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Résumé de l'article

This paper considers the clinical issue of self-harming behaviours, defined as intentional self-injury that results in tissue damage. It is distinct from a suicide attempt, as self-harm does not occur within the context of a conscious wish to die. Self-harming behaviours among children and youth is a recent area of research. To date, studies indicate that in community samples, self-harming behaviours occur in as many as 35% of youth who are sampled (Gratz, 2001). Alarmingly, very little is known about self-harming behaviours among children and youth within the child protection system. This study, drawing from data gathered through a government-mandated reporting procedure of all children and youth in care,attempted to explore self-harming behaviours of children and youth in welfare care. While analyses did not focus explicitly on Aboriginal children and youth, it does consider differences in self-harming behaviours among minority and non-minority children and youth in care of the Children's Aid Society of Toronto. Approximately half of all child welfare cases that go through the child protection system in Toronto fall under the responsibility of the Children's Aid Society of Toronto. Although minority status was not significantly related to the number of self-harming attempts or threats, results suggested that minority children and youth in care were less likely to use puncture-type behaviour (cutting, scratching, stabbing) as a means of serious self harm. Results suggest that although self- harm may be a universal phenomenon, culture may affect how children and youth in care engage in self-harming behaviours. Direction of future research should consider between-cultural effects and more importantly, how these culture-specific differences may impact on children and youth's self-harming behaviours.

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The Effects of Self Harming Behaviours of Youth in Child Welfare Care

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Abstract

This paper considers the clinical issue of self-harming behaviours, defined as intentional self-injury that results in tissue damage. It is distinct from a suicide attempt, as self-harm does not occur within the context of a conscious wish to die. Self-harming behaviours among children and youth is a recent area of research. To date, studies indicate that in community samples, self-harming behaviours occur in as many as 35% of youth who are sampled (Gratz, 2001). Alarmingly, very little is known about self-harming behaviours among children and youth within the child protection system. This study, drawing from data gathered through a government-mandated reporting procedure of all children and youth in care, attempted to explore self-harming behaviours of children and youth in welfare care. While analyses did not focus explicitly on Aboriginal children and youth, it does consider differences in self-harming behaviours among minority and non-minority children and youth in care of the Children's Aid Society of Toronto. Approximately half of all child welfare cases that go through the child protection system in Toronto fall under the responsibility of the Children's Aid Society of Toronto. Although minority status was not significantly related to the number of self-harming attempts or threats, results suggested that minority children and youth in care were less likely to use puncture-type behaviour (cutting, scratching, stabbing) as a means of serious self harm. Results suggest that although self- harm may be a universal phenomenon, culture may affect how children and youth in care engage in self-harming behaviours. Direction of future research should consider between-cultural effects and more importantly, how these culture-specific differences may impact on children and youth's self-harming behaviours.

Introduction

Self-harming behaviours are often linked with adolescence, with frequent media depictions of female-cutting behaviours and reports of copycat suicide attempts. Research, however, is very limited in its knowledge about self-harming behaviours across childhood or amongst vulnerable populations. For instance, children as young as 5-years-of-age can make self-harming gestures, such as pretending to choke themselves or adolescents may scribble across their school notebooks "Better off dead." Adults often say flippantly "just shoot me!" or "I'm going to tear my hair out". For some, self-harming behaviours are frequent events that we know very little about. For the purposes of this study, self-harm is defined as the deliberate destruction or alteration of body tissue without conscious suicidal intent, resulting in injury severe enough for tissue damage. Perhaps what is most shocking is that self-harming behaviours occur frequently in the general population and what is alarming is recent studies have indicated

that self harm appears to be increasing (Favazza, 1992; Gratz, 2001; Rodham, Hawton, & Evans, 2004) where between 15%-35% of sampled adolescents self-identify as having engaged in some form of self-harming behaviours (Gratz, 2006; Laye-Gindhu & Schonert-Reichi, 2005). Thus, it would not be surprising that children and youth in the child care welfare sector may also engage in self-harming behaviours.

To address this concern, the Children's Aid Society of Toronto has closely tracked the number of self-harming incidences of children/youth in care since the year 2000. As a requirement of the Ontario Ministry of Child and Youth Services, all incidences of serious occurrence events must be recorded and documented through the Serious Occurrence Report

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(SOR). An accumulation of data over the years has allowed the Children's Aid Society of Toronto to examine the profile of children and youth in care who engage in self-harming behaviours (Goodman, 2005). However, what remains relatively unclear is whether these patterns are similar across cultures. Given the heterogeneous composition of Toronto's ethno-cultural communities, cross-cultural comparisons are particularly important given the possible intervention implications this information can have. The purpose of this paper is to begin to examine whether cultural differences in self-harming behaviours exist in children and youth in child welfare care. It is suggestive, therefore, of areas of research need, including the importance of considering the context of youth risk behaviours. Specifically, we examined the amount, type and methods of self-harming incidents in children and youth in care who have minority status relative to children and youth in care who do not have minority status.

Culture and its Effects on Suicidal and Self-harming Behaviours

Research in the area of self-harm has been rather limited in that researchers have had difficulties conceptualizing and defining behaviours that are associated with self-harm. Thus, efforts to describe characteristics associated with children and youth who engage in self-harming behaviours have been inconsistent. Similarly, studies examining cultural influence on self-harming behaviours are virtually non-existent, as researchers have focused primarily on suicidal intent and behaviours (Farooqi, 2004). However, given the strong association between suicide and self-harm (Goldston, 2000), similar cross-cultural differences may also emerge with respect to self-harming behaviours.

Drawing from cross-cultural literature on suicide, there are several reasons to suspect that culture may affect self-harming behaviours in different ways. First, research seems to suggest that the rate of suicide may differ across cultures. For instance, cross-cultural comparisons suggest that relative to a Pakistani sample, Americans reported more suicide attempts, multiple suicide precipitants and higher degree of suicide potential (Farooqi, 2004). Similarly, when compared to non-native populations, the suicide rate amongst First Nations peoples is 3-5 times higher (e.g., Kirmayer, 1994). Culture also appears to influence the methods by which individuals engage in suicidal behaviours. For example, when compared to their North American counterparts, Indian immigrant groups report significantly higher rates of suicide by burning (Raleigh & Balarajan, 1992). Taken together, these observations seem to raise the possibility that suicidal behaviours may differ across cultural groups were culture may play an instrumental role in conceptualizing and defining the meaning of suicidal behaviours.

Although self-harm may not necessarily encompass suicidal intent and behaviours, it nevertheless suggests that cultural differences may also exist with respect to self-harming behaviours. Especially since culturally-defined social taboos and religious sanctions conceptualize suicide differently across cultural groups (Farooqi, 2004), these cultural norms may affect how self-harming behaviours are perceived, expressed and understood. To explore this possibility, the goal is to begin to examine the intersection between self-harm and culture through an analysis of self-harming behaviours in minority and non-minority children and youth who are involved with child welfare services. Data from SORs collected during the year 2005 at the Children's Aid Society of Toronto were analysed. Given the exploratory nature of this area, the primary intent is to describe possible group differences between minority and non-minority children and youth in care in the amount, type and method of self-harming behaviours.

First, with respect to the frequency and types of self-harming incidents (i.e., threat to self harm and attempts to self harm), it remains unclear as to whether cultural differences will emerge. Current analyses, therefore, is exploratory in nature. Secondly, given that cultural norms and expectations may in some ways define appropriate behaviours, cultural differences were expected to emerge with respect to the methods used to self-harm.

Preliminary Findings from the Children's Aid Society of Toronto's 2005 Analysis of SOR Data

Methodology

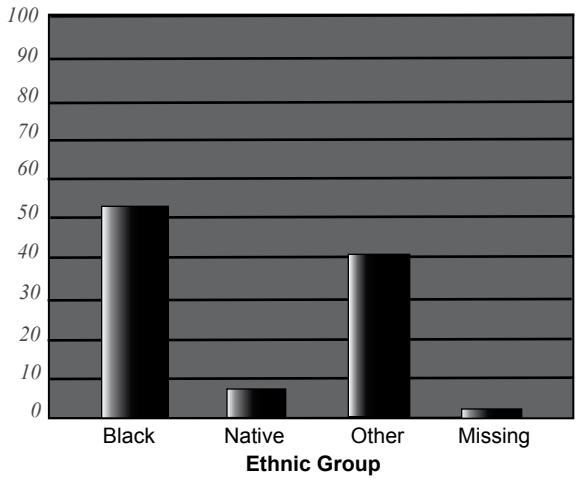
Data from Serious Occurrence Reports (SOR) collected during the year 2005 by the Children's Aid Society of Toronto were analyzed. SORs are completed by the child's worker and submitted to the Ontario Ministry of Child and Youth Services. These reports cover a range of situations with one of them being a self-harming incident or threat to self harm. A total of 72 SORs from children and youth where identified as those with one self-harming incident (including both attempts and threats to self harm). These children and youth represent 75% of the total sample collected by the Children's Aid Society of Toronto during the year 2005. The remaining quarter (excluded from the current analysis) represent children and youth who have engaged in multiple instances of self-harming behaviours. Of the 72 SOR reports used in this study, 38 were from non-minority youth (M age = 15 yrs) and 34 from minority youth (M age = 14 yrs).

Non-minority participants included those who were of European-American heritage. Minority participants included those who were from other ethnic or cultural backgrounds. Of our minority sample, 52% were Black, 6% were Native, 40% were "other" (i.e., Asian, Hispanic, mixed) and 2% whose information was missing (refer to Figure 1). More specifically, a large proportion of minority participants who were categorized as 'other' represent children and youth who are bi-racial with some First Nations ancestry. Minority and non-minority status participants were roughly matched in age and gender.

Results

Data was first explored for cross-cultural differences in the number of self-harming behaviours

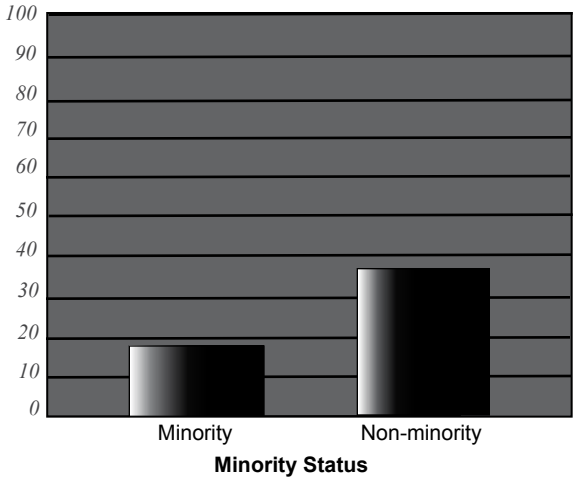
Figure 1: Cultural distribution of minority status participants.



reported by minority and non-minority youth. Specifically, we examined whether cultural differences existed with respect to the number of self-harming attempts and threats that were reported. A two-way contingency table analysis was conducted to evaluate whether minority and non-minority children and youth in care differed in the number of self-harming attempts or threats. The two variables were minority status with two levels (minority vs. non-minority status) and SOR type with two levels (attempt vs. threat). Minority status and number of attempts, Pearson $\chi 2(1, N = 72) = .00$, $p = .99$ and threats, Pearson $\chi 2(1, N = 72) = .00$, $p = .96$ were not significantly related. This suggested that minority and non-minority children and youth in care did not differ in the number of self-harming attempts or threats that are reported.

We were also interested in whether differences existed in how minority and non-minority youth in care engaged in self-harming behaviours. The specific behaviours examined included number of cutting (including scratching and stabbing), head banging and punching, choking or hanging, overdose (with medicine or poison), jumping (e.g., out of cars or windows) and other types of harm. A two-way contingency table analysis was conducted to examine whether minority status was associated with frequency of self-harming attempts. The two variables were minority status with two levels (minority vs. non-minority) and type of self-harming attempt with six levels (cutting, head banging and punching, choking or hanging, overdose, jumping and other). There was a trend for minority status to be related to attempts of cutting, scratching and stabbing only, Pearson $\chi 2(1, N = 72) = 3.30$, p

Figure 2: Percentage of minority and non-minority children and youth who engaged in cutting.



= .07. The proportions of minority and non-minority children and youth in care who engaged in cutting behaviours during a self-harming episode were 18% and 37% respectively (refer to Figure 2). Minority status was not significantly related to other types of self-harming attempts. Results suggest that when compared to minority children and youth in care, non-minority children and youth in care were more likely to engage in cutting behaviours when attempting to self harm. No other differences in self-harming attempts are evident.

Finally, we examined whether minority and non-minority children and youth in care differed in the amount of self-harming threats reported. Number of cutting (including scratching and stabbing), head banging and punching, choking or hanging, overdose (with medicine or poison), jumping (e.g., out of cars or windows) and other types of threats were examined. A two-way contingency table analysis was conducted to examine whether minority status was related to frequency of self-harming attempts. The two variables were minority status with two levels (minority vs. non-minority) and type of self-harming threats with six levels (cutting, head banging and punching, choking or hanging, overdose, jumping and other). Across all types of self-harming threats, minority status was not found to be significantly related to any of the behaviours. These results suggest that despite differences in minority status, how children and youth in care threaten to self-harm did not differ.

Implications for Practice and Directions for Future Research

Preliminary evidence presented in this paper suggests that although minority and non-minority children and youth in care did not differ in the number of self-harming incidence for both attempts and threats, culture may affect how children and youth in care engage in self-harming behaviours. That is, when attempting to self harm, non-minority children and youth in care were more likely to cut, scratch or stab themselves when compared to their minority counterparts. There is no evidence to suggest that minority and non-minority children and youth in care differed in other methods of self harm. In the following section, each of these observations will be examined followed by a discussion of how these findings can impact on practice and future research.

Culture and Amount and Type of Self-harming Behaviours

The analysis did not find any evidence to suggest that minority and non-minority youth differ in the amount of self-harming behaviours. That is, the number of self-harming attempts and threats were similar between groups. Perhaps these similarities were seen given the demographics of our sample. For instance Gratz (2003) argues that childhood abuse and neglect is a major contributor to the risk of self-harming behaviours since it may relate to the development of emotion disregulation. Given their involvement with the Children's Aid Society of Toronto, it is highly probable that a large percentage of our sample experienced some form of abuse or neglect. Thus, despite differences in cultural background and ethnicity, the experience of childhood abuse or neglect may have placed these children at greater risk for self-harm. An interesting avenue for future research would be to examine possible cultural differences in a community sample of youth who self-harm, as well as different cultural communities, including various Aboriginal youth groups. This will help to describe the nature of self-harm in these communities, as well as lay the groundwork for efforts to tease apart the affects of abuse and culture on self-harm.

Culture and the Types of Self-harming Behaviours

Another interesting and important observation that emerged from this analysis is that non-minority and minority children and youth in care appear to dif-

fer in the how they engaged in self-harming behaviours. That is, relative to their minority peers, non-minority children and youth in care were more likely to engage in cutting, scratching or stabbing behaviours. Although statistically this effect was marginally significant, it nevertheless suggests that there may be some preliminary evidence that culture can affect the strategies selected by children and youth in care when engaging in self-harming behaviours.

Perhaps cultural differences seen in cutting behaviours across groups may be related to culturally defined norms and rules. Although it remains unclear as to why these cultural differences were observed, it may be possible that in other cultures, cutting is not conceptualized as self-harming behaviour, nor is it as stigmatized. In some cultures, there is a long history of body cutting and modification that have social significance. For instance, the Bafian tribe of Cameroon hold that being scarred is a way in which tribal members are distinguished from other animals. Alternatively, there may be specific cultural or religious repercussions associated with cutting, scratching or stabbing. For example, as part of the Hinduism doctrine, purposeless mortification of the body is seen as a sign of weakness. Given these cultural differences in how body cutting is conceptualized, minority youth may be more likely to engage in other maladaptive coping behaviours other than cutting during self-harming incidents. Although highly speculative, our observation encourages more research in exploring the cultural meanings associated with different self-harming strategies.

Implications for Practice and Research

Perhaps the most important contribution this paper has to the self-harming literature is the suggestion that self harm may be a universal phenomenon that can be situated along the continuum of risk-taking behaviours common to childhood and adolescence development. Clinically, it would seem of increasing relevance to child protective services populations. Despite differences in cultural background, certain children and youth in care of child protection services appear to engage in some form of self-harming behaviours. Although it remains unclear as to the motives underlying these self-harming episodes, results from the present study underscore the importance of continuing to understand how self-harm is conceptualized by children and youth in care. Most importantly, preliminary results from this study highlight the importance of understanding self-harm within a cultural context. Specifically, more research is required to understand which youth engage in self-harming behaviours, why, and how serious self-harming behaviours are perceived by different cultural community. Lastly, for clinicians working with self-harming individuals, observations presented in this paper shed light into how the profile of self-harm may be different across cultural groups. For instance, depending on cultural norms and values, certain methods of self-harm may be more prevalent in some communities then others. This knowledge can help guide practice and development of effective intervention strategies that are culturally sensitive to the specific needs of these individuals. Although more research is needed to identify the specific needs across cultures, this study emphasizes the importance of this avenue of research.

Given the increasing heterogeneous composition of Toronto's population, examining how culture can affect self-harming behaviours is imperative for clinical practice. However, there are some limitations that must be acknowledged. First, considering that this sample was predominately maltreated children in the care of Children's Aid Society of Toronto, the effects of abuse and culture were confounded. Thus, future research should aim at including a community sample controlling for abuse to examine the specific effects of culture on self-harm. Similarly, we did not distinguish between specific cultural groups in our analysis, due to our limitations in sample size by cultural group. Considering that the effects of culture may impact on self-harm in different ways across groups, future study should also consider comparing the profile of children and youth who engage in self-harming behaviours across different cultures. Nevertheless, this study represents a first step towards identifying the specific needs of various cultural groups of youth with childhood maltreatment histories so that appropriate interventions can be developed to prevent self-harm.

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