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Attitudes Towards Self-Harm

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Abstract

In recent years, research with a concentration on self-harm has begun to surface. Most of this research focuses on methods and functions of self-harm, mental health disorders associated with self-harm, and attitudes towards self-harm from the perspective of others. However, self-harm research that focuses on examining attitudes towards people who self-harm is lacking. More specifically, research is limited on those who self-harm and their attitudes toward someone else who self-harms. The current study sought to fill this gap by examining how the level of familiarity with self-harm affects a person's attitudes towards self-harm and if there are differences between the attitudes of people who have self-injured and people who have not. Participants consisted of 110 people who have self-injured and 45 people who have not self-injured (M_{age} = 28.39, *SD* = 11.94; 83% Caucasian). Results revealed that the more familiarity an individual has with self-harm, the less likely they are to endorse certain negative attitudes towards another person who engages in the behavior. Results also revealed a difference in attitudes between those who self-harm and those who do not, such that those who self-harm report more positive and less negative attitudes towards someone who self-injures. These results suggest that familiarity with self-harm may impact attitudes towards a person who self-injurers and a difference in attitudes between people who have self-injured and people who have not exists. Implications and future directions are included for discussion.

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Chapter I: Literature Review

Self-Harm Overview

Over the past decade, research has begun to focus more on a behavioral phenomenon known as self-injury. According to Glenn and Klonsky (2009), non-suicidal self-injury (NSSI) can be defined as "the deliberate, self-inflicted destruction of body tissue without suicidal intent for purposes not socially sanctioned" (p.25). Ammerman, Jacobucci, Kleiman, Uyeji, and McCloskey (2017) noted that the typical onset of self-harm has been thought to occur in adolescents, but research suggests a wide variation of ages. As stated in Heath, Toste, Nedecheva, and Charlebois (2008), the onset of self-harm may occur as early as 11-years-old, but some individuals might experience their first incident over the age of 20. Non-suicidal self-injury is not the only name given to this type of behavior. It has also been referred to as self-mutilation (Hicks & Hinck, 2008), parasuicide (Ogundipe, 1999), deliberate self-harm (Gratz, 2001), self-injurious behavior (Herpertz, 1995), and self-wounding (Husband & Tantam, 2004) among other names. Despite there being various names to represent this single behavior, they each refer to a person inflicting intentional and deliberate harm to his or her body. Furthermore, NSSI is a behavior considered to be socially unacceptable (differing from behaviors such as getting tattoos or bodily piercings), direct (as oppose to indirect self-harm behaviors like drinking and driving), repetitive, and results in minor or moderate harm (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007).

Not only does this behavior have numerous names, but as many as 14 different types of self-harm have been recognized (Glenn & Klonsky, 2009). Each type ranges in different levels of

severity. Lloyd-Richardson et al. (2007) classified some of these types into two distinct categories depending on severity: moderate/severe (i.e., cutting/carving, burning, self-tattooing, scraping, and erasing) and minor (hitting and biting self, pulling hair, inserting objects under nails or skin, wound picking, and picking at areas of the skin in order to draw blood). Cutting (i.e., the use of sharp objects such as knives, razor blades, scissors, etc. to penetrate and damage the skin) has been identified as the most common form for those who engage in self-harm with hitting and burning following close behind (Klonsky, 2007). As stated in Rosen and Heard (1995), any part of the body may be susceptible to self-harm, but the arms and wrists are often the primary part of the body individuals target for this behavior. In addition, Whitlock, Eckenrode, and Silberman (2006) concluded that females are more likely to target their wrists and thighs whereas males are more likely to injure their hands. It is important to consider the area of the body that has been injured because locations such as the face, eyes, neck, breast, or genitals may indicate psychological disturbance of a greater nature than if other parts were injured instead (Whitlock, 2010).

Self-harm is commonly seen among people with mental health difficulties such as depression, borderline personality and other personality disorders, anxiety, substance abuse, eating disorders, posttraumatic stress disorder, and schizophrenia (Klonsky, 2007). Although self-harm has been known to be a symptom of mental health disorders, it is not yet its own separate disorder in the Diagnostic and Statistical Manual for Mental Disorders (DSM-5; APA, 2013). Self-harm has often times been categorized in with other mental health disorders and suicidal behaviors. According to Zetterqvist (2015), if self-harm is not separated from suicidal behaviors, it can lead to incorrect case conceptualization, risk assessments, and treatments. Kahan and Pattison (1984) proposed self-harm to be classified as a separate disorder known as

deliberate self-harm syndrome in the previous version of the Diagnostic and Statistical Manual for Mental Disorders, but their arguments were not enough to get it added as a disorder. Muehlenkamp (2005) and Shaffer and Jacobson (2009) also proposed that self-harm is its own clinical syndrome. Each of these authors suggested diagnostic criteria, typical patterns of the behavior, functional impairments due to the behavior, and other features for consideration (Zetterqvist, 2015). Despite their arguments for a standalone disorder classification, self-harm remains in the "conditions for further study" category of the DSM (APA, 2013, p. 783).

Self-harm is a prevalent problem occurring in a number of populations, both clinical and nonclinical. Nock and Prinstein (2004) examined self-harming behaviors in 89 inpatient adolescents and found that 82.4% reported instances of self-harm. Another study focusing on a clinical sample indicated that 21% of the 390 participants engaged in self-harming behaviors (Briere & Gil, 1998). As previously mentioned, not only does self-harm occur in clinical populations, it also can be seen in nonclinical ones as well. It has been found that around 4% of the general population has engaged in self-harming behaviors (Briere & Gil, 1998). Gratz (2001) concluded that 35% of college students reported at least one incident of self-harm in their lifetime whereas Whitlock, Eckenrode, and Silverman (2006) determined that 17% of college students engaged in self-harming behavior, ranging from mild to severe. In a study focusing on military recruits, approximately 4% of participants admitted to having a history of self-harm (Klonsky, Oltmanns, & Turkheimer, 2003).

Attitudes towards Self-Harm: Others' Perspectives

When examining the attitudes toward self-harming behavior, many research studies have focused on the attitudes of those in healthcare services (i.e., medicine, nursing, emergency staff, etc.) because they typically treat the individual's self-inflicted cuts, burns, or other wounds.

According to Brophy and Holmstrom (2006), initial responses from the medical staff can be a determining factor in whether or not the self-injurer will continue with and seek future services. When seeking medical attention, it is common for it to be the first time a self-injurer has disclosed their self-harming behavior, and thus, the perspective of those in healthcare services is of particular interest (Cleaver, Meerabeau, & Maras, 2014). For example, by using eight different databases to collect information and following PRISMA guidelines, Rayner, Blackburn, Edward, Stephenson, and Ousey (2018) conducted a meta-analysis to examine this specific interest. Any papers with the focus of self-harm and emergency department staff as participants were included in this systematic review. The Self-Harm Antipathy Scale (SHAS) and the Attitudes Towards Deliberate Self-Harm Questionnaire (ADSHQ) were used in the outcomes of the studies included. The results showed that there exists some level of negative attitudes and antipathy towards self-injurers; however, the results were not indicative of extremely high negative attitudes or predominately negative antipathy levels (Rayner et al., 2018).

Cleaver, Meerabeau, and Maras (2014) used a mixed methods approach to collect data through survey and semi-structured interview methods in order to determine attitudes of staff towards people who engage in self-harm. Participants included 143 nurses and doctors who were asked to complete the Attitudes Towards Young People (ATYP) and Attitudes Towards Young People who Self-Harm (ATYPSH) scales. The findings determined that practitioners' attitudes towards self-injurers are more positive than their attitudes towards young people in general which suggests that practitioners' attitudes towards those who self-harm were influenced by the immaturity of young people, meaning they feel as though young people are too immature to understand the implications of their self-harming behaviors (Cleaver, Meerabeau, & Maras, 2014). Another research study conducted a literature review in four databases, resulting in the

use of 15 articles to further explore nurses' attitudes towards self-harm (Karman, Kool, Poslawsky, & van Meijel, 2014). The authors concluded that attitudes, both positive and negative, exist towards self-harm; however, ten out of the 15 articles reported overall negative attitudes.

Not only have the attitudes of healthcare staff been explored, parental attitudes have also been examined, although the research is limited in this area. It is equally important to study the attitudes of parents because self-harm can impact parents and families and affect parenting behaviors (Baetens et al., 2014). Ferrey and colleagues (2016) set out to explore the effects of self-harm on parents and families by thematic analysis of semi-structured narrative interviews with 37 parents. The interviews consisted of open-ended questions about parental experiences with the self-harming behaviors of their child followed by additional questions to gain more information. Several findings were concluded: 1) shock, anger, and disbelief were among the initial responses experienced by parents, 2), anxiety, stress, depression, and guilt were other emotions felt by parents, 3) parents reported withdrawal from social contact because of the stigma associated with self-harm, 4) parents stated that siblings felt levels of stress, worry, and sadness about how their classmates perceived their sibling's self-harm behavior, but siblings were supportive, and 5) conflicts between availability to their child and work arose which impacted family finances (Ferrey et al., 2016). Furthermore, the results reported by Ferrey et al. (2016) indicated that parents were optimistic and hopeful about their child's future. Another research study examined the attitudes and reactions of parents, specifically mothers, of children who engaged in self-harm behaviors. McDonald, O'Brien, and Jackson (2007) interviewed six mothers and one father who all had adolescents between the ages of 12 to 21 that had engaged in self-harming behaviors. The interview consisted of open-ended questions and was conducted in

an informal, conversational way. After transcribing all interviews, the authors identified common themes present throughout the interviews. The results indicated that parents had initial reactions of guilt, shame, and embarrassment, parents felt that their children engaged in self-harm as a result of emotional fallout from their parents' lives or other family hardships (i.e., limited contact with another parent, divorce, etc.), and parents reported feeling they had not been caring enough as a result of their guilt (McDonald, O'Brien, & Jackson, 2007). In other words, it appears that parents often blame themselves for their child's self-harming behavior to some extent.

In sum, it is clear that healthcare staff attitudes are of the utmost importance when self-injurers seek medical attention for their self-harming behaviors. Research focusing on the attitudes of those in healthcare services has demonstrated that healthcare providers might experience negative attitudes towards self-injurers, but do not have overly negative or express high antipathy towards these individuals. There also appears to be evidence that some nurses experience positive attitudes towards those who engage in self-harm. In regards to parental attitudes towards self-harm, research suggests that parents have feelings of guilt, shock, stress, etc. when initially finding out about their child's self-harming behavior. However, research has also indicated that parents are optimistic about their child's future.

Attitudes towards Self-Harm: Perspective of Self-Injurer

It is important to not only get the perspective of others, but also the perspective of individuals who engage in this behavior. Since this behavior typically manifests at a younger age, as noted earlier, it is equally as important to examine the attitudes of adolescents on self-harm. As stated in Ystgaard et al. (2009), adolescents are likely to seek out help from their peers who are also more likely to have previously or currently engaged in self-harm. Doyle (2018) conducted a cross-sectional survey that used the Lifestyle and Coping survey, a 96-item self-

report survey, to examine and explore the attitudes of adolescents on self-harming behavior. Participants included 856 students from 11 post-primary schools in Ireland who were between the ages of 15 and 17-years-old. The participants included those who self-harmed and those who did not. Overall, a majority of participants agreed that self-harm could have been prevented and individuals who engage in this behavior experience loneliness and depression (Doyle, 2018). Furthermore, the findings showed a significant difference of attitudes between those who self-harmed and those who did not. Those who engaged in self-harm were more likely to believe the behavior was impulsive rather than attributed to loneliness and depression and less likely to believe that the behavior was attention-seeking (Doyle, 2018). This study provides evidence that there exists a difference between the attitudes of those who self-harm and those who do not on certain aspects of the behavior. However, this study focused on participant attitudes' toward the cause of the behavior and not on attitudes toward the person who self-harms.

Other research studies have explored attitudes of self-harm within prison populations by examining prisoner perspectives on the behavior as well as the staff's views. Kenning et al. (2010) investigated the views on self-harm in a qualitative study by conducting semi-structured interviews with women prisoners who have self-harmed and the staff at the prison. In order to be included in this study, women prisoners must have had an incident of self-harm two weeks prior to the interview, which resulted in 15 women prisoners. Kenning et al. (2010) believed this time frame would allow the women to clearly recall their specific feelings and experiences during the incident. The staff of the prison included those from the discipline staff, health care staff, and governing staff, resulting in 15 staff participants. The interviews were transcribed verbatim and discussed with professionals with backgrounds including primary care, psychology, and psychiatry. Thematic categories were classified and agreed upon, and coding was conducted with

thematic analysis. From the perspective of the women prisoners' on their self-harming behavior, the results concluded: 1) "the women prisoners described incidents of self-harm as impulsive, unstoppable acts related to intense feelings of anger, hurt and frustration, over which they had little or no control," 2) self-harm is used as a coping mechanism for their emotions, a way to punish themselves, as a pain and frustration reliever, or a combination of any of these, 3) the women attributed their self-harm to factors such as outside (i.e., past sexual abuse, domestic violence, neglect, etc.) and current situation (i.e., features associated with life in prison), and 4) the women perceived overall positive care and treatment from healthcare staff, but felt as though prison officers had negative attitudes towards them (Kenning et al., 2010, p. 278-280).

In regards to the staff attitudes, results showed: 1) healthcare staff identified stressors of the prison environment as factors for self-harm, whereas prison officers did not suggest the prison environment was a factor, but rather past abuse, domestic violence, and other related factors were the cause of self-harm, 2) prison officers attributed the function of self-harm as a way to manipulate and gain attention while the healthcare and governing staff identified the function as a way of coping and emotional release, 3) prison officers labeled self-harm as genuine (i.e., self-harm attributed to a mental illness and deserved helped) and non-genuine (i.e., self-harm used for manipulative purposes and did not deserve help), but healthcare and governing staff did not make this distinction and demonstrated more tolerance to self-harm, and 4) prison officers reported negative attitudes towards women prisoners who engage in self-harming behavior and recognized this can affect the treatment the women receive from them, and the healthcare staff reported that prison officers display negative attitudes towards the women (Kenning et al., 2010).

In addition, another research study involving women prisoners focused on their attitudes towards their self-harm and scarring as well as the use of medical skin to camouflage the scars left behind. According to Burke, Hamilton, Cohen, Stange, and Alloy (2016), it is important to examine the effects of scarring resulting from self-harm because the presence of scars and a higher number of scars are associated with a stronger level of suicidal ideation. Gutridge et al. (2018) conducted a qualitative research study that used an exploratory focus group of women prisoners which was a part of a larger pilot study. The participants included 10 women currently in a prison located in England who had a history of self-harm, were currently engaging in the behavior, and had scarring from their self-harm. Those who were considered to be too distressed, experiencing psychosis, or posed a potential risk of physical harm to the researcher were excluded from the study. The focus group was facilitated by experienced researchers in self-harm who used a topic guide to gather information about the women's' feelings, attitudes, experiences, and effects of self-harm. Recordings of the focus group were transcribed, coding was developed from the transcripts, and a thematic analysis was conducted. The results are as followed: 1) participants reported feelings of embarrassment, frustration, and anger and a lack of confidence as a result of self-harm scarring, 2) the women stated that the scars often reminded them of "bad times" in their lives, 3) participants expressed a sense of worry that others will perceive and judge them as attention-seeking or "crazy," 4) the women showed interest in covering their scars during social situations, and 5) participants had overall positive feelings about using the medical skin to camouflage their scars (Gutridge et al., 2018).

In sum, examining the attitudes of those who engage in self-harming behaviors is equally as important as studying the attitudes on non-self-injurers. In adolescents, there is evidence that supports a difference in attitudes between those who self-harm and those who do not. Adolescent

self-injurers indicated that self-harm is due to impulsivity rather than feelings of loneliness or depression, but prevention of self-harm is often agreed upon by both those who self-harm and those who do not. When studying self-harm in women prisoners, it has been found that feelings of embarrassment, anger, frustration, and impulsiveness occur as a result of self-harm and scarring. Also, how others perceive them is a concern for women who self-harm. Some self-injurers express interest in ways to cover up their self-injuries and scars. Furthermore, evidence suggests that self-harm acts as a coping mechanism and a function of emotional expression.

The Current Study

When examining attitudes towards self-harm, past research has primarily focused on the perspectives from others, mainly those in healthcare professions. As previously mentioned, Rayner and colleagues (2018) found that emergency department staff experience levels of negative attitudes and antipathy towards self-injurers. Karman et al. (2014) indicated that both positive and negative attitudes towards self-harm occur in nurses, but overall, it appears negative attitudes are more predominant. In addition, Law, Rostill-Brookes, and Goodman (2009) explored the attitudes of healthcare and non-healthcare students by presenting a vignette depicting a young woman who engages in self-harm behavior. One of the results indicated higher levels of positive attitudes (i.e., sympathy, less anger and anxiety, lower levels of perceived risk, coercion, and segregation, and higher levels of helping behavior) were associated with a greater level of familiarity with self-harm (Law et al., 2009). This finding suggests that the more familiarity one has with self-harm, the more likely one is to have positive attitudes towards the self-injurer. Therefore, the current study expanded on this finding and additionally explored whether or not the level of familiarity was associated with positive attitudes towards self-harm in those who self-injure and those who do not which was lacking in previous research.

When asking individuals who self-harm about the behavior, research studies focus on identifying functions, risk factors, feelings, and other related areas. For example, Klonsky (2007) identified seven functions of self-harm (i.e., affect regulation, anti-dissociation, anti-suicide, interpersonal boundaries, interpersonal-influence, self-punishment, and sensation-seeking). Kenning et al. (2010) discovered that self-harm functions as a coping mechanism, emotional regulation, and self-punishment which provides further support for the functions identified in Klonsky (2007). Women prisoners reported feelings of embarrassment, anger, and frustration (Gutridge et al., 2018). However, there appears be few studies that ask self-injurers about their attitudes towards others who engage in this behavior. Therefore, the current study aimed to address this directly by assessing attitudes towards self-injurers of those who self-harm and those who do not. In other words, the current study was not focusing on the self-injurers' attitudes towards their own self-harming behavior, but rather their attitudes towards an individual who engages in similar behavior as their own. As noted earlier, adolescents who self-harm were likely to seek help from others their age who were also more likely to have previously or currently engaged in self-harming behaviors (Ystgaard et al., 2009). Therefore, it is also important to look at various ages and their attitudes toward self-harm because this finding might be consistent across all ages. It is important to get an understanding of how those who self-harm might respond to someone who also self-harms. The current study also included non-self-injurers in order to investigate potential differences between the attitudes of those who self-harm and those who do not.

Hypotheses

For the current study, it was hypothesized that one's level of familiarity with self-harming behaviors would significantly affect a participant's attitudes towards an individual who

engages in self-harm. Specifically, it was hypothesized that those who have lower levels of contact with self-harm would be more likely to have negative attitudes and endorse domains such as blame, anger, dangerousness, fear, avoidance, segregation, and coercion on the Attribution Questionnaire (AQ-27; Corrigan et al., 2003) with lower scores on pity and help, whereas those who have higher levels of familiarity with self-harm would be more likely to have higher scores on the help and pity domains of the AQ-27 and lower scores on the other seven domains, indicating more positive attitudes. It was also hypothesized that those who have engaged in self-harm would significantly differ from those who have not engaged in this behavior. Specifically, those who have engaged in self-harm would endorse higher scores on the help and pity domains, indicating more positive attitudes, whereas those who have never engaged in self-harm would endorse the other domains (i.e., blame, anger, dangerousness, fear, avoidance, segregation, and coercion), indicating more negative attitudes. Two vignettes depicting characters, Mary and Sally, with self-harming behavior prompted by different causal factors were used in this study in order to assess attitudes toward someone who engages in self-harming behavior for internal versus external reasons.

Chapter II: Methods

Participants and Procedure

In this study, participants were recruited online from Reddit, a popular network of communities where users can discuss, post, and vote on content based on their interests. Participants were recruited through "r/depression," "r/BPD," and "r/StopSelfHarm" discussion forums on Reddit. These forums are open to those who suffer from depression, borderline personality disorder, or self-harm, family members and friends who know someone with these difficulties, and those who have never engaged in self-harm. As previously mentioned, self-harm is a common symptom among mental health disorders such as depression and borderline personality disorder (Klonsky, 2007), and therefore, these forums were deemed appropriate for this study.

The original sample consisted of 228 participants; however, due to incomplete surveys, 73 were removed. Thus, the final sample of 155 was used in the current analyses. The current study included those who have engaged in self-harming behavior (n = 110, 71%) and those who have not (n = 45, 29%). Consistent with previous research, cutting was the most common form of self-harm with 101 participants (65%) endorsing this behavior (See Table 1).

The mean age of participants was 28 (SD = 11.94), with ages ranging from 18 to 66 years old. The majority of participants identified as Caucasian (83.2%) with others identifying as African American (0.7%), Hispanic (4.5%), Asian (3.2%), Alaskan/Pacific Islander (0.7%), Multi-racial (6.5%), and Other (1.3%). The majority of the sample identified their gender as female (66.5%) while 29% identified their gender as male and 4.5% as other. In regards to

Table 1

Total Number of Participant Endorsements for the Deliberate Self-Harm Inventory (DSHI)

DSHI Items	Total Sample (n = 155) n (%)
Cut your wrist, arm, or other area(s) of your body (without intending to kill yourself)	101 (65.16)
Burned yourself with a cigarette	20 (12.90)
Burned yourself with lighter or match	48 (30.97)
Carved words into skin	42 (27.10)
Carved pictures, designs, or other marks into your skin	30 (19.35)
Severely scratched yourself, to the extent that scarring or bleeding occurred	83 (53.55)
Bit yourself, to the extent that you broke skin	44 (28.39)
Rubbed sandpaper on your body	10 (6.45)
Dripped acid onto your skin	1 (0.65)
Used bleach, comet, or oven cleaner to scrub your skin	7 (4.52)
Stuck sharp objects such as needles, pins, staples, etc. into your skin, not including tattoos, ear piercing, needles used for drugs, or body piercing	49 (31.61)
Rubbed glass into your skin	12 (7.74)
Broken your own bones	1 (0.65)
Banged your head against something, to the extent that you caused a bruise to appear	36 (23.23)
Punched yourself, to the extent that you	52 (33.55)

caused a bruise to appear	
Prevented wounds from healing	66 (42.58)
Done anything else to hurt yourself that was not asked about in this questionnaire	54 (34.84)

Note. Percentages do not sum to 100 as participants could endorse more than one type of self-harm.

highest level of completed schooling, participants reported completing some high school (2.6%), high school/GED (16.1%), some college (39.4%), college (29.7%), some graduate school (5.2%), and graduate school (7.1% The most commonly endorsed item on the Level of Contact report was "I have self-harmed" (68.4%; See Table 2).

Participants from the aforementioned Reddit forums who were interested in participating in this study were directed to the online survey where they were given a brief overview of the study and then asked to provide informed consent (see Appendix A). Once consent was provided, participants were asked to read two vignettes that each depict a young woman who engages in self-harming behavior. After reading the first vignette, participants completed the Attribution Questionnaire (AQ-27; Corrigan et al., 2003). Participants were then asked to read the second vignette and complete the same measure. These vignettes were counterbalanced such that approximately half of the participants read the vignette about "Mary" (i.e., abuse vignette) first followed by "Sally" (i.e., drug misuse vignette) and the other half read them in the opposite order. After reading the two vignettes, participants were asked to complete a series of measures including the level-of-contact report for measuring their level of familiarity, the Marlowe-Crowne Social Desirability Scale-Short Form (MCSDS-SF; Reynolds, 1982), and a demographic questionnaire, described below. Once all measures were completed, participants were thanked

Table 2

Demographic Variables of Sample

Variables	Total Sample (n = 155) *M*(*SD*) / *n* (%)
Age	28 (11.94)
Gender	
Female	103 (66.45)
Male	45 (29.03)
Other	7 (4.52)
Ethnicity	
White/Caucasian	129 (83.23)
African/African American	1 (0.65)
Hispanic/Latino	7 (4.52)
Asian/Asian American	5 (3.23)
Alaskan/Pacific Islander	1 (0.65)
Other	2 (1.29)
Bi/Multiracial	10 (6.45)
Education	
Some high school	4 (2.58)
High school/GED	25 (16.13)
Some college	61 (39.35)
College	46 (29.68)
Some graduate school	8 (5.16)
Graduate school	11 (7.10)
Level-of-Contact Report	
I have never observed a person who self-harms I was aware of.	3 (1.94)

I have observed, in passing, a person I believe may have self-harmed.	3 (1.94)
I have watched a movie or television show in which a character depicted a person who self-harmed.	14 (9.03)
I have watched a documentary on television about self-harm.	8 (5.16)
I have observed persons who self-harm on a frequent basis.	3 (1.94)
I have worked with a person who had self-harmed at my place of employment.	2 (1.29)
My job includes providing services to people who self-harm.	1 (0.65)
My job involves providing services/treatment for people who self-harm.	8 (5.16)
A friend of the family self-harms.	1 (0.65)
I have a relative who self-harms.	6 (3.87)
I live with a person who self-harms.	0 (0.00)
I have self-harmed.	106 (68.39)
Self-Harm	110 (70.97)
Non-Self-Harm	45 (29.03)

Note. Age is shown as mean and standard deviation (*M*/*SD*). All other variables are shown as number of participants and percentages (*n*/%). The Level-of-Contact report only shows highest level endorsed by each participant.

and debriefed. Following the completion of the study, participants who were interested had the opportunity to enter a $20 gift card drawing. Upon closure of this study, the winner of the gift card drawing was randomly chosen and received the incentive via email.

Materials

Self-Harming Vignettes. Participants were asked to read two vignettes, which were adopted for this study from another study by Law, Rostill-Brookes, and Goodman (2008). The first vignette described a female teenager who engages in self-harming behavior, specifically cutting, as a result of abuse. According to Law and colleagues (2008), in this vignette, the self-harming behavior is due to uncontrollable causes (i.e., abuse). The second vignette also depicted a female teenager who uses cutting for self-harming purposes, but it is a result of drug misuse. As stated in Law et al.'s study (2008), this self-harming behavior is a result of controllable causes (i.e., drug misuse). The controllable and uncontrollable causes of the self-harming behavior in the vignettes are based on attribution theory, which states that a person makes an attribution about the cause and controllability of another's situation or event, which leads to inferences that result in an emotional reaction (Weiner, 1995). Furthermore, people are more likely to make attributions about the cause and controllability of one's mental illness, and therefore, when presented with a person whose mental illness is attributed to drug use, that person is thought to be responsible for their mental illness (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). Alternatively, if one's mental illness is attributed to uncontrollable causes, such as abuse, a person is held less responsible for their mental illness (Corrigan et al., 2003). In the study conducted by Law et al. (2008), both vignettes used the same female teenager, "Mary", because participants in each group were shown only one vignette. Since participants in each group of this study were shown both vignettes, the name in the second vignette was changed to "Sally" (i.e., drug misuse vignette) to avoid confusion with the first vignette, "Mary" (i.e., abuse vignette). See Appendix B to read both vignettes.

Attitudes toward Self-Harming Behavior. Participants' attitudes toward the female teenagers in the vignettes were assessed with the Attribution Questionnaire (AQ-27). Corrigan and colleagues (2003) developed the AQ-27 to measure nine stereotypes about mental illness, sometimes referred to as attributions: blame, anger, pity, help, dangerousness, fear, avoidance, segregation, and coercion. For each of the nine attributions being measured, there are three questions in the subscale. Each question asks participants about a vignette depicting a man named Harry who suffers from schizophrenia. However, other research studies have used vignettes focusing on other mental illnesses such as self-harm (Law et al., 2008). The AQ-27 was modified to fit this study. Specifically, it was modified to ask participants about the characters in the vignettes of this study (i.e., "Mary" and "Sally").The AQ-27 consists of 27 Likert scale items (0 = *not at all* to 9 = *very much*). A higher score for a particular domain indicates respondent endorses that domain (Corrigan, 2008). Following the AQ-27, participants were asked one question on how similar "Mary" and "Sally's" behavior(s) were to their own behavior(s) which was ranked on a Likert scale (0 = *not at all* to 4 = *completely*). This question was mainly used as an additional method of identifying those who engage in self-harm.

The first subscale, blame, measures the belief that a person has control over and is responsible for their mental illness (i.e., "I would think that it was Harry's own fault that he is in the present condition"; Corrigan, 2008). The second subscale, anger, measures how irritated or annoyed one is because people are to be blamed for their mental illness (i.e., "I would feel aggravated by Harry"; Corrigan, 2008). Pity, the third subscale, measures sympathy as well as the belief that people are overcome by their mental illness (i.e., "I would feel pity for Harry"; Corrigan, 2008). The fourth subscale, help, measures whether or not a mentally ill person should receive assistance (i.e., "I would be willing to talk to Harry about his problems"; Corrigan,

2008). Dangerousness, the fifth subscale, measures the belief that a person with a mental illness is unsafe (i.e., “I would feel unsafe around Harry”; Corrigan, 2008). The sixth subscale, fear, measures fear of a person with a mental illness (i.e., “Harry would terrify me”; Corrigan, 2008). Avoidance, the seventh subscale, measures the belief that one should stay away from people with mental illnesses (i.e., “If I were an employer, I would interview Harry for a job”; Corrigan, 2008). The eighth subscale, segregation, measures the belief that those with mental illnesses should be sent to institutions away from their community (i.e., “I think Harry poses a risk to his neighbors unless he is hospitalized”; Corrigan, 2008). The ninth and final subscale, coercion, measures the belief that people with mental illnesses should be forced to participate in medication management or other treatments (i.e., “If I were in charge of Harry’s treatment, I would require him to take his medication”; Corrigan, 2008). See Appendix C to view this measure for Mary and Appendix D to view this measure for Sally.

Previous research has shown fairly good psychometric properties for the AQ-27. Depending on the subscale, test-retest reliability has been shown to have a range. For example, coefficients for pity (.82), danger (.87), fear (.86), and help (.80) demonstrated good reliability, coefficients for avoidance (.78) and segregation (.75) indicated acceptable reliability, and coefficients for responsibility (.55), anger (.64), and coercion (.56) resulted in poor reliability (Corrigan, Watson, Warpinski, & Gracia, 2004). Corrigan et al. (2003) demonstrated high internal consistency reliability for the subscales with alpha coefficients of .70 (responsibility), .74 (pity), .89 (anger), .96 (fear), .88 (helping), and .89 (coercion/segregation).

Level of Familiarity. Participants’ levels of familiarity with self-harm was measured with the level-of-contact report (LOC). The level-of-contact report was developed by Holmes, Corrigan, Williams, Canar, and Kubiak (1999) to assess the level of contact a respondent has had

with mental illness. Holmes et al. (1999) developed this report to measure level of contact continuously whereas previous research studies have measured it categorically, and thus, have limited power. The level of contact report consists of 12 situations that vary in level of intimacy, ranging from least intimate (i.e., “I have never observed a person that I was aware had a severe mental illness”) to most intimate (i.e., “I have a severe mental illness”). Respondents are required to put a check mark by the situations that depict their exposure to severe mental illness. Three professionals in mental illness and psychiatric rehabilitation ranked the 12 situations in order of intimacy which resulted in an interrater reliability of 0.83 (Holmes et. al, 1999). Therefore, scores are based on the level at which the experts ranked the situations. For example, a participant check marked situations ranked 1 (i.e., “I have never observed a person that I was aware had a severe mental illness”), 2 (i.e., “I have observed, in passing, a person I believe may have had a severe mental illness”), and 8 (i.e., “My job involves providing services/treatment for persons with a severe mental illness”). According to the experts involved in the development of this report, if their score is an 8, then this would indicate a higher level of familiarity with a severe mental illness (Holmes et al., 1999). Several studies have modified the level-of-contact report by eliminating items. For example, Corrigan and colleagues (2003) included only seven items which resulted in an alpha reliability of .62. Law and colleagues (2008) modified the level-of-contact report to fit their study by specifically asking participants about their familiarity with self-harm instead of mental illness overall; however, the authors used only six questions to assess for this instead of the original 12. Therefore, all 12 situations presented in the level-of-contact report were modified in this study. Specifically, all situations were changed from contact with a severe mental illness to contact with self-harming behavior, which was the main focus of this study. See Appendix E to view this measure.

Social Desirability. Participants were asked to complete the Marlowe-Crowne Social Desirability Scale- Short Form C (MCSDS-SF). Marlowe and Crowne (1960) created the 33 item MCSDS to measure social desirability (i.e., the desire to respond in a manner that is socially appropriate and acceptable) independent of psychopathology. The MCSDS-SF was later created by Reynolds (1982) as a way to measure socially desirability more efficiently. This measure consists of 13 true (T) and false (F) items that determine if a participant is responding in a manner deemed socially appropriate (i.e., "I am always courteous, even to people who are disagreeable" and "I'm always willing to admit it when I make a mistake"). Scores range from 0-13 with higher scores indicating a respondent answered in a way that is overly socially appropriate (Reynolds, 1982). By using the Kuder-Richardson formula 20, Marlowe and Crowne (1960) determined that the internal consistency of the scale was .88. When developing the short form of the scale, correlation coefficients were found to be .76, indicating a sufficient level of reliability, and convergent validity was acceptable with a correlation of .93 with the original MCSDS (Reynolds, 1982). See Appendix F to view this measure.

Demographic Questionnaire. Basic demographic questions regarding age, gender, ethnicity, and education level were asked in order to collect general information about the participants. Furthermore, participants were asked a series of 18 items assessing for self-harming behavior. These items were adapted from the Deliberate Self-Harm Inventory (DSHI), which is a 17 item self-report questionnaire asking participants to identify certain behaviors they have done intentionally, not accidentally, to hurt themselves (Gratz, 2001). A "None of the Above" option was added for this study to identify those who had never engaged in any of the behaviors. The current study focused on individuals who have and have not engaged in self-harming behaviors, and therefore, these questions were included in the demographic questionnaire to separate

participants into the appropriate group. Items on the original DSHI asking participants about the frequency, severity, and duration of these behaviors were not included because this was not the focus of the current study. See Appendix G to view this measure.

Chapter III: Results

In order to assess for relationships between social desirability and attitudes as well social desirability and familiarity, correlations were calculated. Pearson's correlations revealed modest correlations between social desirability, as measured by the MCSD-SF, and several subscales, as measured by the AQ-27. When examining social desirability against each individual subscale of the AQ-27 for both vignettes, Pearson's correlations revealed a modest correlation between social desirability and blame (r = -0.20, p = 0.01), dangerousness (r = -0.18, p = 0.02), and avoidance (r = -0.16, p = 0.05) for the vignette about Mary (i.e., abuse vignette). In regards to the Sally vignette (i.e., drug misuse), modest correlations were observed between social desirability and blame (r = -0.17, p = 0.03), pity (r = 0.16, p = 0.04), and avoidance (r = -0.22, p = 0.01). Because the correlations were modest and not observed across all subscales nor consistently across similar subscales, social desirability was not controlled for in later analyses. Spearman's correlations also revealed a significant relationship between social desirability and familiarity, as measured by the LOC report, r = 0.38, p < .0001, such that as level of contact increased, social desirability also increased.

Attitudes and Familiarity

To examine relationships between familiarity with self-harm and attitudes toward self-harm, Spearman's correlations were calculated between the LOC report and subscales of the AQ-27 for the vignettes together and each vignette individually. When examining the relationship across both vignettes, a significant positive correlation was found between the LOC and pity, and significant negative correlations were found between the LOC and blame, anger, dangerousness,

fear, avoidance, segregation, and coercion, such that higher contact was associated with less negative attitudes. No relationship was found between the LOC and help. For the Mary vignette, a significant positive correlation was found between the LOC and pity, and significant negative correlations were found between the LOC and blame, anger, dangerousness, avoidance, and coercion, such that higher contact was associated with less negative attitudes. However, no relationship was found between familiarity and help, fear, or segregation. For the Sally vignette, there was a significant positive correlation between the LOC and pity, and there were significant negative relationships between familiarity and blame, anger, dangerousness, fear, avoidance, segregation, and coercion, such that higher contact was associated with less negative attitudes. However, there was no relationship between LOC and help (see Table 3).

Self-Injurers vs. Non-self-injurers and Attitudes

A mixed analysis of variance was conducted with self-injury as a between-participants variable (those who have self-harmed versus those who have not) and vignette (Mary versus Sally) and attitude subscales as within-participants variables. Participants from both groups (i.e., those who have self-injured and those have not self-injured) were likely to rate their attitudes differently depending on whether the vignette was about Mary or Sally, F (1, 153) = 209.11, p < .0001, such that attitudes tended to be more negative across participants when rating Sally (see Table 4). There was also a relationship between a history of self-harming behavior and attitudes towards Mary and Sally, F (1, 153) = 20.81, p < .0001, such that those with a history of self-harm tended to rate both vignettes much less negatively (See Table 4). Finally, across vignettes, it was revealed that participants who reported a history of self-harm rated their attitudes towards self-harm differently on the AQ-27 than those who did not endorse self-harming behavior, F (8, 146) = 9.46, p < .0001 (Figure 1).

Table 3

Correlations between the LOC and AQ-27 (N = 155)

AQ-27 Subscale	Both Vignettes	Mary	Sally
Blame	-0.48****	-0.37****	-0.50****
Anger	-0.39****	-0.25**	-0.46****
Pity	0.29***	0.18*	0.32****
Help	0.07	0.04	0.06
Dangerousness	-0.35****	-0.36****	-0.32****
Fear	0.19*	-0.14	-0.16*
Avoidance	-0.43****	-0.31****	-0.43****
Segregation	-0.28***	-0.08	-0.33****
Coercion	-0.36****	-0.26**	-0.34****

Note. *p < .05, **p < .01, ***p < .001, ****p < .0001

Table 4

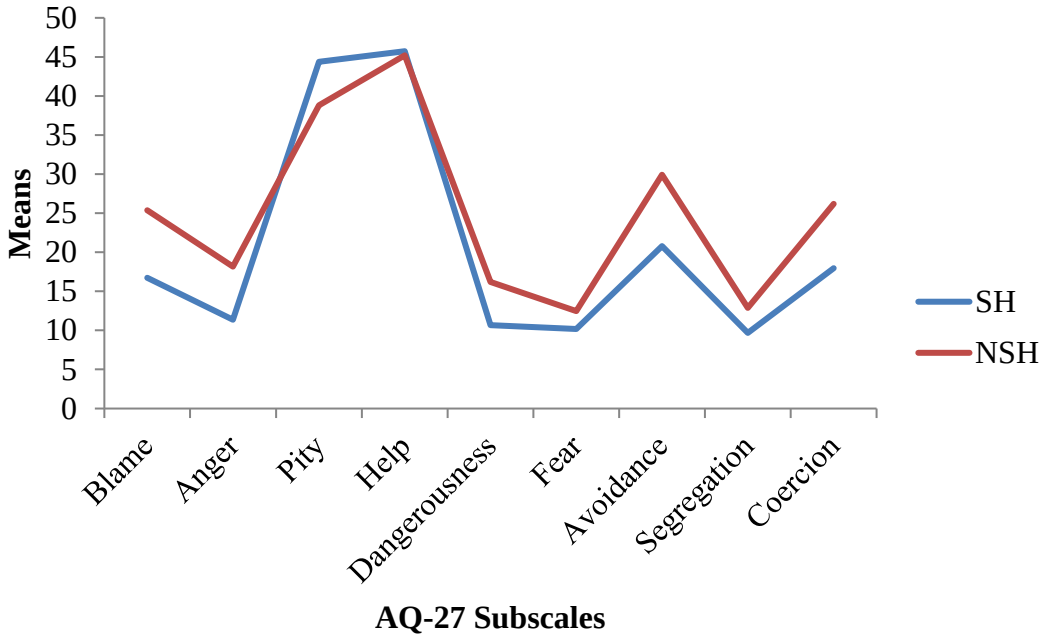
Means and Standard Deviations by Group for all Subscales

	Mary		Sally	
	SH	NSH	SH	NSH
	(n = 110)	(n = 45)	(n = 110)	(n = 45)
Subscale	*M*(*SD*)	*M*(*SD*)	*M*(*SD*)	*M*(*SD*)
Blame	6.09 (3.03)	8.33 (4.53)	10.64 (4.89)	17.02 (6.70)
Anger	4.06 (2.48)	5.08 (3.89)	7.29 (5.49)	13.09 (7.94)
Pity	23.38 (4.10)	21.20 (5.84)	20.98 (4.85)	17.60 (5.45)
Help	23.71 (4.34)	23.49 (3.86)	22.02 (5.14)	21.71 (4.55)
Danger	3.90 (2.20)	5.62 (3.33)	6.78 (4.56)	10.58 (5.83)
Fear	3.99 (2.33)	4.51 (2.92)	6.21 (4.58)	7.96 (4.87)
Avoidance	6.97 (4.62)	10.24 (6.06)	13.81 (6.68)	19.67 (5.51)
Segregation	4.27 (3.07)	4.58 (2.91)	5.40 (3.32)	8.29 (5.07)
Coercion	8.10 (4.74)	11.71 (5.78)	9.88 (5.24)	14.49 (5.93)

Note. SH = Self-Harm. NSH = Non-Self-Harm. Danger = Dangerousness subscale.

Figure 1

Means for all Subscales between Participants who Self-Harm and Participants who do not Self-Harm



Note. SH = History of Self-Harm. NSH = No History of Self-Harm.

Chapter IV: Discussion

The goal of this study was to investigate whether level of familiarity with self-harm impacted attitudes toward individuals who engage in self-harming behavior. This study examined attitudes of the sample as a whole as well as investigated the attitudes of self-injurers versus non-self-injurers. It was first hypothesized that one's level of familiarity with self-harming behaviors would significantly affect a participant's attitudes toward an individual who engages in self-harm. More specifically, those with lower levels of contact with self-harm would be more likely to have negative attitudes and endorse domains such as blame, anger, dangerousness, fear, avoidance, segregation, and coercion on the AQ-27, whereas domains such as help and pity would be endorsed by those with higher familiarity scores, indicating more positive attitudes.

When examining the relationship across both vignettes together as well as the Mary (i.e., abuse) and Sally (i.e., drug misuse) vignettes individually, a significant positive correlation was found between the LOC and pity; however, no significance was found between familiarity and help. When examining the relationship across both vignettes together as well as the Sally vignette, significant negative correlations were found between the LOC and blame, anger, dangerousness, fear, avoidance, segregation, and coercion. For the Mary vignette, significant negative correlations were found between the LOC and blame, anger, dangerousness, avoidance, and coercion; however, in addition, no significance was found between the LOC and fear and segregation. These findings suggest that the more familiarity a person has with self-harm, the less likely they are to have negative attitudes towards self-injurers. Therefore, this hypothesis was partially supported. Another study, which included healthcare and non-healthcare students,

concluded similar findings suggesting that having a greater level of familiarity was associated with higher levels of positive attitudes and lower levels of negative attitudes toward someone who self-harms (Law et al., 2009). Findings like these might indicate that familiarity can impact attitudes and that familiarity might provide a sense of comfort, and thus, result in more positive attitudes. Conversely, having a sense of unfamiliarity with a behavior, person, or something else might bring feelings of uneasiness which leads to negative attitudes.

The one subscale that did not correlate with familiarity, according to predictions, was "help." The lack of correlation between familiarity and "help" indicates that participants with higher or lower levels of familiarity with self-harm were no more likely to want to help Mary or Sally. Therefore, having a history of self-harm makes a person no more likely to want to help. This difference might be due to the fact that participants were recruited from the general public unlike the healthcare workers who participated in the study conducted by Law et al. (2009). However, it appears that participants were willing to help Mary and Sally, regardless of their familiarity level with self-harm. This finding might indicate that while familiarity plays an important role in a majority of attitudes, familiarity is not as important when it comes to helping behavior. One might argue that people are more willing and likely to help others even when they are not familiar with another person.

Results showed that both groups (i.e., self-injurers and non-self-injurers) rated their attitudes differently depending on if they read the vignette about Mary or Sally. More specifically, participants experienced less negative attitudes toward Mary than Sally regardless of their own status of self-harming behavior. This finding suggests that attitudes towards self-injurers might vary depending on whether a person engages in self-harming behavior due to abuse (i.e., Mary) or drug misuse (i.e., Sally). In other words, this finding indicates that the

reason why a person engages in self-harm (i.e., abuse, drug misuse, or another reason) may influence another person's attitudes toward them. One might argue that this might in part be due to whether or not a person believes a self-injurer is responsible for their own self-harming behavior. Law et al. (2009) found differences between participants' attitudes for the two vignettes, specifically that self-harm caused by drug misuse 1) led participants to believe that the self-injurer was responsible for her self-harming behavior and the behavior was viewed as manipulative, 2) made participants feel more anger and show support for coercion and segregation, and 3) led participants to be less helpful. Findings such as the ones reported in the current study as well as the findings stated in Law et al. (2009) suggest that perceived responsibility (i.e., whether the behavior is caused extrinsically or intrinsically) for self-harming behavior may influence the attitudes of others.

Furthermore, it was hypothesized that the attitudes of those who have engaged in self-harming behaviors would significantly differ from the attitudes of those who have not. More specifically, it was hypothesized that those who have self-harmed would endorse higher scores on the help and pity domains and lower scores on the other subscales, indicating more positive attitudes, whereas those who have never engaged in self-harm would endorse blame, anger, dangerousness, fear, avoidance, segregation, and coercion with lower scores on the other subscales, indicating more negative attitudes. Results from the present study also showed a significant interaction between having a history of self-harming behavior and attitudes toward Mary (i.e., abuse vignette) and Sally (i.e., drug misuse vignette). This finding suggests that when compared to non-self-injurers, self-injurers are more likely to have much less negative attitudes toward someone else who self-harms, no matter the reasoning for the behavior. Therefore, this hypothesis was supported. A recent study found a significant difference in attitudes toward self-

harm between self-injurers and non-self-injurers, specifically which self-injurers believed the behavior was attributed to impulsivity and not loneliness, depression, or attention-seeking like non-self-injurers believed (Doyle, 2018). One might speculate that those who self-harm have less negative attitudes because they are able to relate to another self-injurer, and thus, experience more empathy towards them. It is possible that those who self-harm see the behavior as less pathological than someone who has never self-harmed. One might also speculate that someone who self-harms sees similarities between their own behavior and the behavior of the fictional character (i.e., Mary and Sally) more than those who have never self-harmed. This might provide people who self-harm with a sense of understanding toward the fictional character, and thus, lead to less negative attitudes when reading about the self-harming behavior of others.

Limitations

As with any research study, there are several limitations to the current study. As previously mentioned, the final sample consisted of 155 participants with 110 endorsing self-harm behavior and 45 not endorsing any self-injury. The goal of this study was to examine attitudes toward self-harm between these two groups. However, there are significantly more participants who engage in self-harm than those who do not, making the two groups vastly uneven. Therefore, this might have influenced the results of this study. Furthermore, participants were recruited on forums focusing on depression, borderline personality disorder, and self-harm. While these forums are open to others who have never engaged in self-harm, it is not surprising that the majority of participants in the current study fell into the self-injurer group, which may have skewed toward greater familiarity. Being a part of a forum focusing on self-harm, which potentially can be viewed somewhat as a self-help group, might have lead participants who self-harm to have more open attitudes. Therefore, it might have proven beneficial to have recruited

participants from forums unrelated to self-harm or mental health, for greater representation at the lower end of the familiarity spectrum.

Another limitation to this study exists in certain characteristics of the sample. The sample mainly consisted of females, and thus, results might not be generalizable to the overall population. For example, the results might not generalize to other populations who identify as male, transgender, nonbinary, androgynous, etc. Also, the sample mainly consisted of those who classified themselves as Caucasian, and therefore, the results might not be generalizable to other racial and ethnic groups. A recent study found that when compared to transgender females, nonbinary individuals and transgender males reported higher levels of self-harming behavior (Veale et al., 2017). This finding highlights the importance of including other genders in self-harm research. Further, in a study examining self-harm in 3 different cities, young African American females were found to have an increased risk of self-harming behavior than Caucasian and South Asian females (Cooper et al., 2010). This finding highlights the importance of including more diversity regarding racial groups in research studies. It is possible that a more gender and racially diverse group of participants might have yielded different results.

Not only were there limitations with certain characteristics of the sample used, there were also limitations in the methodology of the current study, specifically with certain measures. The Level-of-Contact report was used to assess for familiarity with self-harm among participants. This measure consists of 12 situations that differ in intimacy and is scored by the highest situation endorsed. If a participant were to endorse multiple situations, the score only consists of the highest situation chosen and not by how many different situations he or she is familiar with, based on scoring methods adopted from previous research using this scale. Thus, the question remains as to whether or not the number of self-harm situations a participant is acquainted with

impacts their level of familiarity with self-harm. Therefore, it is possible that an alternative method of assessing for familiarity with self-harm might have resulted in different findings. Additionally, attitudes toward self-harm were assessed using the Attribution Questionnaire-27. Various items on this questionnaire seem to be outdated. For example, one question asks, "How much do you think an asylum, where Mary can be kept away from her neighbors, is the best place for her?" "Asylum" is not a commonly used term in today's society to describe a place for mental health treatment. There is no way to determine if participants fully understood all of the terms, which could lead to ambiguity in AQ-27 scores.

Future Directions

As discussed, there are some limitations to this study which demonstrates areas that future research may improve upon. Future research should replicate the current analyses to ensure reliability of the results. The studies could include equal number of participants in each group (i.e., self-injurers and non-self-injurers) in order to confirm the finding of significant differences in attitudes toward self-harm between these groups. Future research should also include more gender and racial diversity in their sample to ensure greater generalizability.

Future research should also examine whether characteristics such duration or frequency of one's self-harming behavior impacts that self-injurer's attitudes toward someone else who engages in self-harm. For example, how might someone who has self-harmed for seven years rate their attitudes toward Mary or Sally versus someone who has self-harmed for a month? Future research should also examine if the attitudes differ between those who have self-harmed, received treatment, and stopped the behavior versus those who receive treatment and continue the self-harming behavior. Future research should include questions regarding their own self-harming behavior in order to see how that might influence their attitudes.

In regards to familiarity, this study used the Level-of-Contact Report to measure familiarity with self-harming behavior. As stated by Law et al. (2009), this is a "simplified measure of familiarity (i.e., total score for the amount of contact)." With this in mind, future research might include a more nuanced measure in order to gain more detail about contact and familiarity with self-harm. More specifically, looking at the variability across those with multiple levels of familiarity and not simply just the highest level only might provide additional insights.

Since the purpose of this study was only to examine whether or not differences exist in attitudes between self-injurers and non-self-injurers and not to examine the differences between the two vignettes in depth, future research should also examine what aspects of the Mary and Sally vignettes are specifically affecting participant attitudes toward Mary and Sally. In other words, future research should be conducted with a focus on why people have different attitudes toward someone who self-harms due to abuse, drug misuse, or other reasons. As stated previously, Law et al. (2009) found differences between the two vignettes, indicating different attitudes toward a person who self-harms depending on whether the behavior is due to abuse or drug misuse. Therefore, future research might include different reasons behind the self-harm behavior in order to determine if there are specific characteristics of a person's self-harming behavior that make someone more or less likely to have certain attitudes toward a self-injurer.

Conclusion

The current study provided evidence that, to some extent, one's level of familiarity with self-harm impacts their attitudes toward someone who engages in the behavior. Past research focusing on nurses and doctors who have come into contact with self-harming behaviors (Karmen et al., 2014) as well as parents who were made aware of their child's self-harming behavior (Ferrey et al., 2016) has shown that at least some level of negative attitudes exist

toward self-injurers. It is important for nurses as well as parents to be aware of their attitudes toward self-harm and how their attitudes affect their behavior because past research has shown that if a person who self-harms feels as though they are being treated negatively due to their behavior, then that person is less likely to continue services and reach out for help in the future (Brophy & Holmstrom, 2006). Therefore, one might speculate that it is equally as important for those working in the mental health field to be aware of their attitudes toward self-harming individuals because negative attitudes might also lead a person who self-harms to discontinue their mental health treatment. It is imperative that people become more familiar with self-harm, which might help eliminate or lessen negative attitudes toward a person who engages in the behavior. The current study also demonstrated that there is a difference between self-injurers and non-self-injurers' attitudes toward a self-injurer, specifically when compared to self-injurers, non-self-injurers had more negative attitudes toward someone who engages in self-harm. Very little research has focused on this aspect, and therefore, it is important that future research be conducted on this specifically in order to address if and why there is a difference. Whether or not a person has engaged in self-harming behavior, it is important that all people be educated about self-harm and recognize how their attitudes may affect their behavior towards someone who self-harms.

Appendix A: Consent to Participate

Study Title: Attitudes Toward Self-Harm

Primary Investigator: Bradi Cislaghi, Department of Psychology at Murray State University

Faculty Sponsor Contact: Laura Liljequist, PhD | (270) 809-2990 | lliljequist@murraystate.edu

You are being invited to participate in an online research study conducted through Murray State University. This document contains information you will need to help you decide whether to be in this research study or not. You must be at least 18 years old to participate. Please read the form carefully. You should print a copy of this document for your records.

1. **Nature and Purpose of Project:** The purpose of this study is to learn more about whether there is a relationship between an individual's familiarity with self-harm, and their attitudes towards it. This study is being conducted as part of a thesis project.
2. **Explanation of Procedures:** Your participation in this study will require you to fill out a series of questionnaires about yourself as well as your attitudes towards self-harm. You should be aware that the survey contains several explicit descriptions of self-harm behaviors. Your total participation should take no longer than 30 minutes and you will have the opportunity to enter into a drawing for a chance to win a $20 gift card after completion of the study.
3. **Discomforts and Risks:** Some participants may experience significant distress when responding to this survey as it contains explicit and possibly triggering descriptions of abuse, trauma, and self-harm. This distress is not expected to exceed what someone familiar with these behaviors would experience in everyday life, but please know that you can stop participating at any time without penalty. All responses from participants will be treated confidentially and stored in a secure database.
4. **Benefits:** There are no direct individual benefits to you for participating.
5. **Confidentiality:** The researcher will know that you participated in this study but the information you provide will be kept confidential. Your name and other identifying information will not be associated with your questionnaire responses. Your questionnaire responses will be linked using a participant number that will not be associated with your name or contact information in any way. You have the option of entering your name and e-mail address on a second survey which will be used only for the gift card drawing and it will not be linked back to responses on the primary survey. The only individuals who will have access to the data are members of the research team, and no personal identifiers (i.e., name or e-mail address) will ever be stored in or linked to the primary survey database. Personal identifiers stored in the secondary survey database (i.e. names and e-mail addresses) will be destroyed after data collection and the gift card drawing are complete.
6. **Refusal/Withdrawal:** Your participation is strictly voluntary and you are free to withdraw/stop participating at any time with absolutely no penalty. While study participation is voluntary, all questions must be answered in order for your individual responses to be included in the study results.
7. **Contact Information:** Any questions about the procedures or conduct of this research should be brought to the attention of **Laura Liljequist, PhD** at (270) 809-2990 or lliljequist@murraystate.edu.

By checking “Yes”, I acknowledge that the risks and benefits involved and the need for the research have been fully explained to me and that I voluntarily consent to take part in this study.

____ Yes, I am 18 years of age or older, have read this document in its entirety, and would like to participate in this study.

This project has been reviewed and approved by the Murray State University Institutional Review Board (IRB) for the Protection of Human Subjects. If you have any questions about your rights as a research participant, you should contact the MSU IRB Coordinator at (270) 809-2916 or msu.irb@murraystate.edu.

Appendix B: Mary and Sally Vignettes

Directions: Please read the following about Mary.

‘‘Mary is a 15 year old female who lives with her family. Mary exhibits self-harm behavior. She cuts her arms with a sharp instrument which results in some scarring. For the past two years, Mary has been experiencing physical/sexual abuse on a near-daily basis from someone she knows. She has kept this a secret from her family. Mary’s self-harm behavior is caused by abuse.”

Directions: Please read the following about Sally.

“Sally is a 15 year old female who lives with her family. Sally exhibits self-harm behavior. She cuts her arms with a sharp instrument which results in some scarring. For the past two years, Sally has been abusing drugs and alcohol on a near-daily basis. She has kept this a secret from her family. Sally’s self-harm behavior is caused by drug misuse.”

Appendix C: Attribution Questionnaire-27 (AQ-27) for Mary

For each statement, please indicate which number best describes your feelings toward Mary.

1 2 3 4 5 6 7 8 9

NOT AT ALL VERY MUCH

____ 1. I WOULD FEEL AGGRAVATED BY MARY

____ 2. I WOULD FEEL UNSAFE AROUND MARY

____ 3. MARY WOULD TERRIFY ME

____ 4. HOW ANGRY WOULD YOU FEEL AT MARY?

____ 5. IF I WERE IN CHARGE OF MARY'S TREATMENT, I WOULD REQUIRE HER TO TAKE MEDICATION

____ 6. I THINK MARY POSES A RISK TO HER NEIGHBORS UNLESS SHE IS HOSPITALIZED

____ 7. IF I WERE AN EMPLOYER, I WOULD INTERVIEW MARY FOR A JOB.

____ 8. I WOULD BE WILLING TO TALK TO MARY ABOUT HER PROBLEMS

____ 9. I WOULD FEEL PITY FOR MARY

____ 10. I WOULD THINK THAT IT WAS MARY'S OWN FAULT THAT SHE IS IN THE PRESENT CONDITION

____ 11. HOW CONTROLLABLE, DO YOU THINK, IS THE CAUSE OF MARY'S PRESENT CONDITION?

____ 12. HOW IRRITATED WOULD YOU FEEL AT MARY?

____ 13. HOW DANGEROUS WOULD YOU FEEL MARY IS?

____ 14. HOW MUCH DO YOU AGREE THAT MARY SHOULD BE FORCED INTO TREATMENT WITH HER DOCTOR EVEN IF SHE DOES NOT WANT TO?

____ 15. I THINK IT WOULD BE BEST FOR MARY'S COMMUNITY IF SHE WERE PUT AWAY IN A PSYCHIATRIC HOSPITAL

____ 16. I WOULD SHARE A CAR POOL WITH MARY EVERY DAY

____ 17. HOW MUCH DO YOU THINK AN ASYLUM, WHERE MARY CAN BE KEPT AWAY FROM HER NEIGHBORS, IS THE BEST PLACE FOR HER?

____ 18. I WOULD FEEL THREATENED BY MARY.

____ 19. HOW SCARED OF MARY WOULD YOU FEEL?

____ 20. HOW LIKELY IS IT THAT YOU WOULD HELP MARY?

____ 21. HOW CERTAIN WOULD YOU FEEL THAT YOU WOULD HELP MARY?

____ 22. HOW MUCH SYMPATHY WOULD YOU FEEL FOR MARY?

____ 23. HOW RESPONSIBLE, DO YOU THINK, IS MARY FOR HER PRESENT CONDITION?

____ 24. HOW FRIGHTENED OF MARY WOULD YOU FEEL?

____ 25. IF I WERE IN CHARGE OF MARY'S TREATMENT, I WOULD FORCE HER TO LIVE IN A GROUP HOME.

____ 26. IF I WERE A LANDLORD, I PROBABLY WOULD RENT AN APARTMENT TO MARY.

____ 27. HOW MUCH CONCERN WOULD YOU FEEL FOR MARY?

How similar is Mary's behavior(s) to your own behavior(s)?

Not at all	Somewhat	Moderately	Quite a bit	Completely
0	1	2	3	4

Appendix D: Attribution Questionnaire-27 (AQ-27) for Sally

For each statement, please indicate which number best describes your feelings toward Sally.

1 2 3 4 5 6 7 8 9

NOT AT ALL VERY MUCH

____ 1. I WOULD FEEL AGGRAVATED BY SALLY

____ 2. I WOULD FEEL UNSAFE AROUND SALLY

____ 3. SALLY WOULD TERRIFY ME

____ 4. HOW ANGRY WOULD YOU FEEL AT SALLY?

____ 5. IF I WERE IN CHARGE OF SALLY'S TREATMENT, I WOULD REQUIRE HER TO TAKE MEDICATION

____ 6. I THINK SALLY POSES A RISK TO HER NEIGHBORS UNLESS SHE IS HOSPITALIZED

____ 7. IF I WERE AN EMPLOYER, I WOULD INTERVIEW SALLY FOR A JOB.

____ 8. I WOULD BE WILLING TO TALK TO SALLY ABOUT HER PROBLEMS

____ 9. I WOULD FEEL PITY FOR SALLY

____ 10. I WOULD THINK THAT IT WAS SALLY'S OWN FAULT THAT SHE IS IN THE PRESENT CONDITION

____ 11. HOW CONTROLLABLE, DO YOU THINK, IS THE CAUSE OF SALLY'S PRESENT CONDITION?

____ 12. HOW IRRITATED WOULD YOU FEEL AT SALLY?

____ 13. HOW DANGEROUS WOULD YOU FEEL SALLY IS?

____ 14. HOW MUCH DO YOU AGREE THAT SALLY SHOULD BE FORCED INTO TREATMENT WITH HER DOCTOR EVEN IF SHE DOES NOT WANT TO?

____ 15. I THINK IT WOULD BE BEST FOR SALLY'S COMMUNITY IF SHE WERE PUT AWAY IN A PSYCHIATRIC HOSPITAL

____ 16. I WOULD SHARE A CAR POOL WITH SALLY EVERY DAY

____ 17. HOW MUCH DO YOU THINK AN ASYLUM, WHERE SALLY CAN BE KEPT AWAY FROM HER NEIGHBORS, IS THE BEST PLACE FOR HER?

____ 18. I WOULD FEEL THREATENED BY SALLY.

____ 19. HOW SCARED OF SALLY WOULD YOU FEEL?

____ 20. HOW LIKELY IS IT THAT YOU WOULD HELP SALLY?

____ 21. HOW CERTAIN WOULD YOU FEEL THAT YOU WOULD HELP SALLY?

____ 22. HOW MUCH SYMPATHY WOULD YOU FEEL FOR SALLY?

____ 23. HOW RESPONSIBLE, DO YOU THINK, IS SALLY FOR HER PRESENT CONDITION?

____ 24. HOW FRIGHTENED OF SALLY WOULD YOU FEEL?

____ 25. IF I WERE IN CHARGE OF SALLY'S TREATMENT, I WOULD FORCE HER TO LIVE IN A GROUP HOME.

____ 26. IF I WERE A LANDLORD, I PROBABLY WOULD RENT AN APARTMENT TO SALLY.

____ 27. HOW MUCH CONCERN WOULD YOU FEEL FOR SALLY?

How similar is Sally's behavior(s) to your own behavior(s)?

Not at all	Somewhat	Moderately	Quite a bit	Completely
0	1	2	3	4

Appendix E: Level-of-Contact Report (LOC)

Directions: Please read each of the following statements carefully. After you have read all the statements below, place an X by the statements that best depict your exposure to people who self-harm.

____ I have watched a movie or television show in which a character depicted a person who self-harmed.
____ My job involves providing services/treatment for people who self-harm.
____ I have observed, in passing, a person I believe may have self-harmed
____ I have observed a person who self-harms on a frequent basis
____ I have self-harmed.
____ I have worked with a person who self-harms at my place of employment.
____ I have never observed a person who self-harms that I was aware
____ My job includes providing services to people who self-harm
____ A friend of the family self-harms.
____ I have a relative who self-harms.
____ I have watched a documentary on the television about self-harm.
____ I live with a person who self-harms.

Appendix F: Marlowe-Crowne Social Desirability Scale- Short Form C (MCSDS-SF)

MCSDS-SF

Directions: Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you.

T F 1. It is sometimes hard for me to go on with my work if I am not encouraged.
T F 2. I sometimes feel resentful when I don't get my way.
T F 3. On a few occasions, I have given up doing something because I thought too little of my ability.
T F 4. There have been times when I felt like rebelling against people in authority even though I knew they were right.
T F 5. No matter whom I'm talking to, I'm always a good listener.
T F 6. There have been occasions when I took advantage of someone.
T F 7. I'm always willing to admit it when I make a mistake.
T F 8. I sometimes try to get even rather than forgive and forget.
T F 9. I am always courteous, even to people who are disagreeable.
T F 10. I have never been irked when people expressed ideas very different from my own.
T F 11. There have been times when I was quite jealous of the good fortune of others.
T F 12. I am sometimes irritated by people who ask favors of me.
T F 13. I have never deliberately said something that hurt someone's feelings.

Appendix G: Demographic Questionnaire

Demographics

1. What is your age? _____

2. What is your gender?
   - Female
   - Male
   - Other

3. What is your race/ethnic identity? Please select ALL that apply:
   - White/Caucasian
   - African/African-American
   - Hispanic/Latino
   - Asian/Asian-American
   - Alaskan/Pacific Islander
   - Other (please specify)

4. What is your highest level of completed schooling?
   ____Some high school
   ____High school/GED
   ____Some college
   ____College
   ____Some graduate school
   ____Graduate school

5. Please be sure to read each question carefully and respond honestly. Place a checkmark if you have ever done any of the following intentionally, or on purpose, to hurt yourself. Do not checkmark if you did something accidentally (e.g., you tripped and banged your head on accident).
   ____ Have you ever intentionally (i.e., on purpose) cut your wrist, arm, or other area(s) of your body (without intending to kill yourself)?
   ____ Burned yourself with a cigarette?
   ____ Burned yourself with a lighter or a match?
   ____ Carved words into your skin?
   ____ Carved pictures, designs, or other marks into your skin?
   ____ Severely scratched yourself, to the extent that scarring or bleeding occurred?
   ____ Bit yourself, to the extent that you broke the skin?
   ____ Rubbed sandpaper on your body?
   ____ Dripped acid onto your skin?
   ____ Used bleach, comet, or oven cleaner to scrub your skin?
   ____ Stuck sharp objects such as needles, pins, staples, etc. into your skin, not including tattoos, ear piercing, needles used for drug use, or body piercing?

____ Rubbed glass into your skin?
____ Broken your own bones?
____ Banged your head against something, to the extent that you caused a bruise to appear?
____ Punched yourself, to the extent that you caused a bruise to appear?
____ Prevented wounds from healing?
____ Done anything else to hurt yourself that was not asked about in this questionnaire?

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