one's identity", "one was a cry for help--she needed more security than we could offer",

"self-stimulation (for retarded boys)", "staff undivided attention and to punish parents", "to relieve tension...to maintain contact with some form of reality", "for approval from peers", "displacement of anger from significant other to self", "surface scratching = anger and retaliation against restrictions imposed by adults. Swallowing staples = desperate and serious need to be acknowledged--not being able to indicate same in other ways at the time", and "swallowing of tacks was to let staff know the girl could still do what she wasn't supposed to, even while confined in room and supervised--also a desire to be somewhere other than Maryvale, where have more attention, preventing self-destructive behaviour". It was apparent that, even among this small sample, a good cross-section of the theoretical hypotheses had been considered by individuals on staff at Maryvale.

Among the SDSI, 8 of the 16 group members specifically attributed attention-seeking to self-injurious behaviour. The other purposes attributed by this group included "people don't listen", "to punish self", "to get out of Maryvale", "they are down they don't feel there is anything to live for". The attention-seeking was considered by the SDSI to be rooted in a learned pattern of behaviour or a sickness, or as a means to self-depreciate "some say to punish themselves?" Among the SDSI, explanations ranged from "none of your business" (the comment consistently given by this respondent to all self-injury questions), and "I wanted attention", to "I just wanted to die and be left alone". Comparable interpretations were offered by the NSI members including attention-seeking cited by 5 of the 13 members (Question 51).

Interestingly, the members of the ISI either were not sufficiently articulate or were unwilling to be informative as to why they had injured themselves, with two no answers and four uninformative responses (Question 43). The ISI who offered a complete thought indicated she had self-injured "for the girls to pay attention to me".

It appeared that attention-seeking could not be designated as the motivation for all incidents of self-injury, however it was attributed most frequently to self-injurious behaviour. Additional interpretations of intent often reflected hoped for attention responses although not articulated specifically.

Post-Injury Perceptions

Perceptions of whether staff relationships changed with the girls who became known as self-injurers proved not to be a discriminating category, with the majority of the ISI denying that these relationships had changed (Question 49b). The only comment given by an ISI was "they were different towards you", without further elaboration. The explanations of the SDSI reflected a decrease in staff trusting of the ISI, that the ISI were ignored or were subjected to close observation, and that the staff seemed angry and irritated with the ISI, not liking them as much. Only one girl, an NSI, had a different perception of staff responses, "they seemed to know that something was bugging her so they let her off easy". This variance in perception may have been an accurate reflection of intra-cottage and inter-cottage staff responses towards self-injurers.

Almost three-quarters of the ISI indicated that they had not perceived a change in the attitudes among their peers after their self-injuring (Question 57). The two girls who reported that there had been changes indicated "they were pretty mad" and "they weren't as friendly". Staff reaction to the self-injurious behaviour was acknowledged by less than one-half of the ISI and the description of these reactions was consistent with the change in attitudes noted among their peers (Question 58). When asked to compare their most recent incident of self-injury to those in the past, only one informative response was obtained, indicating that "it wasn't as dangerous" (Question 59).

Staff Response to Self-Injurious Behaviour

Nineteen of the staff indicated they responded to the self-injurers, most frequently reporting that, with emotional control, they had described the dangers of the behaviour and that some had expressed feelings of disappointment that their trust in the girl had been let down (Question 13, Appendix G). One staff stated "I was angry with her, telling her I wasn't fooling around. I hoped not to show my anger in the cottage and at hospital but it probably showed". Other responses included "expressed disapproval--bring out child's positive behaviour", "telling her how I cared for her and hoped she would come to staff when she is feeling upset", "warm and reaching out", and "explored pre- and post-injury behaviour".

Numerous staff reported feeling anger, annoyance, safety concerns and frustrations based upon a lack of understanding, as well as a sense of helplessness in protecting the self-injurer from herself and

her environment (tacks, pins). Staff expressed feeling "sorry to see a child in that frame of mind", "some guilt", and initial disbelief. Thirteen of the respondents believed their feelings to be known by the girls, whereas eight believed them to be masked (Question 12, Appendix G).

Almost three-quarters of the staff respondents felt their staff functioning in relation to the members of the ISI were unchanged following incidents of self-injury (Question 14, Appendix G). The staff who felt there had been changes in their function indicated that they were "more aware of what she (self-injurer) was saying and feeling", "watched her closely, let her know I really care about her", and, with one girl, a pin swallower, "we tried to be very calm with her at all times--as she was very moody--moods change in a minute and to extremes". Others commented on becoming cautious, tense and frustrated, and conscious of their own responses and handling.

Reported Responses of Parents or Guardians

More than one-third of the combined group of self-injurers believed that their behaviour had been unknown to their parents or guardians, and they almost unanimously did not want them to know (Questions 46a and b). This lack of difference was unexpected because only four SDSI members had intake records noting self-injurious behaviour. This may have indicated that either this information was deliberately withheld or was not questioned prior to or during intake.

The explanations given by the SDSI for not wanting their self-injuries to be known included "I felt ashamed", not wanting to "hurt" or

"cause trouble" for others, and "wanting to avoid a big lecture on what I did". The ISI respondents explained that their parents' or guardians' responses would have ranged from "couldn't care less" to "would get upset over it".

The reported responses of parents who did know of the behaviour of the ISI ranged from "upset", "angry" and "shock" and negative comments such as "she's retarded, she needs help" (Question 46c). The responses reported by the SDSI were similar and ranged from "my dad started hitting me", "played it cool, but I know they sure didn't appreciate it", to "nothing, they didn't care". One of the SDSI who sought attention found the behaviour to be effective in that "it got help for us". It could be assumed that this experience would predispose this girl to secure attention by such means again in problematic situations.

Peer Perceptions of the Self-Injurers

Among the 23 girls who responded, 13 indicated they had not been surprised to learn of the self-injury (Question 48). The explanations offered by the members of the SDSI were empathetic, "because I often feel the same way", and indicated that, on occasion, they had been confided in prior to the self-injury, which provoked anxiety and a sense of responsibility in some of the SDSI, "she had already told me and I could not stop her because she was in the Unit". The members of the NSI responded with more rejection and detachment, "she did it all the time. When she'd come back from hospital we'd ask her if she was going to show us another disappearing act". These comments tended to concur with the sociometric findings, with the interesting excep-

tion that the ISI comments about other self-injurers were either hostile "she was a very stupid person", or uninformative, rather than the anticipated friendly concern and identification.

Although not statistically significant, the majority of the NSI, in contrast to the SDSI, indicated their feelings had changed (Question 49a). Only two of the SDSI expressed friendly attachment "more concerned, closer" and "I was disappointed in them". The other responses were more hostile and rejecting, "they bragged and I don't like that", "I came to dislike them", and "I made my mistake and now they made theirs". The responses of the NSI who admitted to changed feelings were similar to those of the SDSI with one of the NSI offering the remarkable admission of the fear of being victimized in a similar way, "I changed by not knowing if she would do the same thing to me or not". The comment concurred with the assumption offered by Carson and Lewis (1971) regarding the arousal of fears and fantasies in staff and patients as to their own potential for aggressiveness or the threat the self-injurers represented to them. The advisability of discussing these fears openly in staff and patient meetings had been stressed by Carson and Lewis and would appear to be an appropriate consideration for the resident and staff populations at Maryvale.

Future Self-Injury

The SDSI and ISI differed in their assessment of themselves as to whether they could imagine self-injuring in the future (Question 52). The SDSI more frequently felt they would not self-injure, whereas the ISI, almost without exception, felt that they would participate in

future self-injury (Table 14). It was the impression of the researcher that the member of the ISI who was interviewed had responded to her surgical experience with only transient concern and would self-injure again.

Table 14

Potential for Future

Self-Injurious Behaviour

	Self-Injury	
Group	Yes	No
NSI *	1	10
SDSI **	3	10
ISI	6	1

* $p < .005$. NSI to ISI.

** $p < .025$. SDSI to ISI.

Elaboration of the kinds of self-injury and the probable future circumstances given by the ISI included "same as in the past" (suicide attempt and cutting), and "kill myself to be exact 'cause I want to get out of here--I would be put in the C.U." (Closed Unit). The SDSI who felt they would self-injure in the future described themselves as being "very angry and mad" and doing "the same things" (slit wrists, swallowing poison, objects and pill overdose) under circumstances that would be "probably not the greatest or else you would not

do things to hurt yourself". The member of the NSI who gave an affirmative response did not elaborate, however her response indicated a potential for self-injury if indeed she was not already an undeclared self-injurer.

One member of the ISI responded that she would not self-injure, however, as warned by numerous practitioners (Finch and Pozaanski, 1971), such renouncements of self-injurious or suicidal behaviour are not necessarily reliable assurances. The comments of the SDSI who felt they would not self-injure in the future were typified by "Maryvale has helped me to cope with my problems and I can talk to people" and "I have learned how to control myself and think things out".

Responses to a Potential Self-Injurer

Possible statements suggested by the ISI to someone who was about to self-injure were, without exception, actively preventive (Question 53). The statements of the SDSI similarly were dissuading, if not actively preventive, with the exception of two respondents who preferred not to become involved. The NSI respondents seemed less directed towards intervening, "Go ahead if you want to stay here even longer and if you want to kill yourself".

The majority of each group felt that self-injury was a problem at Maryvale, therefore this was not a differentiating category (Question 54). The ISI commented on the number of girls trying to self-injure and the difficulty staff had in handling this behaviour. The responses of the SDSI also related to the frequency and indicated that pins and tacks were swallowed as the "in thing" or because "it got attention, so like

monkey see, monkey do", and "one does it then others hearing of it do it to be great and talked about". The NSI responses were that too many girls were doing it.

Suggested Handling

Suggestions by the ISI for staff handling included "talking, playing cards and putting things up so the girls can't get it" and "at least pay attention to the girls and why they want to do it" (Question 55). The SDSI responses ranged from praise of the staff to pleas for understanding and that the staff attempt to make the girls not want to self-injure again. The NSI responses focused upon more understanding, "they just don't seem to understand us girls around here" and "be more helpful, treat us like an equal". Several comments were hostile and rejecting, such as "kick the girls (ISI) out and put them in a mental institution believe me they need it". There seemed to be a necessity for staff to be supportive towards the self-injurers as the comments illustrated that they could not rely on the residents to be understanding and accepting of the self-injurers.

Preparation and Opinions about Self-Injuring at Maryvale

Fifteen of the staff claimed not to have been made aware of the potential for self-injurious behaviour occurring among the girls when they were interviewed and accepted as employees, apparently reflecting that this phenomenon was not discussed until it occurred (Question 19, Appendix G). Sixteen of the staff acknowledged gradations in the personal distress caused by self-injurious behaviours (Question 20, Appendix G). As noted with the peer group population, behaviours least

distressing to some were most distressing to others, although some concurrence also was present. Least distressing behaviours were very superficial scratching "for show rather than self-destruction", swallowing tacks and closed safety pins, head banging, and superficial burns. Most distressing self-injury included: ingestion of foreign objects and drugs without knowing what they are, slashing wrists when death was quite possible, and carving and cutting which leave scars whether on hands, arms, legs or stomach.

At the time of this study, 13 of the responding staff felt that self-injuring was a problem at Maryvale, commenting that "it runs in cycles" and "it could become a problem if this type of girl is allowed to stay--the pin swallowing went through every cottage--the girls did not realize the full danger. We don't have facilities for such a sick child" (Question 21, Appendix G).

The explanations of self-injury as a problem included that the girls were easily influenced by others, therefore the phenomenon became contagious and "reached epidemic proportions". Concerns also reflected that there were not enough staff to help, particularly when one-to-one supervision reduced the staff ratio, and that there was a "lack of preparation and training for child care workers to appreciate and handle such situations". Control and difficulties in treating these behaviours in an open setting where "punishment is incorporated as treatment, i.e. (Closed) Unit minus privileges" seemed the overriding problem, given the occurrence and quantity of self-injury among the girls.

Adequacy of Staff Training for Self-Injuring Phenomena

Question 6: Do treatment personnel consider their educational background to have prepared them adequately for working with individuals who self-injure?

Thirteen of the responding staff did not feel that any of their training had been helpful in preparing them to handle self-injurious behaviours and nine felt that they had been prepared (Question 22, Appendix G). Staff were evenly divided as to whether they felt a need to be helped with their own responses to the self-injurious behaviour. Among the 11 staff who felt the need for help, all but one indicated they had expressed this need to appropriate personnel and the majority found the responses received were satisfying (Questions 23a and b, Appendix G).

Those not directly involved or on duty at the time of the incidents expressed interest in hearing various points of view on how to handle the situation and their own response, particularly from someone directly involved with such behaviours.

The desirability of further assistance in the area of working with girls who self-injure was evaluated equally between "very much" and "somewhat" (Question 24, Appendix G). Suggested assistance included a closed, intensive care unit at Maryvale, a resource bibliography on the subject with group discussion of the material relating it to the Maryvale experience, ongoing supervision especially regarding the handling of personal feelings, special classes involving specialists in the field, more focus upon early diagnostic information as well as causes and dynamics of self-injury, continued research, role playing and experimental treatment approaches specifically, and changes in program for

those who self-injure as a bid for attention with assistance for staff in arranging the program geared for these girls.

Additional comments ranged from feeling that the needs of girls who self-injured could not be adequately met at Maryvale to the opinion that "generally the tendency is to overreact and panic--not recognizing adequately the significance of personal rapport/relationship prior to (self-injuring) and subsequently", to encompassing the opinion that self-injurious behaviour needed "to be studied, anticipated and prevented--someone is going to get hurt very seriously if not mortally". One respondent expressed criticism of the program, thereby illustrating one of the problems innate to treatment settings when staff fail to agree with the treatment philosophy or approaches.

Summary

The data collected by means of the Checklist (Appendix D), Sociometric Questionnaire (Appendix E), Interview Questionnaire (Appendix F) and Staff Questionnaire (Appendix G), has been discussed in this chapter. The researcher had anticipated only two resident groups: identified self-injurers (ISI) and girls not identified as self-injurers (NSI). The declaration by 16 girls (SDSI) that they too had self-injured provided evidence for the researcher that self-injurious behaviour, whether covert or overt, occurs among adolescent girls at a high frequency, particularly among those girls with emotional disturbances and separations from family.

Several factors examined in social histories appeared to be associated with self-injury. The six research questions have been dis-

cussed utilizing the data drawn from the various collection instruments. The research hypothesis, that those girls who are least preferred by their peers have exhibited a predisposition towards participation in self-injurious activities, was supported by the findings for the ISI, but not for the NSI and SDSI.

The data reflected variable sensitivities among the staff and residents and, although limited samples, the responses seemed to provide a cross section of perceptions and experiences assumed to be typical of adolescent girls in treatment.

CHAPTER VI

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

In this chapter, a summary of the study, noteworthy findings and conclusions drawn from the data collected, and subsequent recommendations for Maryvale and comparable treatment settings are presented. Study criticisms and considerations for further research also are discussed.

The Study

This study was prompted by the researcher's belief that treatment staff should hold the objective of being able to anticipate their clients' needs and to understand the motivation prompting their behaviour, with consistent, therapeutic responses as the goal. This goal objective was observed to be particularly demanding for the staff at Maryvale during the epidemic-like occurrence of self-injury which led to this study. The study was intended to provide a focus for the review of literature relevant to self-injurious behaviour and to explore the phenomena of self-injury among the group of girls. The observations and opinions of the staff who had become familiar with this type of behaviour through their employment at Maryvale also were polled.

The researcher had designed the study with the expectation that there were three populations to be sampled: the staff, the identified self-injurers and the girls not identified as self-injurers. The self-reports of the girls revealed a fourth group drawn from the group not identified as self-injurers, and subsequently referred to as self-

declared self-injurers. Throughout this study the groups of girls have been identified as: identified self-injurers (ISI), self-declared self-injurers (SDSI), and non-self-injurers (NSI).

Findings

Social Histories

A Checklist (Appendix D) was used in the examination of the master files of 42 residents including 6 known self-injurers who had been discharged prior to the data collection. Although clarification of the etiology of self-injuring was not provided, several apparently associated factors were noted. These factors included: suicide or suicidal threats and gestures by parents or significant others; unresolved relationship separations, particularly losses through death or rejection; physical ailments which had the potential to negate self-image and the sense of self-worth; excessive sexual acting-out, particularly pregnancy and abortion experiences; and, numerous separations through placements and probable wardship status which seemed to connote failure, futility and loss of control and self-determination for the adolescent girl in treatment. Because the data was not available in each case record, differences from which etiological predictors of self-injury could be defined with confidence were not found in the review of master files.

Sociometric Findings

The Sociometric Questionnaire (Appendix E) drew data from a small sample comprised of identified self-injurers (ISI), self-declared self-injurers (SDSI) and non-self-injurers (NSI). Each cottage group varied markedly in composition with regard to the number of members in

the ISI, SDSI and NSI groups. The data obtained reflected a tendency for the members of the ISI to be chosen at a less than expected frequency and to be given more neutral to negative evaluations than the members of the other groups. The members of the ISI consistently underselected members of the SDSI and tended to overselect NSI members as their first choice companions. Members of the SDSI tended to overselect the NSI members as well as each other, whereas the NSI members ranged from less to more than the expected frequencies in their selection of each other.

Although the ISI members received the least preferred ratings, so did the members of the NSI whose evaluations tended towards the extremes, with all ratings being utilized. The original group of girls not identified by staff as self-injurers received predominantly preferential ratings; however the SDSI members were regarded with the most esteem in comparison with either the NSI or ISI members. These findings did not support the hypothesis that those girls who were least preferred by their peers had exhibited a predisposition towards participation in self-injurious activities.

The fact that not all cottage members received rankings in Part II of this questionnaire may have reflected failure to follow instructions consistently. It may be concluded also that the girls cited were those about whom there were formed opinions, and that the evaluations given therefore were informative. Breaks in the continuity of the numerous selection patterns seemed to reflect the respondents' recognition of individual talents, such as in athletics or ability to be considerate of others.

Interview Questionnaire

The Interview Questionnaire (Appendix F), completed by 36 residents, provided responses which indicated differences for some factors among the ISI, SDSI and NSI groups. The SDSI and ISI more frequently reported having witnessed physical violence within their family and daily living experiences. The ISI, as a group, reported having the most friendships with adults at Maryvale. Because the ISI were the least preferred group according to the sociometric data, the reports of adult friendships may have been accurate reflection that a higher proportion of their social interactions was with adults. The SDSI tended to indicate that they did not want their relationships with staff to be different, which was in contrast with the NSI responses, possibly reflecting higher expectations of staff among the NSI. The SDSI, having had frequent separation experiences, appeared to prefer to depend on their own resources and to be skeptical of adult trustworthiness. As a result, the SDSI may have had the least investment in their relationships with staff, and therefore less frequently expressed a desire for changes.

As anticipated, the self-injurers admitted to more self-injurious thoughts than did the NSI. The reports of actual self-injurious activity was the most noteworthy factor in this research in that it led to the definition of the group of 16 self-declared self-injurers who showed an extensive repertoire though lower frequency of self-injurious behaviour and a greater degree of determination in their self-injury. The SDSI felt they would not self-injure again, in contrast to the ISI who almost unanimously foresaw self-injuring in the future.

In addition to these factors, several other response patterns were of interest. The ISI and SDSI, in comparison to the NSI, had more separations from family and more runaway activity prior to their Maryvale placements. The combined group of self-injurers in comparison with the NSI reported having formed more friendships with girls at Maryvale. The self-injurers also felt more accepted than the NSI, which was not expected, particularly for the ISI who appeared to occupy the lower sociometric statuses. As previously stated, the SDSI most frequently indicated that they kept problems to themselves because they doubted that an adult could be helpful. The NSI most frequently reported that their feelings had changed, towards the negative, for girls after they had learned of the self-injurers' activities. In contrast, more understanding and tolerance was shown among the self-injurers, even though the SDSI were capable of being critical of the ISI because of their public, repetitive self-injuring.

Although attention-seeking was a motive frequently attributed to self-injury by the NSI and SDSI, none of the ISI acknowledged this motive. Rather, the ISI defined hoped-for changes or refused to respond about their motives for self-injury. The SDSI reported the consequences of self-injurious behaviour as being lack of trust, being liked less by girls and staff, and being placed in the negative environment of the Closed Unit. In contrast, the ISI did not respond, denied or were insensitive to the negative stimuli. Containment in the Closed Unit, for some may have been a positive experience of reassuring structure, attention and relaxed responsibility, paralleling the implications of the re-

moval of demands under conditions of restraint as discussed by Carr et al., (1976) and Carr (1977).

No consistent pattern of pre-injury circumstances was perceived by the girls, however the self-reports and observations concurred in that, prior to self-injuring, the girls appeared to be upset, angry, feeling lonely, unwanted, and not caring about their immediate future. Effective treatment therefore would necessitate a more specific, individualized assessment of the self-injurer and the environment as experienced by her.

Staff Responses

The Staff Questionnaire (Appendix G), distributed to all direct treatment staff, was responded to by 23 of the 44 staff members. Because the responses did not vary with academic credentials, the data was not presented according to groups with child care, social work or nursing education, but rather as a composite group. As with the residents, no consistent pattern of pre-injury circumstances was reported. Most noteworthy of their response was the unanimous report that the staff felt inadequately prepared for handling both the residents who self-injured and the impact of their activities upon the other residents. It was of interest that, given the level of anxiety and concern among the staff regarding the phenomena of self-injury, only one-half of the selected staff population responded to this questionnaire. This failure to respond may have reflected the passage of the crisis of self-injurious activity, which had occurred in a contagious wave and then subsided. The researcher was unable to determine whether the resolution of this

crisis occurred naturally or as a response to the discharge of several repetitive self-injurers. It was possible also that because the researcher was known to have been a social worker at Maryvale and because of the focus of the study, that the child care staff felt particularly vulnerable or threatened and therefore tended to refrain from responding.

The data for this study was collected in 1976 following the peak occurrence of self-injurious incidents at Maryvale, however, the researcher believed that the findings and recommendations drawn from this exploratory study would continue to be relevant over time for similar high risk populations and treatment settings.

Recommendations

The process of data collection and analysis led the researcher to formulate several recommendations for Maryvale and comparable treatment settings. These various recommendations are presented in the following discussion.

1. During the Intake process, inquire of the referral agent (social agencies, physicians), family, and the girl if there is a history of any self-injurious activity. In the one-to-one discussion with the girl, explore whether there had been thoughts of self-injury and if so, under what circumstance, and what, if anything, had deterred the girl from acting upon her thoughts.

Specific mention of this kind of behaviour could improve the degree of accuracy and completeness of social histories. If self-injurious behaviour had been found to be part of the girl's previous

behaviour, then this information could serve to disclaim the possible accusation that this kind of behaviour was learned at Maryvale. In addition, by acknowledging the phenomena of self-injury, an actual occurrence during the girl's residency possibly would be less shocking and coped with more adequately. It would seem advisable to discuss routinely with guardians the potential for self-injurious behaviour among girls who have a history of difficulties in adjusting and a tendency to react with hostility or depression when under stress. This study has suggested a prevalence of self-injurious behaviour among such a high risk population, the adolescent girls resident at Maryvale.

2. The treatment centre should negotiate a discharge plan proposal with the referral source. This future planning consideration should be discussed during the intake process and the plans should be shared with the potential resident. Lack of certainty about conditions of successful residency and future plans tend to heighten anxieties and a sense of hopelessness which has been found to be a significant indicator of suicidal risk (Kovacs et al., 1975).

3. The treatment centre should focus upon handling approaches including individualized programs, utilizing the various hypotheses for self-injurious behaviour in determining the most effective approach. The centre first must decide if it is accepting of the self-reports of the range and frequency of self-injurious behaviour among its residents. If the data is accepted, then the centre must make a commitment as to whether girls known to have self-injured would be accepted into its program. To exclude them would significantly reduce the potential popula-

tion and would deny the girls who had self-injured the benefits of residential treatment.

If girls who have self-injured are not excluded from the treatment program, then definition of the limits of tolerance for the various types of self-injury would seem desirable. This limit setting would seem to be arbitrary and unattainable however, because of related variables including contagion, frequency and potential risk. Despite the fact that only one of the identified self-injurers required surgical treatment, ingestion of tacks and pins may have miscalculated consequences, including scarring of the esophagus, esophagial bleeding (death probably within three minutes), or development of gangrenous bowel (Danto, 1976). Individualized handling programs therefore must be predicated by routines for necessary medical assessment. Recognizing the life threat, as well as potential litigation, it cannot be denied that self-injurious behaviours command and warrant attention.

4. Pursue the subject of self-injurious behaviour individually with the girls who have admitted to thoughts of or participation in such activities. The discussions should focus upon motives, goals, alternative coping mechanisms, and the inherent risks of the various types of self-injury. During the study there was no evidence that the discussion aggravated further incidents of self-injury. As the social worker and child care staff attempt to become significant others in the life of the resident, these discussions could convey genuine concern and a desire to be helpful, and thereby could develop as a preventative intervention.

5. Behavioural manifestations identified as indicators of camouflaged depression among children and adolescents should be noted as they occur in referral data and observations during residency. Depression, as an intropunitive behaviour, has frequently been associated with suicide attempts, and subsequently self-injury. It is recognized by the researcher that these behaviours (noted in Chapter III, Studies of Suicide Attempters) are frequent among the treatment population, thereby verifying that Maryvale and similar settings admit a high risk population with regard to potential for self-injury.

6. Recognize that anger is a legitimate, natural emotion which requires direction for expression and frequently, permission, to acknowledge and work through. It is necessary to build into the daily living environment acceptable, reasonable and transferable means by which the adolescent girl may give expression to frustration and angry emotions.

7. Utilize the four criteria proposed by Glaser (Chapter III, p. 35) in assessing the degree of seriousness of a verbal warning or actual incident of self-injury.

8. Following an incident of self-injury, a program of prompt removal from peers to an intensive setting, preferably not one comparable to the Closed Unit which seems to connote and accentuate feelings of rejection. The special treatment setting ideally should control harmful potentialities while giving intensive input, teaching the girl skills in relating, self-expression, recognition and expression of emotions and coping skills. The intensive program should attempt to place more demands upon the girl than she normally experienced in her external cottage/school

environment (Carr et al., 1976; Carr, 1977). The objective would be that her gradual transfer out of the intensive program would be a positive experience and that the intensive program in itself would not be rewarding as a reprieve from the responsibilities and pressures of normal programming.

During the re-negotiation for acceptance by the ISI with her peer group following an incident of self-injury, the staff should be prepared to allow the self-injurer to develop a dependency relationship with them as the staff encourage the self-injurers to identify with staff ego strengths until the self-injurer occupies an acceptable position within the cottage milieu. It was apparent the group response tended to be intolerant and rejecting which could render the self-injurer as vulnerable towards repeated self-injury.

9. If contagion of self-injurious activities has become an issue or appears imminent, then to control or suppress this contagion, discharge of repetitive self-injuries has been accepted as a handling approach in various studies. Contagion has been a factor particularly evident among child and adolescent populations in hospital or treatment settings, as well as among incarcerated populations.

10. Recognizing the patterns of responses in this study, intake data collection should focus upon the social history factors of exposure to violence within the family, separations from family, and aspects of health history, particularly those affecting body image, mobility and feminine identification.

11. Routinely maintain a record of the menstrual cycle of adolescent girls. Studies variously have disproved and supported the hypothesis that a correlation exists between the onset of menses and incidents of self-injury.

12. Special programs and social services treating high risk populations should lobby for the specific inclusion of the subject of self-injurious behaviour in the course material presented in the Child Care diploma program. The researcher made enquiries of staff and graduates from Child Care programs at three Southwestern Ontario community colleges and found no confirmation that either this behavioural manifestation or handling approaches were discussed.

13. As requested unanimously by the staff respondents, provide in-service seminars relative to motivational hypotheses and handling approaches specific to self-injurious activity. This didactic and supportive program suggestion should be a fixed component of in-service training regardless of the presence or absence of overt self-injurious activity at the time.

Criticism of the Study

Several criticisms of this study have been acknowledged by the researcher and will be presented briefly.

1. Middle and early adolescence classifications and sibling position (which was a factor noted to be relevant by Cantor, 1972) were not utilized in the data analysis. The researcher considered the ISI, SDSI and NSI group analyses to be most significant, and that to subdivide such a small sample further would be of minimal utility.

2. The Interview Questionnaire drew responses from the girls by administration of the questionnaire by cottage group rather than by direct, individual interview of the ISI members and small group interviews of the members of the original NSI, as originally had been intended.

3. In general, the responses given to some questions seemed to indicate that the process was too complex as too many tasks were required. As a result, responses were withheld or incomplete.

4. The Sociometric Questionnaire presented response difficulties, particularly Part II which was a modified version of the Ohio Social Acceptance Scale. This task possibly was too abstract and multifaceted to be handled by the resident sample in this study.

5. Individual interviewing of staff or alternately, interviewing of cottage groupings of staff, would have drawn more informative responses than the questionnaire which of necessity was generalized. Staff anonymity would have been lost by these data collection method alternatives and, as has been noted, the fact that the researcher was known to have been a staff member may have inhibited staff responses.

6. The questions were geared more to child care staff who had direct, on-site experiences with the self-injuries. The format presented difficulties in generalizing from specific, possibly remote, self-injurious incidents, as well as the parallel problem of describing numerous incidents according to one evaluation per category.

7. The master file records rather than the reports by the treatment staff could have been used to establish the group of self-injurers somewhat more inclusively.

Future Study

Several aspects of this study which could be explored differently in comparable future studies, as well as suggestions for further related research, will be suggested in this section.

1. Design a more case specific comparison study of identified self-injurers and self-declared self-injurers (anticipating the potential for this latter group to be considerable in numbers), budgeting sufficient time for individual interviews. A focus upon individual interviews could aid in the determination of informative differences between those girls who participated in covert self-injury in comparison to those who are detected because of their overt methods. There has been no evidence from this study that the individual interview provoked further self-injury. The cautious, gradual work-up to the topic of self-injury through the discussion of the group life at the treatment centre did not appear to need such extensive development.

2. Follow-up the known self-injurers in this or a comparable study to determine whether or not self-injurious activity persisted as part of their behavioural repertoires. The researcher attempted to do this albeit unsuccessfully. In view of the prolonged completion of this study, the researcher had contacted several referring agencies in the winter of 1978, however case workers had changed and new workers were unfamiliar with the girls, whose whereabouts tended to be unknown. There was neither sufficient time to seek out the girls personally nor to contact guardians to locate the girls and/or obtain consent for follow-up.

One member of the ISI group was known to have continued to

self-injure, in addition to fire-setting following her transfer from Maryvale to a psychiatric treatment setting. Another member of the ISI had self-injured prior to and during a psychiatric hospitalization on a behaviour modification program ward in the fall of 1978.

3. Utilizing a large sample of self-injuries, focus upon etiological factors and potential associations with self-injurious activity. Interviews with families and significant others, as well as medical and case records could serve as the data sources.

4. Design experimental research projects or utilize structured in vivo observations to test the various motivational hypotheses, as ethically permissible.

5. Similar studies should utilize researchers unknown to the study sample, in order to eliminate any constraints imposed by previous or actual associations or affiliations.

Summary

In this closing chapter a summary of noteworthy findings derived from the four data collection processes has been presented. Following a discussion of recommendations for the Maryvale program and comparable treatment settings, several criticisms of this study were considered. Suggestions for further related research also were proposed.

Although individual self-injurers often regard their behaviour as closed, in that their actions are perceived as being their own decision and responsibility, the repercussions of their actions, whether overt and openly flaunted, or covertly masked only to be discovered later, necessitate that this behavioural phenomena be regarded as an open system.

The impact upon others, provoking fears and concern, the potential for imitation, and the belief that the self-injurer can be influenced and directed towards alternative behaviour, further suggest that self-injury is an open system. It appears therefore that effective treatment will be dependent upon the recognition of the different motivations for self-injury and an accurate assessment of the interrelationships which exist between the individual, the situation and the responses given to the situation. This exploratory study has served to identify a known and a self-declared sample of the high risk female adolescent population in treatment with histories of acknowledged self-injurious activity.

APPENDIX

APPENDIX A

UNIVERSITY OF WINDSOR

WINDSOR, ONTARIO N9B 3P4
TELEPHONE: AREA CODE 519
253-4232

January 30, 1976

Mr. A. R. Vossen
Maryvale
3640 Wells Street
Windsor, Ontario
N9C 1T9

Dear Mr. Vossen:

As you are aware from our recent discussions, I am interested in engaging in a research study of self-mutilating behaviour, specifically as seen among the girls in the Maryvale program. The study would be of an exploratory descriptive nature as a beginning step towards greater understanding and direction for treatment responses for this phenomena.

In order to proceed with this study, I request permission to meet with the social work and child care staff involved with the girls who have participated in self-mutilation. I would also request access to the file records of these girls.

I hope that you will choose to participate in this proposed study. I will see that you obtain a copy of the research.

Enclosed is a form which upon your signature will indicate that you give consent to participate in the research proposed for my Thesis requirement.

Thank you for the interest you have shown.

Sincerely,

Kathleen F. Irwin, B.S.W.

L. E. Buckley, D.S.W.

:ER
Encl.

APPENDIX B

MARYVALE

3640 WELLS STREET, WINDSOR, ONTARIO N9C 1T9

PHONE 252-2707

February 9, 1976

Miss Kathleen F. Irwin, B.S.W.,
University of Windsor,
Windsor, Ontario.
N9B 3P4

Dear Kathy:

In response to your letter of request dated January 30, 1976, I am pleased to inform you that we at Maryvale will be pleased to offer our assistance in working with you in your research study. I would appreciate knowing in advance when you intend to commence your study. Perhaps a meeting of Social Workers and Unit Coordinators could be assembled to meet with you at a time when you are about to commence your research project.

Please find attached Mr. Vossen's authorization and agreement.

Sincerely,

Arthur R. Drummond, M.S.W.
Treatment Coordinator

ARD/br

Maryvale, residential treatment centre for emotionally disturbed adolescent girls, agrees to participate in the research project of Kathleen Irwin on the Examination of Self-Mutilating Behaviour among the residents.

Feb 3, 1976
Date

Director

APPENDIX C

Maryvale Brochure Excerpts

COTTAGE:

There are six open cottages staffed by two day shifts and one night shift. Child-care workers are supervised by a department co-ordinator and assistant. New admissions are assessed in a receiving cottage before appropriate grouping in cottage or school. Three intermediate cottages house the girls for the greatest portion of their stay in treatment which could average twenty months. One of these is a more heavily staffed unit containing educational facilities. Two senior cottages house girls during the phasing out period of treatment. Child-care staff's purpose is to provide a consistent, warm, and stable milieu. A full time nurse and part time doctor are available in our clinic.

SOCIAL SERVICE:

Caseworkers handling up to eleven cases act as the youngsters main therapist and as consultants to the teaching and child care staff. They are also the liaison with the girls' former community; meet with agency workers, parents, etc.; keep the referral source up to date on the girl's progress; and plan with those involved in the admission, for the ultimate discharge back to the community. Part time psychiatrists are available on a regular basis for consultation. Psychological services are obtained from the community as required. One caseworker acts as the chairman of the Intake Committee and processes all applications for admission.

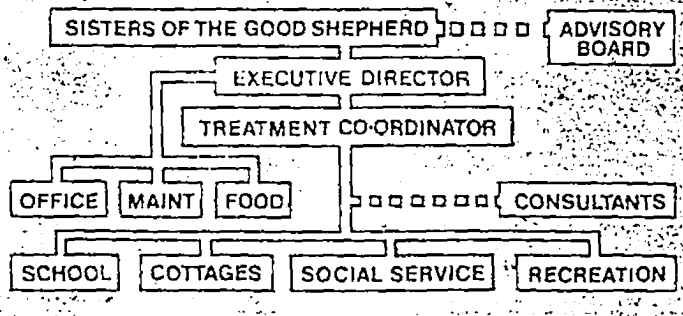
SCHOOL:

The on-campus ungraded school provides teachers to help re-motivate and to provide successful learning experiences. The ultimate goal is to restore the student once more into a community education facility. At any given time, half of the population may be in attendance in Windsor elementary, secondary or vocational schools. Youngsters not yet able to handle group learning situations attend the cottage educational facility. Those who can tolerate group learning part of the day are taught in a special phase in the school, while those who can use a group positively are taught in small ungraded groups. Opportunities for typing, sewing, cooking, arts and crafts, physical education and music are provided. When a student is ready for a community school, arrangements are made while she is still a resident of the treatment centre.

RECREATION:

After-school, week-end, and vacation activities are co-ordinated by a full time person. On-campus programs in the gym, pool, cottage and grounds provide a variety of leisure and therapeutic activity. The surrounding district affords good beach and water resources as well as theatres, parks, zoos, auditoriums, arenas, etc. Detroit and Michigan to the immediate North add further to the recreation department's resources. Our school bus provides transportation for larger group activities and a camping tour in the summer.

ADMINISTRATION



Maryvale is a private non-profit institution governed by the Sisters of the Good Shepherd and an advisory board of citizens operating under the Children's Mental Health Centres Act 1968-69. This Act is administered through the newly formed CHILDREN'S SERVICES BRANCH of the Mental Health Division, Ontario Department of Health.* The treatment program is operated by an executive director and a multi-discipline staff.

* Under the Ministry of Community and Social Services as of July 1, 1977.

APPENDIX D

Checklist

Number: _____
ISI: _____
NSI: _____

1. Birthdate: _____ E (Early) M (Middle)
   Month Year

2. Admission Date: _____ L (Long term) S (Short term)

   Length of Placement: _____
   Months

3. Referral Source: SA (Social Agency), F (Family/Self),
   S (School), M (Medical)

4. Legal Status: NW (Non-Ward), TW (Temporary Ward), CW (Crown Ward),
   P (Private), C (Court/Probation)

5. Family: (a) No. of children _____

   (b) Sib position _____ (eldest to youngest)

   (c) Parental relationship: M (Married), S (Separated),
   D (Divorced), TS (Threats of Separation), W (Widowed),
   R (Remarriage), DS (Deserted), CL (Common-law)

   (d) Parents' Occupation _____

6. Involvement with social agencies, (other than referral source):

   Yes No Unknown

7. Placements prior to Maryvale, (no. of times): _____

8. Separations: number, type, duration

9. Problem areas in family: MC (Marital Conflict), FB (Family Breakdown),
   D (Death of Parent), FH (Financial/Housing), PC (Parent/Child Conflict),
   CC (Child/Child Conflict), A (Alcoholism), CA (Child Abuse/Neglect),
   S (Suicide), V (Violence)

10. (a) Psychiatric diagnosis: _____

    (b) I.Q. rating: _____

    (c) Academic level (completed): _____

11. Health history: E (Excellent), G (Good), H (Handicaps), C (Chronic Illness)

12. Peer Relationship skills at admission: S (Satisfactory), US (Unsatisfactory)

13. Presenting problem(s): _____

14. Incidence of self-injury prior to admission to Maryvale:

    Yes No Unknown

APPENDIX E

Sociometric Questionnaire

MOST OF US CAN THINK OF PEOPLE WE LIKE EVEN IF WE ARE NOT ABLE TO SAY WHY. CHOOSING FROM THE GIRLS LISTED BELOW, WHICH GIRLS WOULD YOU WANT TO BE WITH YOU TO DO THE THINGS DESCRIBED?

WRITE IN THE NAME OF THE GIRL YOU WOULD MOST LIKE TO BE WITH YOU BESIDE 'I', YOUR SECOND CHOICE BESIDE 'II', AND YOUR THIRD CHOICE BESIDE 'III'. IF THERE ARE TIMES YOU CANNOT THINK OF THREE GIRLS, FILL IN ONLY AS MANY AS YOU CAN. IF THERE IS NO ONE YOU WOULD WANT WITH YOU TO DO THE THINGS DESCRIBED, WRITE IN "NO ONE" BESIDE 'I'.

1. WHICH GIRL WOULD YOU LIKE TO HAVE SIT NEXT TO YOU AT MEALS?

   I _____ II _____ III _____

2. WHO WOULD YOU LIKE TO SHARE YOUR BEDROOM WITH?

   I _____ II _____ III _____

3. THE COTTAGE IS PLANNING TO GO ON AN OUTING. THE CAR WILL HOLD ONLY FOUR GIRLS. WHO WOULD YOU LIKE TO HAVE COME WITH YOU IN THE CAR?

   I _____ II _____ III _____

4. WHO WOULD YOU LIKE TO HAVE WALK TO THE STORE WITH YOU?

   I _____ II _____ III _____

5. THE COTTAGE IS GOING ON A WEEKEND CAMPING TRIP. WHO WOULD YOU LIKE TO HAVE IN YOUR TENT?

   I _____ II _____ III _____

6. WHO WOULD YOU LIKE TO HAVE ON YOUR TEAM IN RECREATION PROGRAMS?

   I _____ II _____ III _____

7. WHO WOULD YOU LIKE TO BE WITH DURING RECESS?

   I _____ II _____ III _____

8. WHO WOULD YOU LIKE TO WORK WITH ON A SCHOOL PROJECT?

I _____ II _____ III _____

9. IF SOMETHING IS REALLY BOTHERING YOU, WHO WOULD YOU WANT TO TALK TO?

I _____ II _____ III _____

10. WHO ARE THE ONES WHO MAKE FRIENDS MOST EASILY?

I _____ II _____ III _____

11. WHO ARE THE ONES YOU LIKE TO SPEND YOUR FREE TIME WITH?

I _____ II _____ III _____

12. WHO ARE THE ONES WHO ARE MOST CONSIDERATE (THOUGHTFUL)?

I _____ II _____ III _____

13. WHO ARE THE ONES WHO ARE MOST UNDERSTANDING?

I _____ II _____ III _____

BELOW ARE DESCRIPTIONS OF A PERSON. READ EACH DESCRIPTION, AND IF IT FITS ANY GIRL IN THE COTTAGE (ON YOUR LIST) NAME HER. NAME EVERY GIRL, PICKING THE DESCRIPTION YOU FEEL FITS HER BEST.

A. I WOULD LIKE TO SPEND A LOT OF TIME WITH THIS PERSON AND WOULD ENJOY GOING PLACES WITH THIS PERSON. I WOULD TELL SOME OF MY TROUBLES AND SOME OF MY SECRETS TO THIS PERSON AND WOULD DO EVERYTHING I COULD TO HELP THIS PERSON OUT OF TROUBLE.

_____

_____

B. I WOULD ENJOY WORKING AND BEING WITH THIS PERSON. I WOULD INVITE THIS PERSON TO A PARTY, AND WOULD ENJOY GOING ON PICNICS WITH THIS PERSON AND OUR FRIENDS. I WOULD LIKE TO TALK AND MAKE AND DO THINGS WITH THIS PERSON. I WOULD LIKE TO WORK WITH THIS PERSON AND I WOULD LIKE TO BE WITH THIS PERSON OFTEN. I WANT THIS PERSON TO BE ONE OF MY FRIENDS.

_____

_____

C. I WOULD BE WILLING TO BE IN A CLUB WITH THIS PERSON. IT WOULD BE ALRIGHT FOR THIS PERSON TO BE ON THE SAME TEAM WITH ME OR TO LIVE IN MY NEIGHBOURHOOD. I WOULD BE IN A PLAY WITH THIS PERSON. I WOULD JUST AS SOON WORK WITH THIS PERSON IN SCHOOL. THIS PERSON IS NOT ONE OF MY FRIENDS, BUT I THINK THIS PERSON IS ALRIGHT.

D. I DO NOT KNOW THIS PERSON VERY WELL. MAYBE I WOULD LIKE THIS PERSON, MAYBE I WOULDN'T. I DON'T KNOW IF I WOULD LIKE TO BE WITH THIS PERSON.

E. I'LL SAY "HELLO" BUT I DO NOT LIKE BEING WITH THIS PERSON. I MIGHT SPEND SOME TIME WITH THIS PERSON IF I DIDN'T HAVE ANYTHING ELSE TO DO, BUT I WOULD RATHER BE WITH SOMEBODY ELSE.

F. I SPEAK TO THIS PERSON ONLY WHEN I HAVE TO. I DO NOT LIKE TO WORK WITH THIS PERSON AND I WOULD RATHER NOT TALK TO THIS PERSON.

APPENDIX F

Interview Questionnaire

IDI Responses
SDSI Responses
NSI Responses

Girls:

1 Birthdate: _____
Month Year

2 In your family are you (check one): 234 the youngest child.
996 a middle child
143 the oldest child
100 an only child

3 Was coming to Maryvale the first time you lived away from your family home? 448 Yes 3125 No

If you answered 'no' above, where else have you lived and for how long?

_____

_____

4 When you knew you were coming to Maryvale, what did you hope it would be like?

_____

_____

5 When you first came to Maryvale, did you find living here was what you expected? (check one)

1 no answer

221	002	174	475
very much	somewhat	little	not at all

6 If being at Maryvale was different from what you expected, would you explain how it was different?

_____

_____

7a) In every new situation we have to make changes or adjustments. How would you describe the adjustments you had to make at Maryvale? (check one)

1 non-calculable

352	123	237	031	000
really hard	quite hard	okay	quite easy	really easy

b) If the adjustment was 'hard', would you tell me in what ways it was hard?

_____

8a) At Maryvale you are asked to be part of a group that is made up of many different people. What is it like for you having to be part of such a group? (check one)

2 non-calculable

really hard	quite hard	okay	quite easy	really easy
100	121	387	111	134

b) If you answered 'easy' above, what makes it so? _____

_____

c) If you answered 'hard' above, what makes it so? _____

_____

9 Had you ever run away before you came to Maryvale? 4115 Yes 258 No. 1 no answer

If you answered 'yes' above, approximately how many times did you run away?

_____

10 Did you run away while you were at Maryvale? 6108 Yes 165 No

If you answered 'yes' above, how often did you run away and for how long?

_____

_____

11 In your memory, did anyone in your family ever physically hurt you?

1 no answer

5127 Yes 146 No

12 Have you seen relatives or people you lived with being hurt physically?

5155 Yes 218 No

13 Do you remember if someone has ever deliberately hurt you physically?

1 no answer

5139 Yes 124 No

14 While at Maryvale have you developed friendships with other girls? (check one)

lots	some	few	none
397	463	003	010

15 Have you friends at Maryvale who are helpful to you? 7/412 Yes 021 No

If you answered 'yes' above, in what ways are they helpful?

_____

_____

16 Do you feel that you have been able to be helpful to any of the girls?

5/310 Yes 233 No

If you answered 'yes' above, in what ways do you feel you were helpful?

_____

_____

17 Do you feel that staff encourage friendships among the girls? (check one)

1 no answer

always	often	sometimes	rarely	never
044	122	331	275	000

18 Do you feel accepted, as a person, by the other girls at Maryvale?

3 non-calculable

6/29 Yes 114 No

Explain your answer: _____

_____

19 Do you have friendly relationships (friendships) with any of the adults at Maryvale? (check one)

1 no answer
2 no answer

lots	some	few	none
412	166	165	010

20 How meaningful are these relationships to you? (check one)

1 no answer

very	somewhat	a little	not at all
697	134	022	010

21 There are times when teenagers like to be by themselves, with no one else around.

a) What kinds of things do you do when you choose to be by yourself?

_____

b) Are these the same things you do when someone tells you that you must be by yourself, not with anyone else?

1 no answer
4 no answer

395 Yes 374 No

If you answered 'no', what kinds of things do you do when someone tells you that you must be by yourself?

22 There are times when teenagers like to be with other people. Have there been times at Maryvale when you really wanted to do something with someone and you were not given the permission to do it? (check one)

always	often	sometimes	rarely	never
012	342	445	032	041

1 no answer

Explain your answer.

23 What do you do when you are not given permission to do something with someone?

24 At home or in your neighbourhood you probably had people you could talk to. Are there times at Maryvale for you to sit and talk with some adult as you would like to?

1 no answer
1 non-calculable

589 Yes 174 No

25 Do you feel that staff understand your needs as a person? (check one)

always	often	sometimes	rarely	never
100	121	387	041	224

Explain your answer.

26 Would you like your relationships with the staff to be different?

3 non-calculable

939 Yes 4104 No

If you answered 'yes' above, in what ways would you like your relationships to be different?

27 What qualities would you like to see in the adults who spend time with you?

28 - For all teenagers there are times when you have problems. At Maryvale, can you find adults to talk with you about your problems? (check one)

always	often	sometimes	rarely	never
153	001	356	241	022

1 no answer

29 What kinds of problems have you had since you came to Maryvale?

30 At Maryvale, when you have a problem what do you do usually? (check one)

1 non-calculable
2 non-calculable
1 non-calculable

376 try to handle it on my own
232 talk it over with the staff or other adults
124 talk it over with other girls
020 other (specify) _____

31 If you have discussed problems with adults at Maryvale, did it help you?

8 non-calculable
2 no answer

557 Yes 234 No

Explain your answer. _____

32a) Are there times when you want some adult to talk to and no one is available? (check one)

always	often	sometimes	rarely	never
101	032	373	244	121

1 no answer
1 non-calculable

b) If there are times when you cannot find an adult to talk with you, what do you do?

33 Are there times when you keep problems to yourself because you feel no adult can be helpful to you? (check one)

1 no answer

153	372	222	015	110
always	often	sometimes	rarely	never

34 What kinds of things do you do at Maryvale when you feel angry, frustrated or upset?

_____

_____

35 Since you came to Maryvale have you ever broken or damaged anything?

1 non-calculable

374 Yes 498 No

If you answered 'yes' above, what did you expect would happen to you as a result?

_____

What actually happened? _____

_____

36 Think about experiences you may have had such as a sore throat, bad headaches, cramps, needles or surgery. Check on the scale below the feeling of physical pain that you have compared to other girls you know. (check one)

1 no answer
2 no answer

242	134	264	011	210
bothers me much more	somewhat more	about average	somewhat less	bothers me much less than others

You may know that there are times when people hurt themselves whether accidentally or on purpose. When someone hurts him or herself on purpose we often call this 'self-injury'. The questions which follow ask about your own experiences and thoughts about self-injury, and about experiences you may have had with other people who hurt themselves.

37 If you can think of things that people can do to themselves which may injure them or give them pain, list them below in Column I. Check under ColumnII for each thing you name indicating whether you have experienced it yourself, whether you have experienced it with someone else doing it, or whether you have heard about it only. In Column III, number the things you have listed from '1' to '10', giving the number '1' to the thing you find most upsetting to think about someone doing, and '10' to the thing you find least upsetting.

COLUMN I	COLUMN II			COLUMN III
Kinds of self-injury	Experience			Rank order
	With self	With others	Only heard	

38 Have you ever thought about doing something to yourself which would have been a kind of self-injury?

5/145 Yes 227 No
1 no answer

If you answered 'yes' above, what do you remember about what was going on with you at the time? What kinds of things have you thought about doing? If you thought about it but never did injure yourself, can you describe how it was that you did not injure yourself?

39 Have you ever done anything to yourself which was a kind of self-injury?

1 no answer
2 no answer

7/140 Yes 0/11 No

Answer Questions 40 - 48 only if you answered 'yes' to Question 39 above.

40 In your memory, how often have you done things to yourself which could be considered to be kinds of self-injury? (check one)

- 0 9 one time
- 6 4 2-5 times
- 1 1 6-10 times
- 0 1 11-15 times
- 0 1 more often (specify approximately how often)

41 Can you describe what kinds of things you have done?

_____

_____

Do you remember experiencing pain or any other sensations at the time?

_____

42 As you think about what you did, do you think that you or anyone else could have done anything to change or interrupt the process?

4 2 Yes 3 12 No
1 no answer
1 non-calculable

Explain your answer. _____

_____

43 What are your thoughts about why you injured yourself?

_____

44a) Do you feel that others suspected that you were going to injure yourself before you did it?

1 non-calculable
1 no answer
3 3 Yes 4 11 No

b) Did you want anyone to know? 1 1 Yes 6 14 No
1 non-calculable

c) Did you hope that people would do something different?

2 6 Yes 4 3 No
1 no answer
6 no answer
1 non-calculable

Explain your answer. _____

45a) Did you imagine that anything would happen to you as a result of what you did?

3 11 Yes 4 5 No

b) If you answered 'yes' above, what did you imagine and did this happen?

_____

_____

46a) Did your family (guardian) know of your self-injuries?

4 10 Yes 3 6 No

b) Did you want them to know? 0 1 Yes 7 14 No
1 non-calculable

Explain your answer. _____

_____

c)If they did know, what were their reactions? _____

_____

If you live in a cottage with a girl who you know did something to herself which was a kind of self-injury, answer Questions 47 and 48.

47 What do you remember about how the girl was feeling just before she injured herself?

_____

_____

48 Were you surprised to find out that the girl had injured herself?

7 no answer 2 no answer 4 no answer

343 Yes 283 No

If you answered 'no' above, can you explain why you were not surprised?

_____

_____

49a)As you think about the girls at Maryvale who have done things to themselves which were kinds of self-injury, did your feelings towards any of them change when you found out what she had done?

358 Yes 393 No

1 no answer 2 non-calculable 3 no answer

If you answered 'yes' above, how did your feelings change?

b)Did staff relationships with any of the girls seem to change?

285 Yes 576 No

1 no answer 2 no answer

If you answered 'yes' above, how did they seem to change?

_____

50 If you or one of the girls at Maryvale was to do some kind of self-injury, how comfortable would you be reporting this to staff? (check one)

1 no answer 2 no answer

043	011	252	555
very comfortable	somewhat comfortable	somewhat uncomfortable	very uncomfortable

51 Can you tell me why you think people injure themselves?

_____

_____

52 Do you see yourself as ever behaving in a way that could injure yourself in the future?

631 Yes 1010 No
3 no answer
2 no answer

If you answered 'no' above, but you have done things in the past which injured you, how do you see the future as being different?

If you answered 'yes' above, what kinds of things might you do?

What do you think the circumstances would be like?

53 What would you say to someone who is thinking of doing something which would injure her?

54 Do you consider this self-injuring behaviour to be a problem at Maryvale?

511 Yes 224 No
1 no answer
2 non-calculable
2 no answer

If you answered 'yes' above, how do you consider it to be a problem?

55 Do you have any suggestions for the staff as to what they could do?

56 Any further comments?

ADDITIONAL QUESTIONS FOR KNOWN SELF-INJURERS

57 Did you notice any changes in the way the girls treated you after they found out about the self-injuring things you had done?

2 Yes 5 No

If you answered 'yes' above, what changes did you notice?

58 Did you notice any staff reactions to what you did?

3 Yes 4 No

If you answered 'yes' above, what did you notice?

Did this result in any change in your relationships with staff?

If you answered 'no' above, were you expecting something to happen?

59 Compare your most recent incident of self-injury to incidents in the past.

60 Any further comments you would like to make?

APPENDIX G

Staff Questionnaire

Attached is a copy of the questionnaire which is part of the study I am undertaking.

Please complete the questionnaire on your own as your individual perceptions are of particular interest. Your responses are treated confidentially - do not sign your questionnaire. Reply by June 25, (Friday).

Use the envelope provided to seal your responses, and deposit it in the large envelope labelled 'K. Irwin' on the mailbox shelf area in the 'A' building.

THANK YOU for your co-operation.

Kathleen Irwin, B.S.W.

Staff Questionnaire

Staff:

Behaviours labelled as "self-mutilating", "self-destructive" or "self-injurious" have been considered by some people to include smoking, drinking, drug use, excessive sleeping, car racing, sky diving and so on. Self-injurious behaviour also includes those behaviours of which you may be aware having worked with adolescents.

For the purpose of this study, however, you are asked to consider self-injurious behaviours limited to self-initiated, excessive scratching, puncturing and cutting of skin tissue, and the ingestion of toxins or foreign objects (such as pins, tacks, glass, and buttons). Incidents of self-injurious behaviour as they have been experienced and observed at Maryvale are the focus of this study.

It would be appreciated if you would take time to answer the following questions. Your individual contribution will be of value in the development of a more adequate understanding of these behaviours and its effects upon residents and staff. (If additional space is required, please use the overleaf page or attach a separate page, numbering your responses).

1. How long have you been on staff at Maryvale? _____ Years _____ Months

2. The following questions relate to your educational backgrounds.

a) What was the last high school grade you completed? _____

b) Indicate certificated courses which you have taken and consider to be relevant to your work. Include whether or not these courses have been completed.

_____

_____

c) Indicate university programs which you have taken and whether or not you completed these programs.

_____

_____

d) Indicate in-service training you have received and the length of these programs.

_____

_____

e) Other (specify) _____

_____

3.a) "Self-determination" can be defined as a voluntary or conscious creating of one's own fate, an acceptance and affirmation of oneself as a fate-creating power. Do you believe that individuals have a right to self-determination?

18 Yes 4 No 1 no answer

b) If you answered 'yes' above, does this include self-injurious behaviour?

5 Yes 12 No 1 no answer

c) If you answered 'yes' to a) or b) above, would you include:

a) persons aged 12 and under 6 Yes 8 No 4 no answer

b) persons aged 13 - 16 7 Yes 6 No 4 no answer 1 non-calculable

c) persons aged 17 - 21 13 Yes 2 No 2 no answer 1 non-calculable

4. Do you experience any conflict between beliefs and practices in working with girls who participate in self-injurious behaviour?

8 Yes 14 No 1 no answer

5.a) Have any of the girls in your cottage, or with whom you work directly, participated in self-injurious behaviour?

22 Yes 1 No

b) If you answered 'yes' above, were you at work at the time that the incidents of self-injurious behaviour occurred?

17 Yes 5 No 1 no answer

Have you had direct, first person involvement with a girl at the time of her participation in self-injurious behaviour?

14 Yes 9 No

Have you discussed incidents of self-injurious behaviour which occurred in other cottage units with the staff involved?

20 Yes 3 No

c) Please indicate approximately how many incidents of self-injury form the basis of your experience.

_____

How many of these were a result of your work at Maryvale?

_____

6. In relation to the other girls with whom you have worked, rate the girls who self-injure as to their: a) ability to maintain relations: (1 non-calculable)

much higher	somewhat higher	average	somewhat lower	much lower
1	0	0	7	14

b) perception of self-worth

much higher	somewhat higher	average	somewhat lower	much lower
1	1	0	6	15

c) need for attention

much higher	somewhat higher	average	somewhat lower	much lower
17	4	0	0	2

d) ability to operate independently

much higher	somewhat higher	average	somewhat lower	much lower
1	0	1	7	14

e) tendency to lead

much higher	somewhat higher	average	somewhat lower	much lower
2	2	3	8	8

f) tendency to be influenced by peers (2 no answer)

much higher	somewhat higher	average	somewhat lower	much lower
6	11	2	3	0

It is possibly difficult to reply to Questions 7 and 8 unless you were directly involved with a cottage unit. If you find this is so, you may choose not to respond.

7. Think of an average day and use the following terms to describe the cottage environment among the girls as you recall it on the day an incident of self-injury occurred.

a) (10 no answer)

very tense	somewhat tense	average	somewhat relaxed	very relaxed
0	7	4	1	1

b) (11 no answer)

very argumentative	somewhat argumentative	average	somewhat congenial	very congenial
0	9	2	1	0

c) (11 no answer; 1 non-calculable)

very disruptive	somewhat disruptive	average	somewhat orderly	very orderly
0	7	4	0	0

Any other significant conditions? _____

_____

8. Describe the staff relationships as you recall them on the day any incident of self-injury occurred.

a) (10 no answer)

very tense	somewhat tense	average	somewhat relaxed	very relaxed
0	4	7	2	0

b) (11 no answer)

very divisive	somewhat divisive	average	somewhat cohesive	very cohesive
0	2	6	1	2

c) (11 no answer)

very disorganized	somewhat disorganized	average	somewhat organized	very organized
0	3	6	2	1

Other significant conditions. _____

_____

9. Are you aware of any clues which may have been indicative of the girl's intentions to injure themselves?

14 Yes 9 No

If you answered 'yes' above, explain what you feel these indicators were.

_____

_____

10. Do you recall if the girls were experiencing any frustrations, fears or concerns prior to the incidents of self-injury?

16 Yes 6 No 1 non-calculable

If you answered 'yes' above, explain your answer including how long prior to the incidents you noticed these factors.

_____

_____

11. What do you recall of the events immediately prior to any incident of self-injury?

_____

_____

12.a) What was your immediate feeling response when you learned of an incident of self-injury?

_____

_____

b) Is it your opinion that your feelings were known to the girls?

13 Yes 8 No 2 non-calculable

13. Did you respond to the girl following her self-injury?

19 Yes 3 No 1 non-calculable

If you answered 'yes' above, how would you describe your response?

_____

_____

If you answered 'no' above, is there something you would have liked to have said or done?

_____

_____

14. Do you feel that there was any change in the way you responded to the girls in your staff function following the incidents of self-injury?

6 Yes 17 No

If you answered 'yes' above, explain the changes. _____

_____

15. Could you anticipate which girls would adopt self-injurious types of behaviour?

13 Yes 9 No 1 no answer

16. Among the girls who self-injured, did you notice a greater than usual preoccupation with their bodies?

7 Yes 14 No 2 no answer

17. During your contacts with the girls who self-injured do you recall if they expressed attitudes or conceptions about death?

8 Yes 13 No 2 no answer

If you answered 'yes' above, explain the girls' comments.

_____

_____

18. Do you feel that there was purpose to the girl's self-injurious behaviour?

23 Yes 0 No

If you answered 'yes' above, give your interpretation of the girl's purpose.

_____

_____

19. Were you made aware of the potential of self-injurious behaviour occurring among the girls when you accepted employment at Maryvale?

8 Yes 15 No

20. Are there some types of self-injurious behaviour which you find more distressing than others?

16 Yes 7 No

If you answered 'yes' above, what types do you find most distressing?

_____

What types do you find least distressing? _____

_____

21. Do you consider self-injurious behaviour to be a problem for Maryvale?

13 Yes. 7 No 3 no answer

If you answered 'yes' above, how do you consider it to be a problem?

_____

_____

22. Did any training you have had adequately prepare you to handle girls who participated in self-injurious behaviour?

9 Yes 13 No 1 no answer

23. Have you felt the need to be helped in handling your own response to the girls' self-injurious behaviour?

11 Yes 11 No 1 non-calculable

If you answered 'yes' above, did you express this felt need to the appropriate personnel?

11 Yes 1 No

If you answered 'yes' above, did you receive a satisfying response to your request for help?

9 Yes 1 No 1 non-calculable

If you answered 'no' above, were there reasons you chose not to seek help? Explain.

_____

_____

24. Do you feel further assistance in this area of working with girls who self-injure would be useful?

very much	somewhat	little	not at all
11	11	0	0

1 no answer

25. If, in your opinion, further assistance would be useful, what would you suggest?

26. Are there any further comments you would like to make about this self-injurious behaviour?

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Interview

Danto, B., Director, Suicide Prevention and Drug Information Centre, Detroit, Michigan. Interview, May 9, 1976.

VITA AUCTORIS

Kathleen Florence Irwin was born May 18, 1950 in Pembroke, Ontario. She attended Ottawa's Percy Street Public School, completing sixth grade in 1961, then Glashan Public School for two years, completing eighth grade. She attended Glebe Collegiate Institute through December 1966 and graduated from grade 13 in 1968 from Smiths Falls District Collegiate Institute, Smiths Falls, Ontario.

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