Self-injury in people with intellectual disability and epilepsy: A matched controlled study

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A B S T R A C T

We aimed to identify the presence of self-injurious behavior in a sample of 158 people with intellectual disability and epilepsy as compared with a control sample consisting of 195 people with intellectual disability without epilepsy. The Italian Scale for the Assessment of self-injurious behaviors was used to describe self-injurious behavior in both groups. The groups were matched for ID degree: mild/moderate (20 and 20 respectively), severe/profound (45 in both samples) and unknown (4 in both samples). Seventy-four percent of the first sample were diagnosed with symptomatic partial epilepsy.

The prevalence of self-injurious behaviors was 44% in the group with intellectual disability and epilepsy and 46.5% in the group with intellectual disability without epilepsy (difference not significant).

The areas most affected by self-injurious behaviors in both samples were the hands, the mouth and the head. The most frequent types of self-injurious behaviors were self-biting, self-hitting with hands and with objects.

Self-injurious behavior is frequently observed in individuals with epilepsy and intellectual disability.

Our study does not suggest that the presence of epilepsy is a risk factor for self-injurious behavior in this patient group.

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1. Introduction

Intellectual disability (ID) is currently defined as: “characterized by significant limitations both in intellectual functioning and adaptive behavior as expressed in conceptual, social and practical adaptive skills. This disability originates before age 18”.1 Some individuals with ID develop behavioral disorders, characterized in a proportion by: violent outburst of anger and stereotypical or self-injurious behavior (SIB).2–4 The most commonly used definition5 of SIB is based on descriptive criteria, in which behaviors are described as leading to self-inflicted damage on tissue, immediately or cumulatively. There are varying types of SIB that involve many parts of the body. Rojahn6 reported that the most common forms of SIB associated with ID are self-biting, head-hitting and self-scratching. The prevalence of SIB was higher in people with severe ID. Kahng et al.7 identified the most common forms of SIB as: head hitting with objects or hands (49%), self-biting (30%), pica (7.8%), self-scratching (5.7%), hair-pulling (4.5%), eye-hitting (4.2%), skin-picking (2.3%) and bruxism (0.7%).

Impaired cognitive function and associated ID are common in people with epilepsy8; the degree of impairment can vary due to a wide range of factors including, for example, epilepsy syndrome. Furthermore, behavioral disorders are more frequent in people with epilepsy than in the general population.8 Behavioral changes that can occur in association with epilepsy include physical and verbal aggression, mood changes, social disinhibition and SIB.10

In a study of individuals with ID,11 11% showed aggressive behavior, 34% of whom showed SIB. A recent study12 found that a high proportion (60.4%) of adults with ID showed at least one behavioral disorder with varying degrees of severity or frequency. Severe behaviors were frequently found in 18% of subjects presenting with aggression, destructiveness and self-injury; whereas 6% had tantrums. The occurrence of severe behavioral disorders was significantly associated with gender (female), severity of ID and the presence of epilepsy.

Extreme self-injury, such as head-banging, skin-gouging and self-biting in people with ID is often persistent, responding poorly