

The relationship of self-injurious behavior and other maladaptive behaviors among individuals with severe and profound intellectual disability

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Abstract

Participants were 101 individuals with self-injurious behavior (SIB) and severe or profound intellectual disability who were matched by gender, age, and level of intellectual disability to controls. Persons with SIB were more likely to exhibit the challenging behaviors of physical aggression, property destruction, sexually inappropriate behaviors and stereotypes when compared to controls, suggestive of co-occurring behaviors. Moreover, the maladaptive behavior of irritability, as assessed by the aberrant behavior checklist (ABC) was able to correctly classify 72.8% of the sample into their respective group memberships. Implications of these findings are discussed.

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Self-injurious behavior (SIB) is a severe and chronic form of aberrant behavior that poses serious risks to persons with intellectual disabilities (Iwata, Dorsey, Slifer, Bauman, & Richman, 1982). Tate and Baroff (1966) defined SIB as a behavior(s) that produces injuries to an individual's body. SIB has resulted in physical trauma and medical complications including permanent tissue damage, bone fractures, dismemberments, and in the most severe cases, death (Yang, 2003). Moreover, SIB is frequently a life-long behavior that persists from childhood through adulthood (Schroeder, 1996). According to Rojahn (1994), the most common forms of SIB are head banging, self-biting, and self-scratching. In addition, hand-to-head SIB occurs

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frequently in persons with intellectual disabilities (Griffin, Williams, Stark, Altmeyer, & Mason, 1986). According to Thompson and Caruso (2002), SIB may occur in interrupted sessions that last for a few seconds or prolonged episodes that may last for hours. Self-injurious behavior is also problematic for direct care staff, teachers, professionals, and other family members because of negative psychosocial effects and stress (Mossman, Hastings, & Brown, 2002). Additionally, SIB depletes limited financial and staff resources within institutional or community settings.

Prevalence estimates of SIB range from 5 to 16% (Schroeder, Rojahn, & Oldenquist, 1991). Additionally, researchers have reported that prevalence rates are negatively correlated with intellectual ability (McClintock, Hall & Oliver, 2003; Rojahn & Esbensen, 2002). Thus, estimates of SIB are highest in individuals with severe and profound levels of intellectual disabilities. Self-injurious behavior is a common feature of many disorders including Tourette's syndrome, and schizophrenia (Baumeister & Frye, 1985). Researchers have suggested that SIB has a strong overlap with other types of psychopathology including depression, bipolar, and obsessive-compulsive disorder (Matson, 1986; Charlot, Doucette, & Mazzacappa 1993; Bodfish et al., 1995). Self-injury is also common in individuals with certain disabilities such as Lesch-Nyhan syndrome (Baumeister & Frye). Researchers have suggested an association between social skills deficits and self-injurious behavior (McClintock et al., 2003). Specifically, individuals with intellectual disabilities are more likely to display negative social skills and undesirable social behaviors. Additionally, SIB has been associated with physiological conditions including otitis, gastroesophageal reflux disease, menstrual periods, and sleep deprivation (Thompson & Caruso, 2002).

Behavioral interventions based on functional analysis have decreased incidents of self-injurious behavior (Pelios, Morren, Tesch, & Axelrod, 1999). Differential reinforcement of alternative behavior (DRA), response interruption and prevention, and social skills and communication training has been reported to be effective in reducing incidents of SIB (Rush & Frances, 2000). Additionally, enriched environments with empirically identified preferred stimuli decreased self-injurious behavior (Lindauer, DeLeon, & Fisher, 1999). Pharmacological treatments for SIB include the atypical antipsychotics of clozapine, olanzapine, quetiapine, and risperidone (Aman & Madrid, 1999). Anderson and Ernst (1994) reported that benzodiazepines, neuroleptics, antidepressants, chloralhydrates, and anticonvulsives are frequently used for the behavioral control of SIB. Clozapine has been reported to be effective in reducing self-injurious behavior and aggression in persons with profound mental retardation who had been unresponsive to previous pharmacological interventions (Hammock, Levine, & Schroeder, 2001). Buitelaar (1993) however recommends caution when using psychotropics to treat SIB citing both their sedating properties to decrease cognitive and physical abilities and long-term side effects.

Self-injurious behavior has typically been treated as a discrete behavior independent from other forms of challenging behaviors (Bodfish & Lewis, 2002). However, several researchers have reported an association between SIB and other maladaptive behaviors (Bihm & Poindexter, 1991; Sigafos, Elkins, Kerr, & Attwood, 1994; Collacott, Cooper, Branford, & Mc Grother, 1998). Nottestad and Linaker (2002) in a study of individuals before and after deinstitutionalization reported that SIB was a significant predictor of aggressive challenging behavior in the community. According to Landesmann-Dwyer (1981), aggression frequently results in re-institutionalization. Maladaptive behaviors are often associated with unsuccessful community relocation (Sutter, Mayeda, Call, Yanagi, & Yee, 1980; Hemming, 1982). Consequently, the purpose of this study was to extend previous research by determining the

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