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The Effects of Suicide Intent and History of Self-harm on Emotional Reactions and Willingness to Help

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Abstract

The present study was a preliminary investigation of factors that affect potential helpers' emotional responses, perceptions and willingness to help when confronted with information about a hypothetical friend who overdoses. One hundred and forty-two undergraduate students attending Edith Cowan University (Joondalup Campus) were randomly assigned to one of six conditions and read two vignettes. In the first vignette, information was provided of a hypothetical female friend's overdose. The second vignette included information about the overdose that either supported or contradicted information in the first vignette regarding the woman's history of self-harm. Participants then completed a questionnaire designed to measure their emotional reactions to the woman, their willingness to help, perceived motives for the overdose and predictions of future self-harm. The data from the study were analysed using mixed model ANOVAs. There was reason to believe from the literature reviewed, that participants would express more positive emotions and greater willingness to help when the stated intention for the overdose was to die and there had been no previous self-harm, than when the intention for the overdose was not to die and there had been a history of self-harm. Further, it was predicted that participants would choose interpersonal motives to account for the overdose when the intention was "not to die" and there had been a history of self-harm. Intrapersonal motives were predicted to have been selected when the intention was to die and there was no history of self-harm. Contrary to predictions, participants reported high positive emotions and claimed they would help regardless of the reported intention for the overdose and history of self-harm. In addition, the motives identified by participants as possible explanations for the overdose were not found to be associated with suicide intent and history of self-harm. As with James and Hawton's (1985) findings, participants in this study reported a mixture of interpersonal and intrapersonal motives for the woman depicted in the vignettes, despite differences in suicidal intent and history of self-harm. Predictions of future self-harm were found to be associated with stated suicidal intent, with the likelihood of future self-harm being rated as higher when the stated intention for the overdose was to die than when it was

not to die. The results from this study suggest information regarding suicidal intent and history of self-harm of a hypothetical overdose do not affect university students' reported emotions and willingness to help. However, it would be premature to conclude that suicide intent and history of self-harm do not affect potential helpers' judgements. Further methodological improvements and replication of the study with other population groups such as medical staff and other helping professions are required before such a conclusion can be drawn. The finding for predictions of future self-harm is encouraging and warrants further research.

Declaration

I certify that this thesis does not, to the best of my knowledge and belief:

i) incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education;

ii) contain any material previously published or written by another person except where due reference is made in the text; or

iii) contain any defamatory material

Signature:

Paul Buttigieg

Date: 20 December 2000

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Chapter 1: Introduction

Investigations into attitudes, emotional responses and willingness to help individuals who deliberately self-harm has generally focused on how medical staff respond to patients who present to hospital for medical treatment following self-harming behaviour. In these studies, hospital staff have overwhelmingly reported unfavourable attitudes towards patients who deliberately self-harm (Ramon, Bancroft, & Skrimshire, 1975; Hawton, Marsack & Fagg, 1981, and Ghodse, Ghaffari, Bhat, Galea, & Qureshi 1986). In addition, many medical staff find it difficult to accept the reasons given by those who self-harm and view the self-harm as serving communicative, manipulative and punitive functions (Patel, 1975; Hawton et al., 1981; Hawton & Catalan, 1988). Birtchnell and Alarcon (1971) and Bancroft, Skrimshire, and Simkins (1976) have argued patients who express suicidal intent only do so to gain acceptability for their act of self-harm, or to influence helping agencies. James and Hawton (1985) found that close family and friends (significant others) report similar views to those expressed by medical staff.

Despite investigations into the attitudes of medical staff and significant others towards those who self-harm, to date the research work has not clearly identified factors that affect people's judgements, emotional reactions and willingness to help when a person self-harms. Further, there has been little attention paid to the way potential helpers interpret and react to a significant other's self-harm. Yet, once treated, people who self-harm usually return to their home, family and friends. When

they do, what kind of responses and reactions might they receive from the people they know? The reactions of potential helpers to self-harming behaviour may have a marked influence on the way people who self-harm are treated. The aim of the present study is to investigate the possible effects of stated suicide intent and history of self-harm on the reported emotions, willingness to help, the perceived motives/reasons for the self-harm and predictions of future self-harm on potential helpers. By identifying factors that elicit particular responses it would then be possible to investigate how these views translate into actual behaviours towards people whom self-harm.

Terminology

Graham, Reser, Scuderi, Zubrick, Smith, and Turley (2000) in their review of the literature, note suicide or completed suicide are terms widely used and generally accepted to categorise deaths that occur as a result of deliberate actions taken by an individual to kill him or her self. However there is no such agreement in the literature regarding the use of terminology for non-fatal self-injurious behaviour (O'Carroll, Berman, Maris, Moscicki, Tanney, and Silverman, 1996; Graham et al., 2000). Despite the debate, the term "self-harm" or "deliberate self-harm" is currently preferred in the literature to refer to non-fatal self-injurious behaviour. However, to complicate the matter, the term "attempted suicide" is still widely used by the general public to describe deliberate self-harm that does not result in death. Further still, the term deliberate self-harm can also be problematic as it can refer to fatal and non-fatal consequences of deliberate self-harming behaviour. In keeping with the use of current terminology, the term deliberate self-harm or self-harm is used in this paper. However, the term is only used to denote non-fatal self-harming behaviours. When a death results from deliberate self-harm, the term suicide is used. Deliberate self-harm

is used to describe self-harming behaviour that is repetitive in nature (for a more detailed review of the debate refer to O'Carroll et al., 1996). The term "attempted suicide" has been used in this paper when referring to articles that have adopted this terminology.

The problem with the use of the term attempted suicide is that it is not always clear from the behaviour what the intention was. Neither the act of self-harm nor the method used can be considered on face value to constitute an attempted suicide. For example, Bancroft et al. (1976) found that people report a range of motives for their deliberate self-harming behaviour in which death is not the only preferred outcome. Dear, Thomson, and Hills (2000) in a study of prisoners who self-harmed in prison found the intentionality for the self-harm and the lethality of the method used did not always correspond with one another. There were prisoners who used non-lethal methods but reported their intention of wanting to die and those who did not want to die using methods such as hanging.

Incidence and Prevalence of Suicide and Deliberate Self-harm

Suicide and deliberate self-harm now presents a public health challenge in the developed world. As with many other Western nations, more people die as a result of suicide in Australia than from motor vehicle accidents (Commonwealth Department of Health and Family Services, 1997). Approximately 3 % of deaths in Australia are attributed to suicide (Graham et al., 2000). Like most other industrialised nations, the incidence of completed suicide in Australia has remained relatively stable in the twentieth century with the exception of some fluctuations during the depression of the 1930's, the period during the Second World War, and in the mid 1960's. The rate of

completed suicides in Australia is 21 per 100, 000 males and 5.5 per 100, 000 females (Graham et al., 2000). The difference in the rate of completed suicide between men and women can largely be explained by the method used. Men have generally used more lethal methods such as firearms, hanging or jumping, whereas women tend to ingest medication or poison. Graham et al. (2000) also note that there have been changes in the age patterns of people dying as a result of suicide over the past century, with an increased rate for youth, and in particular, males in the 15 to 24 year old age group.

The prevalence of non-fatal deliberate self-harm is typically calculated from hospital accident and emergency presentations and hospital admissions. However, it has been noted by Silburn and Zubrick (1995) that not all people who self-harm present to hospital emergency departments for medical treatment. Consequently, a wide variation is found in the estimates of rates of self-harm based on the type of records consulted. Kaplan, Sadock and Grebb (1994), for example, report the estimated figure for attempted suicide in the United States of America is about 8 to 10 times greater than the rate for completed suicides. Davis and Schruender (1990) on the other hand, suggest for every completed suicide in Australia there may be as many as 30-40 attempted suicides. Baume, Cantor and McTaggart (1998) note that other researchers have estimated there are between 30 and 50 suicide attempts for every completed male suicide and between 150 and 300 attempts for every completed female suicide per annum. In addition, people who attempt suicide often attempt again. Hawton and Catalan (1981) in a review of hospital presentations in the UK, found between 6-15 % of people who attempted suicide, reattempted within one year of receiving medical treatment. Kaplan et al. (1994) report 1-2 % of those who have

made a suicide attempt complete a suicide in the year following, while a third to a half of those who eventually complete suicide have a history of previous attempts. Regardless of the precise rate of deliberate self-harm there are a large number of people in the community who are likely to know and be affected by someone who has self-harmed.

Clinical studies reveal distinct demographic differences among people who suicide compared with those who deliberately self-harm (Patton, 1995; Weissman, 1995). As reported earlier, people who complete a suicide tend to be male, use more lethal techniques and are reported to suffer from more severe types of psychiatric disorders than those who self-harm. People who self-harm on the other hand, are more likely to be female, use less lethal methods and suffer from less severe types of psychiatric disorders. (Kaplan et al., 1994; Wolfersdorf, Hole, Steiner, & Keller, 1990). However, previous self-harm with suicidal intent has been identified as the single best predictor of completed suicide (Hawton & Catalan, 1988), with estimates of risk varying between a seven-fold increase (Fawcett, Scheftner, Clark, Hedeker, Gibbons, Coryell, 1987) to as much as a 50-100 fold increase (Diekstra, 1992). There is also evidence to suggest the period of greatest risk of a completed suicide is within 6-months of an incident of self-harm (Graham et al., 2000).

The Reasons Self-harmers Give for Their Overdose

The motivation for self-harm has important implications for both the treatment and prevention of future self-harming behaviour (Boergers, Spirto, & Donaldson, 1998). In order to identify these motives, Bancroft et al. (1976) and Bancroft, Hawton, Simkin, Kingston, Cumming, and Whitwell (1979) investigated the reasons patients (n= 125 and n= 46 respectively) gave for their overdose immediately after they had

received medical care. Patients were given a list of possible reasons for taking an overdose and asked to choose those that applied to them. Based on patient responses, 44 % indicated they wanted to die, while, 52 % indicated they wanted relief from a terrible state of mind and 42 % reported they wanted to escape from their situation. Only 19 % of those interviewed indicated they were trying to influence others. Other researchers who have examined the reasons people give for an overdose have used Bancroft's self-report methodology (eg Boergers et al., 1998; Michel, Valach, & Waeber, 1994; Hawton, et al., 1982).

Adults from the UK, (Bancroft et al., 1976; Bancroft et al., 1979) and adolescents in the UK (Hawton et al., 1982) the Netherlands (Kienhorst, DeWilde, Diekstra, & Wolters, (1995) and USA (Boergers et al., 1998) when interviewed, have generally endorsed remarkably similar reasons for their overdose. For example, Michel et al. (1994) found the motives most often given by adult patients for their overdose was "unbearable thoughts and situations" and that they could "no longer endure their emotional pain." Less than half of the respondents reported they wanted to die from their overdose. Boergers et al. (1998) investigated the reasons American adolescents have for attempting suicide (n= 120) and examined the relationship between these reasons and psychological functioning. Consistent with research of adults who overdose, adolescents frequently cite motives of wanting relief from a terrible state of mind, to escape and to die. Less than 30 % of respondents endorsed motives relating to wanting to make people sorry, to influence others or to seek help.

Medical Staff Find it Difficult to Accept the Reasons Given by Those Who Self-Harm

The attributions that potential helpers make regarding the perceived reasons for self-harm are likely to have a marked influence on the way people who self-harm are treated. During the 1970s and 1980s the attitudes of medical staff became the focus of attention of researchers interested in identifying the type of responses those who deliberately self-harm received when they presented to a hospital for treatment. Patel (1975) surveyed physicians' and nurses' attitudes at a large teaching hospital in the UK (n= 56) towards individuals who presented to Accident and Emergency departments following self-poisoning. He found nearly half of the junior medical staff held unfavourable attitudes to those who presented. Medical staff indicated they found those who deliberately self-harmed to be a nuisance, often presenting late at night to the hospital or in the early hours of the morning and taking up valuable medical resources.

Treating medical staff tend to view self-harming behaviour as a way of communicating distress and manipulating others (Bancroft et al., 1976; Patel, 1975). Yet relatively few self-harmers characterise their own self-harm in such a manner. Hawton et al. (1982) compared the reasons given by patients for their self-poisoning with the explanations provided by psychiatrists. In this study, Hawton et al. (1982) interviewed 41 inpatients recently admitted following a deliberate self-harm by overdose. As part of the interview, patients were provided with a list of possible reasons for overdosing. Patients were then asked to indicate which reasons from the list best reflected their intentions for the overdose. Non-treating psychiatrists were subsequently provided with clinical information for each of the patients interviewed and then asked to choose explanations (from the same list as given to the patients) that

best reflected their impression of the patient's motive. The most surprising finding in this study was the psychiatrists' frequent endorsement of hostile and manipulative reasons for the self-harm. In contrast, the patients often reported motives related to gaining relief, escaping, or death as reasons for their self-harm. The frequent and consistent discrepancy between the reasons given for self-harm and the explanations offered by medical staff might have implications for how those who self-harm are treated when they present for medical treatment, which in turn may affect recovery and possibly contribute to future self-harm.

Relatives Also Find it Difficult to Accept The Reasons Given by Those Who Self-harm

Surprisingly, little attention has been paid to the ways in which close relatives and friends (significant others) interpret and react to those who self-harm. This lack of attention is especially noteworthy as patients often report relationship difficulties with a partner (Bancroft et al., 1976; Michel et al., 1994) or parents (Boergers et al., 1998) as an event preceding their self-harm. In addition, survivors of deliberate self-harm invariably return to their home, family and friends. Like medical staff, the reactions of significant others may have important implications for the kind of support the self-harmer might receive, how they recover and whether they self-harm again. The only study to address some of these issues was James and Hawton (1985) that suggested significant others make attributions similar to medical staff regarding perceived motives for self-harm.

James and Hawton (1985) compared the reasons given by 34 patients admitted for medical treatment following an overdose to the explanations offered by significant others. The most marked difference between the self-harmers and significant others

was in regard to the perception of suicidal intent, with 33 (97%) significant others judging an absence of suicidal intent, while 41 % of the patients reported their motive to be of suicidal intent. In addition, like the studies involving medical staff, significant others generally viewed the overdose as having communicative, manipulative and punitive functions. In a majority of cases, significant others stated they believed the overdose was a means of communicating distress and attributed manipulative motives for the overdose. The significant others also believed the deliberate self-harming behaviour was directed at them and was either a form of punishment or an attempt to sway their actions. When the overdose was attributed as being either for manipulative or punitive reasons, significant others frequently reported they believed the overdose was directed towards them. James and Hawton also noted the significant others reported a mixture of emotional reactions to the overdose. As well as evoking sympathy, the overdose also lead the significant others to experience intense feelings of guilt and anger. A surprising finding from this study, was the anger reported by the significant others tended to be significantly higher the greater the apparent seriousness of the act in terms of suicidal intent.

Self-harmers Give Intrapersonal Motives and Observers Give Interpersonal Explanations

Boergers et al. (1998) and Michel et al. (1994) in their reviews of the literature observe that self-harmers typically give intrapersonal reasons for their overdose, while, medical staff and relatives often give interpersonal explanations. Intrapersonal motives refer to reasons; of wanting to die, alleviate unbearable thoughts and emotions and to escape. While interpersonal motives refer to reasons of; wanting help, wanting to hurt someone or wanting to influence an outcome. However, the results of

most studies, (eg Bancroft et al., 1975; James and Hawton, 1986; & Michel et al., 1994) reveal self-harmers frequently offered intrapersonal motives for their overdose while medical staff and significant others usually chose interpersonal or a combination of intrapersonal and interpersonal explanations for someone's overdose.

Why should there be difference in the motives reported by self-harmers and potential helpers such as medical staff and close family and friends? An explanation offered by Bancroft et al. (1976) is that people who overdose report suicidal intent in order to justify their behaviour and to enhance the impact of the overdose. This however is a debatable point and it is implausible that people from different age groups and different countries would offer very similar reasons for their self-harming behaviour, all with the intention of either wanting to punish or manipulate others.

James and Hawton (1985) offered a more plausible explanation, suggesting the suicidal intent reported by the self-harmer may reflect their wishes at the time of taking the overdose. This view is also consistent with Shneidman's (1986) definition of suicidal behaviour as a conscious act of self-induced annihilation, and is best understood as a multidimensional malaise in a needful individual rather than a random or impulsive act. Instead, Shneidman proposes individuals engage in suicidal behaviour in order to gain a solution to their problem or crisis that is invariably causing intense suffering. Inherent in Shneidman's definition is the need to view the suicide/self-harm in context and ascertain the intention of the individual's self-harm.

Medical staff and significant others, on the other hand, might be able to view the self-harm within a broader context and therefore take a more objective view of the

overall circumstances surrounding the overdose, as compared to the individual who self-harms. Alternatively, medical staff and significant others might base their explanations on the belief the self-harm is motivated by the need to manipulate or punish, and this is being directed towards them. Another possible explanation is that the self-harming behaviour is misinterpreted and people fail to appreciate the true degree of suicidal intent.

There are a number of ways to interpret the discrepancies between the reasons offered by those who self-harm and the explanations reported by others. However, as James and Hawton (1985) conclude from their research, the type of treatment a person who deliberately self-harms receives is likely to be influenced by how others interpret the overdose and by their immediate feelings regarding the behaviour. Three main implications arise from this research with medical staff and significant others. First, interpretation of the overdose can be expected to differ between those who have the self-harmed and others. Second, although most people have positive emotions (such as sympathy, pity and empathy) towards the individual who has overdosed, some will experience strong feelings of anger and disgust. In turn these feelings, and perceived suicidal intent, might impact on their willingness to help. Staff coming in contact with self-harmers might therefore require specific suicide awareness training in order to develop a broader understanding of why people engage in self-harming behaviour and the type of treatment they may require. It might be necessary for significant others to express their feelings and attributions and have this experience normalised by health professionals before they can offer support to those who self-harm. Third, if there is to be an opportunity for the self-harmer to receive the support they need/want in order to resolve the underlying issues that might have precipitated self-harm, self-harmers and

significant others may need to discuss their different reasons and explanations for the self-harming behaviour.

What Do Self-harmers Who Overdose Find Helpful When Receiving Hospital Based Treatment?

A natural extension of the research with medical staff and significant others was to identify behaviours self-harmers found helpful when receiving medical treatment and to assess if patients could, in fact, detect the attitudes of their treating medical staff. Treloar and Pinfold (1993) were interested in how patients rated the care they received from the different professionals they had contact with during their hospital admission following an overdose. In addition, the study assessed if patients could correctly identify the attitudes of staff to those who had overdosed. Treloar and Pinfold found a significant association between the amount of help perceived by the patient following an overdose, with the sympathy and the listening behaviour of the treating staff.

The Link Between Suicidal Intent and Emotions, Willingness to help, and Perceived Motives

Hawton and Catalan (1988) suggest the emotions experienced and willingness to help a person who has overdosed are likely to be influenced by the attributions made regarding the perceived precipitant and the apparent intentions for the self-harm. In a study by Ramon et al. (1975), doctors and nurses working at a general teaching hospital in the UK (n= 132) were presented with four case studies describing individuals who self-harmed by either overdosing or self-poisoning with carbon monoxide. Respondents indicated their sympathy for each case and their readiness to help. The scenarios can be summarised as: an impulsive overdose by an older woman,

an impulsive overdose by an "immature" 18 year old, a "manipulative overdose by an alcoholic" 45 year Scottish man and a planned CO2 gassing by a 55 year old depressed man. The term "depressive motives" was used to refer to motives communicating despair, with the aim of withdrawal, escape or death by the self-harmer. While the term "manipulative motives" was used to describe acts of self-harm where the intent to die was not readily evident and the circumstances were suggestive of either wanting to punish or change the actions of others.

In Ramon's et al.'s study, doctors clearly differentiated between self-harmers whom they thought had been trying to kill themselves and those whom they believed did not want to die. Depressive motives were ascribed to the scenarios in which the circumstances (precipitants) and intentions were suggestive of wanting to die, while manipulative motives were ascribed when the circumstances and intentions were suggestive of not wanting to die. Respondents found depressive motives more acceptable as a reason for the self-harm and this was strongly associated with greater levels of positive emotions such as sympathy and readiness to help. The scenario of the 55 year old depressed man evoked the highest level of sympathy and readiness to help. Manipulative motives were rated as less acceptable and associated with less sympathy and readiness to help. Both scenarios depicting an impulsive overdose by an "immature" 18-year-old and an "older" woman evoked the least level of sympathy. The depiction of an "alcoholic 45 year old Scottish man" who had overdosed on previous occasions elicited the least levels of readiness to help. Similar differences in attitudes and emotions were found by Hawton et al. (1981) in a study of psychiatrists, using the same methodology. However, psychiatrists differed from physicians in that

their attitudes were generally more sympathetic and they expressed greater willingness to help than the physicians.

Although there is an implied level of suicidal intent in Ramon et al.'s (1975) study with high suicidal intent attributed to depressive motives and presumably low suicidal intent to manipulative motives, it is not entirely clear this is the case. In a sense, these terms are more suggestive of possible explanations for the self-harm. Ghodse et al. (1986) investigated whether the attitudes of health care professionals were related to the intention of an overdose. Ghodse et al. gave hospital staff (n= 323) a questionnaire in which participants indicated their attitudes as favourable, neutral or unfavourable, regarding the presentation of self-harmers. The acts of self-harm were depicted as; accidental self-poisoning, suicidal attempt, suicidal gesture, or an overdose in the context of alcoholism or drug dependence. Patients who had taken an overdose accidentally were viewed more favourably than those who had intentionally overdosed and, in turn, were viewed more favourably than those who overdosed whilst intoxicated or dependent on drugs

The Link Between History of Self-harm, Emotions, Willingness to Help, and Perceived Motives is Unclear

As discussed earlier, a history of self-harm with suicidal intent has been identified as the single best predictor of death by suicide (Hawton & Catalan, 1987). An appropriate and timely response by potential helpers might help to reduce future self-harm risk and thereby avert a completed suicide. However, it is unclear how potential helpers respond to information about a significant other's self-harming history and subsequently how this might effect potential helpers' reactions and responses. It would therefore be useful to first establish how history of self-harm

might influence emotions, willingness to help and perceived motives for an overdose. Unfortunately, there has been little research that has investigated the role of history of self-harm on peoples' reactions and responses. Where history of self-harm has been included in vignettes, it has appeared with other information in which details about gender, method of self-harm and details about mental illness have differed for each of the vignettes presented to participants. For example, in Ramon et al's study information about previous self-harm was presented with other details in vignettes that were highly emotive and judgemental. One such vignette was that of a 45-year-old alcoholic Scottish man who had overdosed after phoning the hospital in an intoxicated state and refusing to give his details. It was also revealed in the vignette that he had overdosed on at least three other occasions in the context of psychosocial stressors associated with being sacked because he was drunk and two relationship break-ups. It is difficult to know what aspects of the information in this vignette people are reacting to when they give their responses. Is it that he is 45 years old, Scottish, an alcoholic, threatening self-harm whilst intoxicated, his history of previous overdoses or a combination of these factors? Clearly, in order to investigate the effects of self-harming history, a study would need to hold constant details such as the demographics of the person who self-harms, the method used, circumstances of the self-harm and the suicidal intent.

Prediction of Future Self-harm

There are a number of factors that clinicians use to identify the suicide risk of a patient in order to devise and implement appropriate safety and treatment strategies (Kaplan et al., 1994). When the risk of future self-harm is considered high, clinicians implement assertive interventions such as hospitalisation or close monitoring in the community. Obviously clinicians are trained to observe for known suicide risk factors

and to then respond accordingly. People in the general community do not, on the other hand, receive this training in identifying and responding to suicide risk factors. Yet based on the rates of self-harm, potential helpers in the community are either likely to know a person who is at high risk of self-harm or know a friend/relative who has self-harmed. As reported earlier, Hawton and Catalan (1981) in a review of hospital presentations in the UK found between 6-15 % of people, who attempted suicide, reattempted within one year of receiving medical treatment. An appropriate and timely response to people at elevated risk of self-harm by potential helpers in the community could help to reduce the incidence of self-harm. Three important questions arise from this assertion. First, do potential helpers in the community make predictions of future self-harm? Second, if potential helpers do make predictions of future self-harm, what kind of information do they respond to regarding an incident of self-harm in order to reach such a prediction? Third, do predictions of future self-harm in turn determine the kind of help given by potential helpers? Identifying factors of a self-harm that are likely to elicit predictions of self-harm would aid in investigating the questions posed.

A review of how clinicians reach their formulation of risk is useful in identifying factors that potential helpers in the community might use to reach their opinion of future risk. Kaplan et al. (1994) provides a comprehensive list of clinical indicators of self-harm risk. Two important factors clinicians use in determining level of future risk of self-harm is the person's level of suicide intent for the self-harming behaviour and their history of self-harm. It would be important to establish if information regarding suicide intent and/ or history of self-harm influence potential helpers' predictions of future self-harm. Subsequent research could then investigate if

predictions of future self-harm determine the kind of help given by potential helpers to those who either self-harm or are perceived to be at elevated risk of self-harm.

Is There a Difference in Responses by Potential Helpers With and With Out a Personal Experience of Self-harm?

In attempting to account for the differences between the responses of nurses and doctors in their study Ramon et al. (1975) suggested the shared meaning of self-poisoning might be a crucial element in determining the reactions of the potential helper. That is, the staff who responded in a more sympathetic way in the study might have done so because of their own experience of self-harming thoughts or self-harming behaviour. For example, Ramon and colleagues note doctors are in a high risk group for completed suicide yet tend not to present to public hospitals for help, while, nurses are in a high risk group for self-harm by overdose and often do present to a hospital. Obviously caution is required, since Ramon et al.'s comments are only speculative in explaining the difference in responses of doctors and nurses in their study.

Ingram and Ellis (1995) investigated the attitudes of college students with suicidal and non-suicidal experiences toward suicide victims in different situations. Subjects read one of four scenarios depicting a man with either cancer, AIDS, schizophrenia or depression who had suicided. They found the man in the cancer and AIDS scenarios was viewed as the most physically unhealthy and the most justified in committing suicide. Of direct relevance to this study, those identified as "suicide ideators" viewed the man in all four scenarios to be more justified in committing suicide than did the "nonideators." Ingram and Ellis categorised suicidal ideators based on whether they reported they had attempted suicide or seriously contemplated

suicide while nonideators were defined as those who had not attempted suicide or had never considered suicide. Interestingly, women did not evaluate the victims in the scenarios any differently than the men. Ingram and Ellis (1995) concluded from their study that people do react differently to a hypothetical suicide depending on 1) the circumstances that led to the suicide and 2) their own suicidal experiences.

Difficulties with The Research

The studies reviewed in this paper have intrinsic value in shedding light on the attributions medical staff and significant others make concerning those who self-harm by overdose, on potential helpers emotional responses and willingness to help. However, it is unclear what factors relating to an overdose may systematically elicit favourable or unfavourable attitudes, positive emotions and willingness to help. Where studies have required medical staff to rate their attitude to vignettes depicting self-harm, often no attempt has been made to systematically manipulate the attributes of the person who self-harmed, the method used or reasons for the self-harm. Instead, there has been an emphasis on attempting to present to respondents a cross section of scenarios medical staff are likely to be confronted within a hospital environment. For example, in Ramon et al. (1975), doctors and nurses working at a general teaching hospital in the United Kingdom were presented with four case studies depicting individuals who subsequently self-harmed by either overdosing or self-poisoning with carbon monoxide. Alternatively, respondents have been provided with clinical information of patients (Bancroft et al., 1976; Hawton et al., 1981a; Hawton et al., 1981b) recently admitted to a hospital due to deliberate self-harming behaviour. The purpose in these studies was to replicate day to day clinical practice and decision making. In James and Hawton's (1985) study significant others commented on the self-harm of their relative or close friend without necessarily having direct access to

information regarding the stated intention and circumstances of the person who overdosed. In addition, the methodologies used in these studies have been limited to correlational designs and characterised by the use of non-standardised data collection, small sample sizes (Hawton & Catalan, 1988) and poorly constructed questionnaires (Ghodse et al., 1986; Treloar & Pinfold, 1993). In all cases there has been no mention of reliability and validity data of the measures used or outcomes from pilot studies of vignettes or justification of the choice of vignettes.

In James and Hawton's (1985) study, patients admitted to two general hospitals in the UK and a significant other were interviewed following an overdose. The researchers did not disclose to the significant others information that the patient had told them regarding their intention, how lethal the overdose was or the circumstances regarding the overdose. Significant others were therefore left with having to refer to information that may have not been directly relevant to the overdose. Again, as with the studies involving medical personnel, this study offers a reasonable summary of how people respond to real life situations. It therefore allows statements of how people with specific attributes and circumstances surrounding their self-harm might be treated. However, it is not possible to comment on what are the underlying qualities people might refer to, to systematically discriminate between different incidents of self-harm. One factor identified from these studies that appears to have a causal affect on emotional responses and willingness to help is suicidal intent. Another possible factor is history of self-harm.

Due to the methodological flaws of the studies reviewed, it is unclear what factors of an overdose systematically evoke particular emotions, judgements about motives for the overdose and willingness to help. By understanding the effects of

specific factors on these processes it would then be possible to develop strategies that might reduce the impact of negative responses on potential helpers, and hopefully, encourage more supportive responses to those who self-harm. There is some indication from the research reviewed that suicidal intent and history of self-harm might systematically evoke particular emotional reactions, judgements and willingness to help in potential helpers. Although the methodological flaws of the studies reviewed have been highlighted, there are advantages to continuing with this type of research. At a very practical level, the use of simulation research is more viable than actually approaching people who's close friend or family member has recently overdosed to investigate the possible effects of suicide intent and history of self-harm on a potential helper. In addition, replicating elements of the studies cited would permit some comparison to be made of the findings from this study, and hence, increase the potential generalisability of the data.

It is obviously important in this study to avoid repeating the methodological flaws of the studies reviewed and hence, improve the validity of the results. For example, in the studies cited; 1) participants made ratings on a number of different scenarios, 2) participants were presented with information about suicide intent and history of self-harm that was confounded with other variables such as different demographics, circumstances of the person self-harming and methods of self-harm, and 3) there was no counter balancing of the order in which the scenarios were presented. Solutions to these problems would be to use a between-subjects design, manipulating information only about suicide intent and history of self-harm and standardising the accounts in which a person self-harms.

Potential helpers in the community often receive information about a friend or relative's self-harm from the people they know. At times, this information may be inaccurate and conflicting. This can create a dilemma for the potential helper in deciding who is the more credible informant, or choosing the more plausible information. Unfortunately, it is unclear from the literature, how people might react if they were first informed it was the first time a person had overdosed, only later to find out that the person had in fact previously self-harmed. It would therefore be useful to investigate how providing contradictory information about someone's overdose would affect potential helpers emotional reactions and responses. The use of a mixed between and within subject design would permit this kind of investigation.

Aim of the Study

Despite the incidence and prevalence of self-harm there have been few investigations into the specific factors that systematically affect the responses and judgements of a potential helper towards a significant other who has overdosed. The present study is designed as a preliminary investigation of how the stated intention of an overdose (to die or not die) and history of deliberate self-harm (previous self-harm or first act of self-harm) affect a potential helper's emotions, willingness to help and attributions regarding motives for an overdose. Based on the literature reviewed six hypotheses were developed.

Hypothesis 1

The first hypothesis is that participants will report a greater level of positive emotions when the stated intention for an overdose is to die than when the stated intention is not to die. As discussed earlier in this report, people who overdose often

evoke strong feelings in those around them. In Ramon et al.'s (1975) study, medical staff reported a range of positive and negative emotions based on whether or not they believed the intention for an overdose was to achieve death.

Hypothesis 2

Participants will report higher positive emotions when informed it is the first time a significant other has overdosed than when informed there has been previous self-harm. As outlined earlier, there is evidence from studies by Ramon et al. (1975) and Ghodse et al. (1986) that people respond differently when someone has previously self-harmed. However, due to the confounding of history of self-harm with other factors in these studies, it is unclear how potential helpers react when informed about history of self-harm. Epidemiological research also indicates that previous self-harm is often associated with increased risk of death by suicide (Graham et al., 2000). It would therefore be useful to know how a potential helper's reactions and judgements are affected when presented with different information about self-harming history.

Hypothesis 3

Participants will report a greater level of willingness to help when the stated intention for an overdose is to die than when the stated intention is not to die. In Ramon et al.'s (1975) study, medical staff also reported different degrees of readiness (willingness) to help based on whether they believed the motive for the overdose was to achieve death or as a form of manipulation (not die).

Hypothesis 4

Participants will report a greater level of willingness to help when it is the first time a significant other has overdosed than when a significant other has a history of self-harm. There is an interest in ascertaining if potential helpers respond differently depending on whether they know it is the first time someone they know has overdosed or if he/she has previously self-harmed. Although no hypothesis has been postulated, clinical observations suggest that an interaction may occur between suicide intent and history of self-harm. Potential helpers may respond differently when a person overdoses with the intention of wanting to die and who has previously self-harmed as compared to a person who does not want to die and has previously self-harmed.

Hypotheses 5 and 6

The fifth hypothesis is that participants will report a greater level of interpersonal motives and a lower level of intrapersonal motives when the stated intention for the overdose is not to die. Finally, the sixth hypothesis is that participants will report a greater level of interpersonal motives and a lower level of intrapersonal motives when there is a history of self-harm.

Ramon et al.'s (1975) findings and Boergers et al.'s (1998) assertions regarding the kind of attributions people make about the motives for an overdose are tested with the last two hypotheses. Ramon et al. (1975) found the perception of depressive (intrapersonal) motives were more acceptable and evoked more sympathy and readiness to help in both doctors and nurses than when the perceived motives were of manipulation (interpersonal). Based on these findings, it would be reasonable to presume the suicidal intention of wanting to die would elicit intrapersonal attributions

while the stated suicidal intention of not wanting to die would elicit interpersonal attributions. There is also evidence to suggest that repeated self-harming is viewed as a form of manipulation or attention seeking behaviour (Michel et al., 1994). However, James and Hawton (1986) found, although, self-harmers often reported intrapersonal based motives, significant others reported a mixture of intrapersonal and interpersonal motives.

Exploratory Questions

Given the exploratory nature of this study there are also a number of questions of interest. Unfortunately, there is little relevant research literature that can be consulted to provide guidance in the formulation of hypotheses. The investigation of how suicide intent and history of self-harm might affect predictions of future self-harm is one such interest. Does the intention of wanting to die evoke higher ratings of predicted likelihood of future self-harm than the intention of not wanting to die? How does a history of self-harm affect ratings of predicted likelihood of future self-harm? Specifically, does information regarding previous acts of self-harm elicit higher ratings of predicted future self-harm when it is the first time a person has overdosed? In addition, potential helpers often receive information regarding a significant other's overdose from family members or friends. When potential helpers are told either a close friend or family member has self-harmed and are not informed about history of self-harm, do they respond as if it was the first incident of self-harm? In addition, there is an interest in investigating how potential helpers might respond to information about history of self-harm that is conflicting or contradictory. It is unclear from the literature reviewed, how people would react if they receive contradictory information regarding history of self -harm. That is, when they are informed it was the first time a

person has overdosed only later to discover the person had in fact previously self-harmed.

Chapter 2: Methodology

Participants

Questionnaires were distributed to students attending first and second year Psychology lectures and tutorials at Edith Cowan University Joondalup Campus, Western Australia. Of the 145 questionnaires distributed, 142 (98%) questionnaires were completed and returned (38 males and 104 females). Participants ages ranged from 17 to 55 years ($\underline{M}$ = 25.4, $\underline{SD}$ = 9.30) and were strongly skewed to the lower end of the age range. One hundred and fourteen (80%) of the participants were enrolled as full time students and ninety-eight (69%) of the participants were in paid employment in addition to studying. Sixty-one (43%) of participants described themselves as single, while, 23 (16%) were married and living together and 17 (12%) were living in a defacto relationship. Forty-three (30%) of the participants reported they were in a relationship but not living together.

Participants were also categorised according to whether or not they reported personal self-harming behaviour (PSHB) and knowledge of a significant other's self-harming behaviour (SSHB). All participants responded to these questions, with 24 (17%) of the participants reporting they had either seriously contemplated or attempted suicide. While 44 (31%) of the participants reported they knew of either a close friend or relative who had either seriously contemplated or attempted suicide. There were no significant differences in the demographic profile of participants with personal history of self-harm or knowledge of significant others self-harming behaviour and participants with no personal history of self-harm or knowledge of significant others self- harming behaviour.

Materials

Participants received a booklet containing two vignettes and a questionnaire. The written material was divided into five sections: 1) First Vignette, 2) Dependent Variable Measures, 3) Second Vignette 4) Dependent Variable Measures (second administration) and 5) Demographic Information.

First Vignette

The first section consisted of a cover sheet introducing the study (Appendix A) and one of six brief fictional accounts of a woman who is a close friend, who overdoses but does not die (Appendix B). The woman's husband conveys the information about the overdose to the reader following a chance meeting. There were six versions of the story describing the woman's overdose with details about the suicide intent and history of self-harm altered to reflect the independent variables. There were two levels of the first independent variable, suicidal intent, and these were to "die" or "not die", and three levels of the second independent variable, history of self-harm, and these were, the "first known overdose", "previous acts of self-harm" and "history of self-harm not reported".

Preparation of The Vignettes

Although the story adopted in the study was fictional, it was based on accounts repeatedly found in epidemiological and clinical studies related to suicide and self-harming behaviour. The vignettes depicting a woman overdosing were developed in order to reflect as much as possible a scenario the participants were likely to encounter should a significant other self-harm. As discussed earlier in the report, women who self-harm typically tend to overdose in the context of psychosocial

stressors associated with relationship difficulties (Bancroft et al., 1979; Michel et al., 1994).

The details in each of the stories were the same except for information regarding history of self-harm and stated suicidal intent. Suicidal intent was determined by the stated intention for the overdose (Die/Not Die), lethality and chance of discovery. The degree of lethality was manipulated by providing information about the amount of tablets taken (a small or large amount) and whether the belief the amount of tablets taken was potentially fatal (she believed it would/would not kill her). High suicide intent was characterised by the stated intention to die the taking of a perceived lethal amount of tablets that she believed to be potentially fatal and a low chance of discovery. While, low suicide intent was characterised by the stated intention of not wanting to die, the taking of a small amount of tablets that she believed not to be potentially fatal and a high chance of discovery. The second independent variable, History of self-harm refers to knowledge about the incidents of self-harming behaviour: 1) first known episode of deliberate self-harm, 2) previous episodes of self-harm and 3) no comments about previous episodes of deliberate self-harm.

Dependent Variable Measures

Perceived level of suicidal intent. Participants rated on an 11-point scale ranging from 0 (definitely did not want to die) to 10 (definitely did want to die) the perceived level of suicidal intent of the woman who overdosed in the vignette they were given. The perceived level of suicidal intent was used to check if there was a manipulation effect of the independent variable of suicidal intent.

Emotions. The first dependent variable relates to participants' emotional reactions towards the woman following news of her overdose. The measure for emotions is based on two major affective factors identified by Meyer and Mulherin (1980) in their study of help giving behaviours. Meyer and Mulherin identified a bipolar affective dimension of anger versus concern, with negative emotions such as anger and disgust at one pole and positive emotions such as concern and sympathy at the other. They also identified a unipolar positive emotional factor labelled empathy and comprised of pity and sorrow. The emotion scale therefore comprised of 6 emotions: anger, disgust, sympathy, concern, pity and sorrow. The emotion scale developed by Meyer and Mulherin (1980) has been used in studies by Weiner (1980a & 1980b), Reisenzein, (1986), Schmidt and Weiner (1988), and Ho & Venus (1995) due to its construct and reliability properties. In this study, participants were instructed to:

"As much as you can, imagine how you would feel towards the woman when you found out she had overdosed. Please circle the number that best reflects what your response would be for each of the following (emotions listed)."

Each item had a 7-point rating scale ranging from 0 (strongly disagree) to 6 (strongly agree). Scores for each item were summed to form a single emotions score with the two negative emotions, anger and disgust reverse scored. High scores on the emotion scale indicate a positive emotional response while low scores indicate a negative emotional response to the woman.

Willingness to help. Participants rated their willingness to help the woman after learning about her overdose on a single measure with an 11-point scale ranging from

0 (No, I definitely would not help) to 10 (Yes, I definitely would help). Willingness to help was operationalised by the dimensions of being available to listen, visiting, and helping when needed by the woman. The intention of defining willingness in this way was to underscore to participants the nature of help they were required to consider before responding.

Perceived motives. The Reasons for Overdose Scale (Hawton et al., 1982) was modified and used to measure the perceived influence of interpersonal motives for the overdose. The original scale instructs adolescents to select from a series of statements those that best describe their reason(s) for self-harm. Adolescents were allowed to choose as many of the items as they wished. The items in the Reasons for Overdose Scale were originally derived from the work of Bancroft et al. (1976) and modified versions of the list have been used with adults (James & Hawton 1985; Michel et al., 1994). The altered instructions for this scale were adopted from the version used by Michel et al. (1994) that required a response to all items from those who had self-harmed. The extent of the influence of each of the motives listed was rated on a 3-point scale; no influence, a minor influence or a major influence. The Reasons for Overdose Scale comprises of motives that are either intrapersonal based or interpersonal based. The intrapersonal motives comprises of 3-items; (1) to die, (2) get relief from a terrible state of mind and (3) escape for a while from an impossible situation. While the interpersonal motives comprise of 7-items: (1) make people understand how desperate she was feeling, (2) make people sorry for the way they treated her, (3) frighten or get some- one back, (4) try to influence some one or get them to change their mind, (5) show how much she loved someone, (6) find out whether someone really loved her or not, and (7) get help from someone. In this

study, the items listed were used to define intrapersonal and interpersonal motives respectively. The Reasons for Overdose Scale was used to allow comparisons with previous studies cited. No other relevant scales were identified during the literature review.

Predictions of future self-harm. A single scale was developed to measure the predicted likelihood of future self-harm. Participants indicate on an 11-point scale ranging from 0 (most unlikely) to 10 (most likely) what they think the likelihood is of the woman overdosing again.

Second Vignette

The second vignette was used in order to create the within subject design component of the study. In the second vignette all participants read they accidentally meet their friend's mother the next day. During their brief conversation the woman's mother expresses her concerns because it is not the first time her daughter has self-harmed.

Dependent Variable Measures (Second administration)

Following the reading of the second vignette participants were required to complete the same measures in the Dependent Variable Measures Section (affect, willingness to help perceived motives and prediction of future self-harm). The only measure not included in this section was Perceived level of suicidal intent, which was used as an initial manipulation check.

Demographic Information

The last section consisted of questions designed to elicit information regarding participants' age, gender, enrolment status, employment status, current relationship, previous relationships, and suicidal experiences of significant others and self. The Suicide Ideation Questionnaire developed by Ingram and Ellis (1995) was used to elicit information about participants suicidal experience and knowledge of significant others' suicidal experience.

In responding to the two questions relating to suicidal experiences, participants were required to choose one of four possible options: (1) attempted suicide in the past, (2) seriously contemplated suicide in the past, (3) had thoughts of suicide in the past, and (4) had never considered suicide in the past. Participants first responded by choosing a statement that to the best of their knowledge reflected their close family members or close friends suicidal experience. Participants were then asked to choose a statement that reflected their own suicidal experience. Ingram and Ellis (1995) classified the first two options as constituting a suicidal experience and the last two options as constituting no suicidal experience. According to Ingram and Ellis, research has shown that the items differentiate between those who have experienced suicidal ideation and those who have not.

Procedure

Following ethics approval and permission from relevant lecturers and tutors, students were approached during their psychology lectures and tutorials. They were informed the purpose of the study was to investigate community attitudes towards people who overdose and invited to participate. Students were informed verbally and

in writing of their rights under the ethical guidelines of voluntary participation and were advised they would not be identified with any of their responses. In addition, students were informed they did not have to complete the questionnaire if they did not wish to do so and could discontinue at any time. Instructions were also included in the introduction outlining how participants could seek assistance should they experience emotional difficulties after reading and completing the questionnaire. After the participants read the cover sheet, they turned over the page and completed the questionnaire (Appendix C). All participants then turned to the second vignette (Appendix D) and then recorded their responses on the same measures in the next section of the questionnaire and completed the section on Demographics (Appendix E).

Participants were randomly assigned to one of six conditions and received one of six vignettes; 1) First known overdose and Intention to die (n = 25), 2) First Known overdose and No intention to Die (n = 26), 3) Previous Overdose(s) and Intention to Die (n = 25), 4) Previous Overdose(s) and No Intention to Die (n = 25), 5) Don't know about previous overdose(s) and Intention to die (n = 20); and 6) Don't know about previous overdose(s) and No Intention to die (n = 20).

Chapter 3: Results

The Statistical Package for Social Sciences (SPSS) for Windows (version 7.05) was used in all statistical analyses. To investigate the effect of the manipulation of stated suicide intent, a one-way ANOVA was performed. A manipulation effect was found for suicidal intent. Participants perceived higher levels of suicidal intent for the conditions where the stated intention was to die ($\underline{M}$ = 6.96, $\underline{SD}$ = 2.05, $\underline{n}$ = 70) than for the conditions where the intent was not wanting to die ($\underline{M}$ = 3.70, $\underline{SD}$ = 2.28, $\underline{n}$ = 71), $\underline{F}(1, 140) = 79.07$, $\underline{p}<.000$.

The Effects of Suicide Intent and History of Self-harm on Emotions, Willingness to help and Motives

There were two between subjects variables: suicide intent (die/not die) and history of self-harm (first attempt/previous attempts/don't know). The within subject variable was scenario (second vignette-previous deliberate self-harm). Of the 142 completed questionnaires there was no missing data for the dependent variables.

The Mauchly's Test of Sphericity revealed no significant results, indicating there were no violations of the assumption of homogeneity of variance. An inspection of the responses to all scales revealed a normal distribution for all measures, except for willingness to help. Willingness to help was negatively skewed towards higher levels of helping. Analysis of the demographic profiles with the independent variables revealed no significant associations.

Cohen's (1992) table of recommended sample sizes was consulted in order to determine the sample size required for this Study. Cohen offers a useful table summarising the sample size required for different statistical tests to detect large,

medium and small effect sizes and at different levels of statistical significance (.01, .05 & .10). According to Cohen's table, a sample size of 35 is preferable when using ANOVA with 6 groups in order to detect a medium effect size at the .05 level of statistical significance. There was a failure in obtaining the recommended sample size for each condition in this study, with the median cell size being 24.

In order to test hypotheses relating to the effects of suicide intent and history of self-harm a series of mixed model ANOVAS were performed on the mean ratings of emotions, willingness to help, motives and prediction of future self-harm. The mean scores and standard deviations for emotions, willingness to help and motives are found in tables 1-4. Regardless of the stated suicidal intent and history of self-harm, participants recorded high levels of positive emotions and willingness to help. Participants also reported that both intrapersonal and interpersonal motives influenced the overdose with scores in the moderate range for both scales.

Table 1

Participants ratings of emotions in each of the six conditions after reading the first and second vignettes

		Vignette 1			Vignette 2		
History of Self-harm	Stated Intention	M	SD	n	M	SD	n
First Time	Die	27.5	5.96	24	25.00	6.33	24
	Not Die	27.15	4.4	26	24.62	6.05	26
Previous	Die	26.58	4.75	24	26.00	4.87	24
	Not Die	25.88	6.24	24	25.42	5.89	24
Don't Know	Die	29.6	5.52	20	28.00	6.95	20
	Not Die	25.55	6.07	20	25.30	5.58	20

Note: A maximum score of 36 was possible, with higher scores reflecting higher levels of positive emotions.

Table 2

Participants ratings of willingness to help in each of the six conditions after reading the first and second vignettes

		Vignette 1			Vignette 2		
History of Self-harm	Stated Intention	M	SD	n	M	SD	n
First Time	Die	8.64	1.98	25	8.60	2.00	25
	Not Die	8.46	1.75	26	8.04	2.31	26
Previous	Die	8.84	2.13	25	8.64	2.36	25
	Not Die	8.76	1.59	25	8.88	1.27	25
Don't Know	Die	8.9	1.65	20	8.35	2.13	20
	Not Die	8.40	1.64	20	8.05	1.88	20

Note: A maximum score of 10 was possible with the higher the score, the higher the willingness to help.

Table 3

Participants ratings of intrapersonal motives in each of the six conditions after reading the first and second vignettes

		Vignette 1			Vignette 2		
History of Self-harm	Stated Intention	M	SD	n	M	SD	n
First Time	Die	3.92	1.44	24	4.00	1.66	24
	Not Die	3.59	1.55	27	3.89	1.80	27
Previous	Die	3.56	1.16	25	3.92	1.30	25
	Not Die	3.32	1.46	25	3.60	1.64	25
Don't Know	Die	3.95	1.15	20	4.05	1.35	20
	Not Die	3.85	1.23	20	3.90	1.30	20

Note: A maximum score of 6 was possible, with the higher the score, the greater the perceived influence of intrapersonal motives.

Table 4

Participants ratings of the perceived influence of interpersonal motives in each of the six conditions after reading the first and second vignettes

		Vignette 1			Vignette 2		
History of Self-harm	Stated Intention	M	SD	n	M	SD	n
First Time	Die	4.42	2.79	24	6.58	3.11	24
	Not Die	6.08	2.57	25	8.40	2.84	25
Previous	Die	5.57	3.29	23	6.52	3.62	23
	Not Die	6.26	2.66	25	6.92	2.41	25
Don't Know	Die	5.55	2.72	20	7.15	2.23	20
	Not Die	5.26	2.38	19	6.47	3.06	19

Note: A maximum score of 12 was possible, with the higher the score the greater the perceived influence of interpersonal motives.

One purpose of the analysis was to determine if stated suicide intent and history of self-harm affected participant emotions, willingness to help and selection of interpersonal motives to account for the overdose. It was predicted that wanting to die would elicit higher levels of positive emotions and willingness to help than not wanting to die. While information about this being the first overdose would elicit higher levels of positive emotions and willingness to help than when there was previous self-harm. Tables 5 and 6 display the results of the mixed model ANOVAs. These tables reveal there were no differences in reported levels of positive emotions and willingness to help based on whether the stated intention for the overdose was to die and not to die. In addition, there were no differences in emotions and willingness to help when participants were informed it was the first time the woman had overdosed or that there had been previous self-harm.

There was however, an interaction for scenarios and history of self-harm based on participants' reports of emotional responses when they read the first and second vignettes. Participants who were initially informed it was the first time the woman had overdosed and later discovered it was not the first incident of self-harm decreased in their reports of positive emotions.

Table 5

Analysis of Variance for Emotions

Source	df	F	Eta2
	Between Subjects		
History of Self-harm (HSH)	2	0.58	0.009
Suicidal intent (SI)	1	2.48	0.018
HSH x SI	2	1.00	0.015
S within group Error	132	(58.99)	
	Within Subjects		
Scenarios (S)	1	17.46***	0.117
HSH x S	2	3.97*	0.057
SI x S	1	0.57	0.004
HSH x SI x S	2	0.45	0.007
Within group error	132	(6.84)	

Note: * p< .05, *** p<.001

Table 6

Analysis of Variance for Willingness to Help

Source	df	F	Eta2
	Between Subjects		
History of Self-harm (HSH)	2	0.57	0.008
Suicidal intent (SI)	1	0.54	0.004
HSH x SI	2	0.25	0.004
S within group Error	135	(6.89)	
	Within Subjects		
Scenarios (S)	1	8.03**	0.056
HSH x S	2	1.86	0.027
SI x S	1	0.07	< 0.001
HSH x SI x S	2	1.75	0.025

Note: ** p< .01

The second purpose of the analysis was to determine if participants' attribution of motive for the overdose differed by the degree of interpersonal influence based on suicide intent and history of self-harm. It was expected that not wanting to die would elicit higher levels of interpersonal influence compared to wanting to die. Further, higher levels of interpersonal influence were expected when there was a history of self-harm than when it was the first overdose. Tables 7 and 8 display the results of the mixed model ANOVAs. There were no main effects or interactions found for interpersonal motives. Instead, participants chose a combination of interpersonal and

intrapersonal motives as influencing the overdose regardless of the suicide intent and history of self-harm.

Table 7

Analysis of Variance for Intrapersonal motives

Source	df	F	Eta2
	Between Subjects		
History of Self-harm (HSH)	2	1.42	0.021
Suicidal intent (SI)	1	.016	< 0.001
HSH x SI	2	0.13	0.002
S within group Error	135	(5.51)	
	Within Subjects		
Scenarios (S)	1	8.08**	0.056
HSH x S	2	0.42	0.006
SI x S	1	3.60	0.026
HSH x SI x S	2	0.29	0.004
within group Error	135	(2.16)	

Note: ** p< .01

Table 8

Analysis of Variance for Interpersonal motives

Source	df	F	Eta2
	Between Subjects		
History of Self-Harm (HSH)	2	0.08	< 0.001
Suicidal intent (SI)	1	1.26	0.010
HSH x SI	2	1.33	0.020
S within group Error	130	(20.37)	
	Within Subjects		
Scenarios (S)	1	11.99***	0.084
HSH x S	2	1.11	0.017
SI x S	1	0.06	< 0.001
HSH x SI x S	2	0.05	< 0.001
within group Error	130	(12.10)	

Note: *** p<.001

The Effects of Suicide Intent and History of Self-harm on Predictions of Future Self-harm

As an exploratory investigation, the data was analysed regarding the possible influence of suicide intent and history of self-harm on the prediction of future self-harm. The means and standard deviations for predictions of future self-harm based on suicide intent and history of self-harm are found in Table 9. While the results of the mixed model ANOVA for predictions of future self-harm are found in Table 10.

Table 9

Participants' ratings of prediction of future self-harm in each of the six conditions after reading the First and Second Vignettes

		Vignette 1			Vignette 2		
History of Self-harm	Stated Intention	M	SD	n	M	SD	n
First Time	Die	6.40	1.83	25	8.08	1.32	25
	Not Die	5.85	2.44	27	7.69	1.93	26
Previous	Die	6.88	1.78	24	8.25	1.39	24
	Not Die	5.56	2.04	25	7.60	1.12	25
Don't Know	Die	6.30	1.69	20	7.85	1.84	20
	Not Die	5.30	1.66	20	7.50	1.54	20

Note: A maximum score of 10 was possible, with the higher the score, the higher the prediction of future self-harm.

Table 10 shows there was a main effect for the likelihood of future self-harm for suicide intent. Future self-harming behaviour was considered more likely when the stated intention was to die than when it was not to die. There were no main effects or interaction found for history of self-harm.

Table 10

Analysis of Variance for Prediction of future self-harm

Source	df	F	Eta2
	Between Subjects		
History of Self-Harm (HSH)	2	0.58	0.009
Suicidal intent (SI)	1	7.22**	0.051
HSH x SI	2	0.37	0.006
S within group Error	134	4.74	
	Within Subjects		
Scenarios (S)	1	147.54***	0.524
HSH x S	2	0.11	0.002
SI x S	1	2.71	0.020
HSH x SI x S	2	0.39	0.006
within group Error	134	(1.48)	

Note: ** p< .01, *** p<.001

The Effects of Not Informing Participants of the Frequency of Self-harm

Inspection of Tables 1 and 2 reveals very little differences in means between participants informed it was the first time there was previous self-harm and no reference made regarding frequency of self-harm. The results of the between subject ANOVAs for emotions and willingness to help found in Tables 5 and 6 reveal there were no main effects or interaction for history of self-harm (first time/previous/don't know).

How Do Participants Respond When Provided with Contradictory Information Regarding History of Self-harm?

Within subject ANOVAs were employed to investigate the impact of providing contradictory information regarding history of self-harm. The means and standard deviations for emotions, willingness to help, interpersonal motives and future self-harm when provided with the second vignette are found in Tables 1, 2, 4 and 9 respectively. It was expected that participants would change little from the reading of the first and the second vignette when information regarding history of self-harm was confirming. That is, when participants were initially informed there had been previous self-harm and this was confirmed in reading the second vignette. While participants would differ in their responses when initially informed it was the first time there had been self-harm, and then informed in the second vignette that there was a history of self- harm. The within subject ANOVAs revealed that regardless of whether the information about previous self-harm was confirming or contradictory, that changes in responses occurred across scenarios within participants. There was a significant within subject decrease in sympathy (Table 5), willingness to help (Table 6), interpersonal motives (Table 8) and predictions of future self-harm (Table 10).

An interaction between Scenarios and History of self-harm was also found for emotions (Table 5). Sympathy decreased significantly following reading of the contradictory information regarding history of self-harm. That is, when participants were initially informed this was the first time the woman had self-harmed and were subsequently told she had previously self-harmed their scores for emotions were significantly lower.

Personal Suicidal Experience and Knowledge of Significant others' Suicidal Experience as Possible Confounding Variables

The lack of between subject main effects or interactions led to an investigation for possible confounding effects. The most likely considered confounding factor was participants' suicidal experience. A principal aim of the study was to examine the effects of suicide intent and history of self-harm on emotions and willingness to help. Therefore 4-way ANOVAS were performed to determine the effects of participants personal self-harming behaviour (PSHB) and knowledge of significant others' self-harming behaviour (SSHB) on sympathy and willingness to help. There were insufficient numbers of participants with PSHB and SSHB in the two conditions in which there was no mention of the frequency of self-harming behaviour. These conditions were therefore not included in the analyses. The means and standard deviations for emotions and willingness to help for participants with a PSHB and SSHB are found in tables 11 to 14.

Table 11

Ratings of Sympathy by participants reporting personal self-harming behaviour (PSHB) and no self-harming behaviour (no PSHB) after reading the First and Second Vignettes

History of Self-harm	Stated Intention		First Vignette			Second Vignette		
			M	SD	n	M	SD	n
First Time	Die	PSHB	31.00	3.01	05	30.80	2.78	05
		No PSHB	26.58	6.25	19	23.47	6.14	19
	Not Die	PSHB	29.67	5.54	06	29.00	5.73	06
		No PSHB	26.58	3.91	19	24.11	5.45	19
Previous	Die	PSHB	27.00	4.14	08	27.63	4.93	08
		No PSHB	26.00	5.09	15	25.00	4.90	15
	Not Die	PSHB	24.00	4.58	05	23.60	4.93	05
		No PSHB	26.37	6.62	19	25.90	6.15	19

Table 12

Ratings of Emotions by participants reporting significant others' self-harming behaviour (SSHB) and no significant others' self-harming behaviour (no SSHB) after reading the First and Second Vignettes

History of Self-harm	Stated Intention		First Vignette			Second Vignette		
			M	SD	n	M	SD	n
First Time	Die	SSHB	30.00	4.39	12	27.58	5.16	12
		No SSHB	25.00	6.44	12	22.42	6.53	12
	Not Die	SSHB	31.63	3.42	08	29.75	3.33	08
		No SSHB	25.26	3.16	19	22.79	5.78	19
Previous	Die	SSHB	26.39	4.17	13	27.00	4.20	13
		No SSHB	26.30	5.56	10	24.50	5.72	10
	Not Die	SSHB	26.18	5.93	11	25.73	6.00	11
		No SSHB	25.62	6.72	13	25.16	6.05	13

Table 13

Ratings of Willingness to help by participants with personal self-harming behaviour and no self-harming behaviour after reading the First and Second Vignettes

History of Self-harm	Stated Intention		First Vignette			Second Vignette		
			M	SD	n	M	SD	n
First Time	Die	PSHB	9.60	0.89	5	9.80	0.45	5
		No PSHB	8.40	2.11	20	8.30	2.13	20
	Not Die	PSHB	9.17	1.60	6	8.13	1.81	8
		No PSHB	8.22	1.86	18	8.81	2.66	16
Previous	Die	PSHB	8.75	1.16	8	9.17	1.60	6
		No PSHB	8.81	2.56	16	7.67	2.52	18
	Not Die	PSHB	8.80	1.79	5	8.60	1.95	5
		No PSHB	8.75	1.59	20	8.95	1.10	20

Table 14

Ratings of Willingness to help by participants reporting knowledge of significant others' self-harming behaviour and no significant others' self-harming behaviour after reading the First and Second Vignettes

History of Self-harm	Stated Intention		First Vignette			Second Vignette		
			M	SD	n	M	SD	n
First Time	Die	SSHB	9.58	0.9	12	9.17	1.53	12
		No SSHB	7.77	2.31	13	8.08	2.29	13
	Not Die	SSHB	9.50	0.76	08	8.00	2.91	14
		No SSHB	8.00	1.88	18	9.40	1.07	10
Previous	Die	SSHB	8.43	2.71	14	9.50	0.76	08
		No SSHB	9.30	0.95	10	7.39	2.48	18
	Not Die	SSHB	9.42	0.90	12	9.17	1.27	12
		No SSHB	8.15	1.86	13	8.62	1.26	13

As stated earlier, it was predicted participants with a personal history of self-harming behaviour and knowledge of significant other's self-harming behaviour would respond differently compared to participants with no such personal history or knowledge. The data was divided into two groups, participants reporting personal self-harming behaviour (PSHB) and no personal self-harming behaviour (no PSHB). Tables 15 to 18 show the results of the mixed model ANOVAs based on PSHB and SSHB. A between subject interaction was found for PSHB and History of Self-Harm. Participants with PSHB reported higher levels of sympathy compared to those with no PSHB when informed it was the first time the woman had overdosed. Analysis of variance revealed there were no main effects or interactions for willingness to help. With the repeated measure ANOVA models, a significant within subject decrease in positive emotions occurred from the first vignette to the second as observed earlier, regardless of whether the information regarding previous self-harm was confirming or

contradictory. However, the within subject decrease in willingness to help found earlier ceased to be significant once the data was divided into the 2 groups of PSHB and no PSHB. The within subject interaction observed earlier for emotions was not found when the data was analysed according to these two groups.

The data was also divided into two groups based on participants reporting knowledge of significant others' self-harming behaviour (SSHB) and no significant others' self-harming behaviour (no SSHB). Analysis of variance revealed a main effect for sympathy. Participants with SSHB reported higher levels of positive emotions compared to participants with no SSHB. A between subject interaction between history of self-harm and SSHB was also found. Participants with knowledge of SSHB reported higher levels of positive emotions when informed it was the first time the woman had overdosed compared to those with no knowledge of SSHB. Again, as with participants with PSHB, no between subject main effects or interactions for willingness to help were found when the data was analysed according to participants with SSHB and no SSHB. The within subject difference for participants with SSHB from reading the first and second vignettes increased in it's level of significance for sympathy while there ceased to be an interaction between History of self-harm and scenarios. The within subject interaction observed earlier for willingness to help continued though the size of the effect was smaller.

Table 15

Analysis of Variance for Emotions: Personal Suicidal Experience Vs No Personal Suicidal Experience

Source	df	F	Eta2
	Between Subjects		
Personal	2	3.65	0.04
History of Self-Harm (HSH)	1	2.58	0.28
Suicidal intent (SI)	1	0.71	< 0.001
Personal x HSH	1	4.50*	0.05
Personal x SI	1	1.52	0.02
HSH x SI	1	0.11	< 0.001
Personal x HSH x SI	1	0.21	< 0.001
Error	88	(52.31)	
	Within Subjects		
Scenarios (S)	1	4.66*	0.050
Personal x S	1	3.23	0.035
HSH x S	1	2.13	0.024
SI x S	1	0.01	< 0.001
Personal x HSH x S	1	0.72	0.008
Personal x SI x S	1	0.55	0.006
HSH x SI x S	1	0.04	< 0.001
Personal x HSH x SI x S	1	0.016	< 0.001
Error	88	(6.93)	

Note: * p< .05

Table 16

Analysis of Variance for Emotions- Suicidal Experience of Significant others Vs No Suicidal Experience of Significant others

Source	df	F	Eta2
	Between Subjects		
Significant other (SO)	1	6.01*	0.046
History of Self-Harm (HSH)	2	0.66	0.010
Suicidal intent (SI)	1	0.88	0.007
SO x HSH	2	4.15*	0.062
SO x SI	1	0.53	0.004
HSH x SI	2	1.94	0.03
SO x HSH x SI	2	0.37	0.006
Error	126	(54.74)	
	Within Subjects		
Scenarios (S)	1	14.63***	0.104
SO x S	1	0.65	0.005
HSH x S	2	2.96	0.045
SI x S	1	0.80	0.006
SO x HSH x S	2	0.30	0.005
SO x SI x S	1	0.91	0.007
HSH x SI x S	2	0.30	0.005
SO x HSH x SI x S	2	0.45	0.007
Error	88	(6.93)	

Note: * $p < .05$, *** $p < .001$

Table 17

Analysis of Variance for Willingness to Help: Personal Suicidal Experience Vs No Personal Suicidal Experience

Source	df	F	Eta2
	Between Subjects		
Personal	1	0.67	< 0.001
History of Self-Harm (HSH)	1	0.08	< 0.001
Suicidal intent (SI)	1	0.81	< 0.001
HSH x SI	2	0.48	< 0.001
Personal x HSH	2	1.52	< 0.001
Personal x SI	2	0.21	< 0.001
Personal x HSH x SI	2	0.19	< 0.001
Error	126	(7.08)	
	Within Subjects		
Scenarios (S)	1	4.66	0.050
Personal x S	1	3.23	0.035
HSH x S	1	2.13	0.024
SI x S	1	0.01	< 0.001
Personal x HSH x S	1	0.72	0.008
Personal x SI x S	1	0.55	0.006
HSH x SI x S	1	0.04	< 0.001
Personal x HSH x SI x S	1	0.016	< 0.001
Error	88	(6.93)	

Table 18

Analysis of Variance for Willingness to Help: Suicidal Experience of Significant others Vs No Suicidal Experience of Significant others

Source	df	F	Eta2
	Between Subjects		
Significant other (SO)	1	2.85	< 0.001
History of Self-Harm (HSH)	2	0.47	< 0.001
Suicidal intent (SI)	1	0.20	< 0.001
HSH x SI	2	0.21	< 0.001
SO x HSH	2	3.27*	0.05
SO x SI	1	0.70	< 0.001
SO x HSH x SI	2	1.77	0.03
Error	128	(6.53)	
	Within Subjects		
Scenarios (S)	1	6.38*	0.05
HSH x S	2	1.83	0.3
SI x S	1	0.11	0.00
S x HSH x SI	2	0.93	0.14
S x SO	1	0.06	< 0.001
S x SI x SO	1	0.06	< 0.001
S x HSH x SO	2	3.98*	0.06
S x SI x HSH x SO	2	3.83*	0.06
Error	128	(0.47)	

Note: * $p < .05$

CHAPTER 4: DISCUSSION

The effects of suicide intent and history of self-harm on potential helpers' emotional reaction, perceived motives, willingness to help and predictions of future self were examined in response to vignettes depicting a hypothetical female friend who had overdosed. Based on a review of the literature, it was expected that participants would express more positive emotions and greater willingness to help when the stated intention for the overdose was to die and there had been no previous self-harm than when the intention for the overdose was not to die and there had been a history of self-harm. Further, it was predicted that participants would choose interpersonal motives to account for the overdose when the intention was "not to die" and there had been a history of self-harm. Intrapersonal motives were predicted to have been selected when the intention was to die and there was no history of self-harm. Contrary to predictions, participants reported high positive emotions towards a fictional friend who recently overdosed and claimed they would help her regardless of the reported intention for the overdose and history of self-harm. Participants also reported a mixture of interpersonal and intrapersonal motives to account for the woman's overdose. However, predictions of future self-harm were influenced by suicidal intent, with the vignette depicting an intention to die yielding higher ratings of the likelihood of future self-harm. Providing contradictory information about history of self-harm resulted in changes in emotions. A decrease in reported positive emotions occurred when participants were initially informed that it was the first time the woman had overdosed and in the second vignette informed that it was not the first incident of self-harm.

A question that arises from the findings of this study is why did the depicted suicide intent and history of self-harm in the vignettes fail to elicit differences in participants' emotional reactions and willingness to help? Perhaps people who have not been in such a situation created by the conditions in the study cannot validly respond to questions regarding how they would feel and their willingness to help. Alternatively, people might differ in their emotional reactions and responses depending on whether or not they have a personal experience of self-harming behaviours or thoughts. Ingram and Ellis (1995) noted in their study that people with suicidal experiences differed in their responses to vignettes relating to suicidal behaviour compared to those who did not report suicidal behaviours. The responses of participants who disclosed information about their own self-harming behaviour or knowledge of a significant other's self-harming behaviour were therefore examined. However, based on the results of this analysis, personal self-harming behaviour and knowledge of significant others' self-harming behaviour did not systematically effect the responses of participants with regard to their reported emotional reactions and willingness to help. It would appear in this study, participants own self-harming experience or knowledge of significant other's self-harming experience did not lead to significant differences in their responses compared to participants who did not report a personal experience of self-harm, whether it be there own self-harm, or the knowledge of a significant other's self-harm.

The Findings Regarding Emotions and Willingness to help Following an Overdose

An intention of the study was to present information regarding suicide intent and history of self-harm in a way that reflects how potential helpers in the community

receive details of a significant other's overdose. Predictions of how suicide intent and history of self-harm would impact on participants' reported emotions and willingness to help were not supported. Participants did not report higher levels of positive emotions and willingness to help when the stated intention for the overdose was to die than when the stated intention was not to die. In addition, participants did not report higher levels of positive emotions and willingness to help based on the history of self-harm of the woman depicted in the vignettes. The findings of this study of university students differ from Ramon et al.'s (1975) findings of responses from medical staff. In Ramon et al's study, medical staff reported different levels of emotion and willingness to help based on whether they believed the intention for the overdose was to achieve death or as a form of manipulation. In their study, medical staff reported higher levels of sympathy and greater willingness to help when the perceived intention for an overdose was to die than when viewed as a form of manipulation. Based on the results of this study, it would appear that university students were not affected by information on suicidal intent and history of self-harm with regard to their emotions and willingness to help.

The Findings Regarding Perceptions of interpersonal Motives Following an Overdose

Ramon et al.'s (1975) findings and Boergers et al.'s (1998) assertions regarding the attributions made about perceived motives for an overdose were investigated by the use of two hypotheses. The first hypothesis predicted participants would report a greater level of interpersonal motives and a lower level of intrapersonal motives as reasons for the woman in the vignette overdosing when the stated intention was not to die. While the second hypothesis predicted participants would report a greater level of

interpersonal motives and a lower level of intrapersonal motives when there is a history of self-harm. The two hypotheses posed were not, however, supported by the findings of this study. As with James and Hawton's (1985) findings, participants in this study reported a mixture of interpersonal and intrapersonal motives for the woman depicted in the vignettes despite differences in suicidal intent and history of self-harm in attempting to explain her overdose. These findings differ from the findings of Ramon et al. (1975). In their study, medical staff more often chose interpersonal motives as an explanation for an overdose when they believed the intention of a patient was to die. While the medical staff more often chose intrapersonal motives as an explanation for the overdose when they believed there was no intention to die. Based on the findings of this study, the intrapersonal/interpersonal distinction regarding suicide intent and history of self-harm does not appear to be a useful one. Further, Beorgers et al. (1998) recommendations in distinguishing between cause explanations and reason explanations in attempting to understand the motivation for self-harm may only be helpful in categorising the kind of responses given by those who self-harm.

The Findings Regarding Predictions of Future Self-harm Following an Overdose

The investigation of how suicide intent and history of self-harm effect predictions of future self-harm was exploratory and there was little relevant research literature from which to predict particular associations. Based on the findings from this study, suicide intent appeared to effect ratings of the likelihood of future self-harm. The intention of wanting to die evoked higher predictions of future self-harm than the intention of not wanting to die. While history of self-harm did not effect predictions of future self-harm. This finding helps to answer the questions posed

earlier. There is support for the proposition that potential helpers in the community evaluate information about an act of self-harm to determine the likelihood of future self-harm. In order to make a prediction of future self-harm, the participants needed to have attended to information relating to risk factors presented in the vignettes. The finding for predictions of future self-harm is encouraging and provides a basis for future research. It justifies the search for other self-harm risk factors that potential helpers in the community use to reach a prediction of future self-harm. Further, it then permits exploration of how predictions of future self-harm might impact on potential helpers' willingness to help a person perceived to be at risk of self-harm. This knowledge could have important clinical implications in how health professionals might elicit the assistance of social supports in helping to reduce the risk of self-harm in vulnerable individuals.

The Findings of Not Providing Information Regarding History of Self-harm Following an Overdose

There was some concern during the design stage of the study that participants might not believe information about history of self-harm when they were informed it was the first time the woman had overdosed. In order to investigate if potential helpers do not believe when told it was the first time the woman overdosed a group of participants were not given information about history of self-harm. Informing participants that the woman had either overdosed for the first time, had a history of self-harm or not providing information about history of self-harm did not result in reported differences in emotions, willingness to help, interpersonal motives or predictions of future self-harm. Due to the failure in finding differences in participants' responses to information about history of self-harm, it is not possible to draw conclusions about whether or not potential helpers believe the information they

receive about history of self-harm. Attempting to draw conclusions about the implications of these findings is speculative. The results might suggest that university students accept information on history of self-harm and that history of self-harm does not affect the reactions and responses measured in this study. Alternatively, history of self-harm might affect potential helpers' reactions and responses but due to methodological factors participants might not have focused attention on the information provided in the vignettes about history of self-harm.

The Findings of Providing Conflicting Information Regarding History of Self-harm

Regardless of whether the information in the second vignette was confirming or contradictory, significant changes were found in the participants' reported emotions, willingness to help, interpersonal motives and predictions of future self-harm. An interaction was found for history of self-harm and the vignette that participants received. Participants who initially read that the woman in the vignette had overdosed for the first time later reported less positive emotions after reading the second vignette when informed she had a history of self-harm. This interaction suggests participants' emotional reactions might have been influenced by the contradictory information about history of self-harm when initially informed it was the first incident of self-harm. However, given that changes in participants' responses also occurred when information about history of self-harm was confirming, caution is required in the interpretation of these results and there are doubts about the meaning of these findings. At this point, it is prudent not to draw a conclusion regarding the effect of contradictory information about history of self-harm. Explanations for these

findings and suggestions for future research are dealt with in later sections of this report.

Possible Explanations for The Findings

It would be premature to conclude that suicide intent and history of self-harm do not affect a person's emotional reactions, willingness to help and perceptions of motive for an overdose as there are a number of possible explanations for the current findings. In a study such as this, it is important to establish if a manipulation effect of the independent variables has occurred as this could lead to a failure to obtain data that supports the hypotheses. Inspection of the manipulation check for suicide intent revealed that participants correctly identified vignettes designed to reflect high and low suicidal intent. Unfortunately, a manipulation check was not included for history of self-harm. Failure in finding significant differences between participants in their responses based on history of self-harm could have therefore been due to a lack of a manipulation effect. Alternatively, participants might have been affected by information about suicide intent and history of self-harm in ways that were not measured in this study. Further, the measures used in this study could have been inadequate in detecting changes in participants' responses. However, Ramon et al. (1975) used less sensitive measures in their study and significant differences in sympathy and readiness to help were found among the medical staff.

The use of university students studying psychology could also have affected the results of this study. As noted earlier, participants reported high levels of positive emotions and willingness to help regardless of the suicidal intent and history of self-harm. This might be a true reflection of how potential helpers not working in medical

facilities with patients who have self-harmed feel and the extent to which they want to help a close friend following an overdose. However, a basis for this study and the hypotheses postulated were the surprising similarity between significant others' and medical staffs' responses to a person who overdoses. As outlined earlier, Hawton et al.'s (1981) study of significant others' responses to a family member who was admitted to hospital following an overdose were surprisingly similar to the findings of Ramon et al.'s (1975) and Ghodse et al.'s (1986) studies. In Ramon et al.'s (1975) study, medical staff's attitudes to patients who had overdosed were sampled, while in Ghodse et al.'s (1986) medical staff's attitudes were sought to vignettes depicting people who had self-harmed under different circumstances and using different self-harming methods were examined. Similar findings in these studies were found, despite differences in sample groups (eg medical staff and significant others), type of situation (real patients in hospital and hypothetical vignettes) and differences in the way responses were measured. Instead, the participants responses in this study might have been significantly influenced by factors associated with social desirability rather than differences in professional training and actual work experience with patients requiring treatment following self-harm.

Potential helpers' own self-harming experience or knowledge of a significant other's self-harming experience could also have affected the results of the study. However an analysis of the data did not reveal significant differences in responses of participants with either a personal self-harming history or knowledge of a significant other's self-harming history and participants with no such experience. These findings differ from Ingram and Ellis' (1995) findings of university students with suicidal and no suicidal experiences with regards to their participants responses to vignettes

depicting individuals who suicided under different circumstances. Other possible factors that could have affected participants' responses were the gender of the self-harmer. Men and women might respond differently to information about an overdose. The possible effects of gender differences in this study were not explored because the number of males in each of the conditions did not permit a comparison with female responses. However, in Ingram and Ellis' (1995) study gender differences in responses were not observed.

Failure to find significant differences in responses due to suicide intent and history of self-harm could have also been due to other methodological issues. The mixed model design and structure of the vignettes could have caused participants to be unduly influenced by other information in the vignettes. Differences in participants' responses were not expected when information about previous self-harm was confirmed. It might be that, irrespective of whether the information was confirming or contradictory, participants considered the consequences of the overdose on other people more after reading the second vignette. In the first vignette, the husband reported the details of the self-harm in a matter of fact manner and he expressed no judgement or emotion. While in the second vignette, the mother used emotive language in expressing concern for her daughter. Participants' responses might have also been affected by demand characteristics, such as, perceived experimenter expectations of unconditional empathy that could have emerged after they were requested to respond to the second vignette. Alternatively, participants might not have read the information carefully in the first vignette. Confronted with a second vignette, this could have lead participants to take more notice of the information presented, with information about history of self-harm emphasised in the second vignette. A final

possible explanation for these findings, is that participants might have responded to the information from two different sources the way that potential helpers in the community respond. It might be that potential helpers are more effected by news of a person's overdose the more they hear about it from different people.

Statistical factors could have also been responsible for the failure to find significant differences in participant responses. The statistical power in detecting changes in responses was higher for the within subject analyses than for the between subject analyses. As reported earlier, significant results were found for the within subject manipulation of history of self-harm, but not for the between subject manipulations of suicide intent and history of self-harm (except for predictions of future self-harm). These findings could have been due to the lower levels of statistical power for the between subject analyses. The recommended sample size in detecting a possible medium effect size according to Cohen's (1992) power tables was not achieved in this study. Since the recommended group size was not reached for each condition, it is possible there was insufficient statistical power to detect changes with a medium effect size during the statistical analysis. It would be reasonable to expect that if statistical significance was not reached due to poor statistical power, that there would be a trend in the data for some scores to be approaching statistical significance. An inspection of the ANOVA tables, however, did not reveal p-values close to the 0.05 level of significance. The lower statistical power inherent in the analyses is therefore not likely to have been a relevant factor in the results obtained. The changes found in participants responses after reading the second vignette could have been due to a statistical artefact and not due to the increased statistical power of performing within subject ANOVAs.

Methodological Limitations

There are several limitations to this study that must be considered when interpreting the results. First, it might be possible that male and female potential helpers are affected differently by information regarding suicide intent and history of self-harm. Second, the gender of the person who overdoses might also affect male and female potential helpers differently. The data from this study was not examined for sex differences because there were insufficient numbers of males in each of the conditions to make this form of comparison. Third, a manipulation check for history of self-harm was not incorporated into the design of the study. The lack of an effect of history of self-harm might have occurred due to participants not taking notice of the information about history of self-harm until reading the second vignette. Fourth, participants' reports of emotions and willingness to help may bear little relation to how they would actually react and respond if confronted by a close friend who had recently overdosed. This unfortunately is a common problem with simulation research. Finally, small sample sizes and the combining of participants who had either attempted suicide and seriously contemplated suicide may have been factors that affected the results. For example, people who have actually attempted suicide may differ in the way they react and respond to a close family member or friend who overdoses as compared to people who have contemplated suicide but insufficient numbers in this study precluded this effect from emerging.

Suggestions for Future Research

Taking into account the initial reasons for the study, the subsequent findings and the limitations, many of the questions posed remain unanswered and it would be

useful to repeat this study in a modified form. How do potential helpers react and respond when informed of the suicidal intent of a friend's self-harming? Do potential helpers react and respond differently depending on whether they know it is the first time someone has overdosed or if he/she has previously self-harmed? Finally, how do potential helpers react and respond when they receive conflicting information about a close family member or friend's self-harm? These issues are important as answers to these questions could help clinicians enlist the support of their clients/patients family and friends in order to reduce the likelihood of future self-harm. This information would also be of value for informing public health initiatives, which aim to raise public awareness about, self-harm and gain the support of the community to reduce the likelihood of people self-harming again.

However, for future studies to be viable it will be necessary to develop other ways of measuring willingness to help given the influence of such factors as social desirability. Including a manipulation check for History of self-harm would also be necessary in order to ascertain if there is, in fact, a manipulation effect. Investigating for differences when the gender of the person depicted in the vignette is changed and also differences between gender of the participants might also provide answers to some of the questions raised. A possible variation of the study would be to investigate if different methods of self-harm and different circumstances affect potential helpers' reactions and responses. For example, if other methods of self-harm, such as. by firearm or hanging affect responses. However, there is a difficulty in using these scenarios as these methods are widely viewed by helping professions and the public as being very lethal. Trying to create vignettes in which a person uses one of these methods but denies suicidal intent to die will be difficult to achieve. Finally, although

personal self-harming experience and knowledge of significant other's self-harming experience appeared to have no significant impact on responses, other factors such as knowledge and attitudes about self-harm might have an influence. It would therefore be useful to inquire about attitudes regarding suicide and self-harming behaviour.

Conclusion

Reducing the incidence and prevalence of deliberate self-harm has become a public health challenge in the developed world. One way of achieving such a goal might be through improving the kind of responses and support self-harmers receive from the people they know. Identifying factors that affect potential helpers emotional reactions and responses might subsequently assist when devising strategies to enhance potential helpers' willingness to help. The present study was a preliminary investigation of the influence of stated intention of an overdose and history of deliberate self-harm on emotions, willingness to help, perceptions of motive regarding an overdose and predictions of future self-harm.

Predictions of how suicide intent and history of self-harm affect participants' reported emotions and willingness to help were not supported. Instead, participants reported high levels of positive emotions and willingness to help regardless of the suicide intent or history of self-harm. Ramon et al.'s (1975) findings and Boergers et al.'s (1998) assertions about the kind of attributions potential helpers make regarding perceived motives for an overdose were also not supported by the findings of this study. As a result, it was concluded that the intrapersonal/interpersonal distinction of explaining an overdose based on suicide intent and history of self-harm is not a useful one. Suicide intent did, however, affect ratings made by participants of the likelihood

of future self-harm. The intention of wanting to die evoked higher predictions of future self-harm than when the intention of the woman in the vignette was not to die. While informing participants the woman had either overdosed for the first time, had a history of previous self-harm or not including information about history of self-harm, did not result in reported differences in emotions, willingness to help, motives or predictions of future self-harm. Finally, providing conflicting information about history of self-harm led to inconclusive findings.

In closing, an appropriate and timely response by potential helpers might help to reduce future self-harm and possibly avert a completed suicide. By understanding the effects of suicide intent and history of self-harm it might be possible to develop strategies which could reduce the impact of these factors on potential helpers and possibly facilitate more supportive responses to those who self-harm.

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Appendix A

Cover sheet and Consent Form

Community Attitudes to an Overdose

Hello, I am a student enrolled in the Master of Psychology (Clinical) program at Edith Cowan University. As part of my course requirements I am completing a project on community attitudes towards people who overdose. There have been numerous studies that have investigated medical staffs' attitudes towards those who overdose, but few which have investigated the attitudes of non-medical staff. Could you please assist me in redressing this situation by reading the following story and then completing the accompanying questionnaire. It will only take about ten minutes to complete.

This study meets the necessary ethical requirements and has been approved by the Edith Cowan University Ethics Committee. Participation in this study is completely voluntary and anonymous. You can choose either not to respond or to discontinue at any time. A report will be written and there is an intention to publish the findings from the study. No effort will be made to identify you with your responses during the data analysis and writing of the report. There is no direct benefit to you in participating in this study; other than to perhaps think about some of the issues raised. If you would like to know more about this study or would like a copy of the results when they are available, then you are welcome to contact me on 9400 9599 during normal business hours.

People you can contact if you need to talk about your reactions to the study

While participating in this study, if you find yourself experiencing strong negative emotions or thoughts that won't go away about death or suicide then it is important that you speak to someone about these experiences. You may like to consider speaking to my supervisor, Greg Dear on 94005052 or perhaps contacting a counselling service. The University based counsellor is available on 94005560. You may instead prefer to speak to someone not involved with the university, you can do this by calling the Samaritan's Telephone Counselling Service on 93815555 or Crisis Care on 9325 1111.

Yours sincerely

Paul Buttigieg

Please keep for your information

Appendix B

First Scenario

VIGNETTE ONE

Instruction: While reading the story below, try to imagine as much as you can that the woman is a close and special friend. Once you have read the story turn over and answer the questions on the following pages.

One night while shopping you bump into a close friend's husband. In the past you had often gone out socially with your friend and her husband until they separated recently. Since then, you have not heard from her, and this is the first time you have spoken to her husband since the break up. As it has been so long, you invite him to sit down at a nearby café. He reluctantly accepts your offer and it is obvious he is not the happy, outgoing person he was previously. He eventually tells you his wife is not coping well with the separation. He also hesitates and begins to tell you how hard it has been for her coming to terms with their marriage break-up. Later in the conversation, he tells you about her overdose a couple of days ago and that she had never done something like this before.

Apparently, she had been thinking she could not cope for much longer feeling the way she has, and decided the only thing she could do was to kill herself. She gathered all the pills she could find and took them all; believing what she had taken would most likely kill her. You then ask him what happened next. He goes on to say that her mother unexpectedly came to visit. She knocked but no one answered the door. As her daughter's car was in the driveway, the mother let herself in and found her lying on the sofa. When her mother approached, she noticed medication packages on the floor and coffee table. The mother immediately called for an ambulance and her daughter was taken to hospital and discharged the next day.

VIGNETTE TWO

Instruction: While reading the story below, try to imagine as much as you can that the woman is a close and special friend. Once you have read the story turn over and answer the questions on the following pages.

One night while shopping you bump into a close friend's husband. In the past you had often gone out socially with your friend and her husband until they separated recently. Since then, you have not heard from her, and this is the first time you have spoken to her husband since the break-up. As it has been so long, you invite him to sit down at a nearby café. He reluctantly accepts your offer and it is obvious he is not the happy, outgoing person he was previously. He eventually tells you his wife is not coping well with the separation. He also hesitates and begins to tell you how hard it has been for her coming to terms with their marriage break up. Later in the conversation, he tells you about her overdose a couple of days ago and that she had never done something like this before.

Apparently, while thinking she could not cope for much longer feeling the way she has, she gathered a small-hand full of pills and took them. She didn't really want to die and did not believe what she had taken would kill her. You then ask him what happened next. He goes on to say that her mother dropped in to see her at the time she normally does. She knocked but no one answered the door. As her daughter's car was in the driveway, the mother let herself in and found her lying on the sofa. When her mother approached, she noticed medication packages on the floor and coffee table. The mother immediately called for an ambulance and her daughter was taken to hospital and discharged the next day.

VIGNETTE THREE

Instruction: While reading the story below, try to imagine as much as you can that the woman is a close and special friend. Once you have read the story turn over and answer the questions on the following pages.

One night while shopping you bump into a close friend's husband. In the past you had often gone out socially with your friend and her husband until they separated recently. Since then, you have not heard from her, and this is the first time you have spoken to her husband since the break up. As it has been so long, you invite him to sit down at a nearby café. He reluctantly accepts your offer and it is obvious he is not the happy, outgoing person he was previously. He eventually tells you his wife is not coping well with being separated. He also hesitates and begins to tell you how hard it has been for her coming to terms with their marriage break-up. Later in the conversation, he tells you about her overdose a couple of days ago and that she has done something like this before.

Apparently, she had been thinking she could not cope for much longer feeling the way she has, and decided the only thing she could do was to kill herself. She gathered all the pills she could find and took them all; believing what she had taken would most likely kill her. You then ask him what happened next. He goes on to say that her mother unexpectedly came to visit. She knocked but no one answered the door. As her daughter's car was in the driveway, the mother let herself in and found her lying on the sofa. When her mother approached, she noticed medication packages on the floor and coffee table. The mother immediately called for an ambulance and her daughter was taken to hospital and discharged the next day.

VIGNETTE FOUR

Instruction: While reading the story below, try to imagine as much as you can that the woman is a close and special friend. Once you have read the story turn over and answer the questions on the following pages.

One night while shopping you bump into a close friend's husband. In the past you had often gone out socially with your friend and her husband until they separated recently. Since then, you have not heard from her, and this is the first time you have spoken to her husband since the break up. As it has been so long, you invite him to sit down at a nearby café. He reluctantly accepts your offer and it is obvious he is not the happy, outgoing person he was previously. He eventually tells you that his wife is not coping well with being separated. He also hesitates and begins to tell you how hard it has been for her coming to terms with their marriage break-up. Later in the conversation, he tells you about her overdose a couple of days ago and that she has done something like this before.

Apparently, while thinking she could not cope for much longer feeling the way she has, she gathered a small hand-full of pills and took them. She didn't really want to die and did not believe what she had taken would kill her. You then ask him what happened next. He goes on to say that her mother dropped in to see her at the time she normally does. She knocked but no one answered the door. As her daughter's car was in the driveway, the mother let herself in and found her lying on the sofa. When her mother approached, she noticed medication packages on the floor and coffee table. The mother immediately called for an ambulance and her daughter was taken to hospital and discharged the next day.

VIGNETTE FIVE

Instruction: While reading the story below, try to imagine as much as you can that the woman is a close and special friend. Once you have read the story turn over and answer the questions on the following pages.

One night while shopping you bump into a close friend's husband. In the past you had often gone out socially with your friend and her husband until they separated recently. Since then, you have not heard from her, and this is the first time you have spoken to her husband since the break up. As it has been so long, you invite him to sit down at a nearby café. He reluctantly accepts your offer and it is obvious he is not the happy, outgoing person he was previously. He eventually tells you that his wife is not coping well with being separated. He also hesitates and begins to tell you how hard it has been for her coming to terms with their marriage break-up. Later in the conversation, he tells you about her overdose a couple of days ago.

Apparently, she had been thinking she could not cope for much longer feeling the way she has, and decided the only thing she could do was to kill herself. She gathered all the pills she could find and took them all; believing what she had taken would most likely kill her. You then ask him what happened next. He goes on to say that her mother unexpectedly came to visit. She knocked but no one answered the door. As her daughter's car was in the driveway, the mother let herself in and found her lying on the sofa. When her mother approached, she noticed medication packages on the floor and coffee table. The mother immediately called for an ambulance and her daughter was taken to hospital and discharged the next day.

VIGNETTE SIX

Instruction: While reading the story below, try to imagine as much as you can that the woman is a close and special friend. Once you have read the story turn over and answer the questions on the following pages.

One night while shopping you bump into a close friend's husband. In the past you had often gone out socially with your friend and her husband until they separated recently. Since then, you have not heard from her, and this is the first time you have spoken to her husband since the break up. As it has been so long, you invite him to sit down at a nearby café. He reluctantly accepts your offer and it is obvious he is not the happy, out-going person he was previously. He eventually tells you that his wife is not coping well with being separated. He also hesitates and begins to tell you how hard it has been for her coming to terms with their marriage break-up. Later in the conversation, he tells you about her overdose a couple of days ago.

Apparently, while thinking she could not cope for much longer feeling the way she has, she gathered a small-hand full of pills and took them. She didn't really want to die and did not believe what she had taken would kill her. You then ask him what happened next. He goes on to say that her mother dropped in to see her at the time she normally does. She knocked but no one answered the door. As her daughter's car was in the driveway, the mother let herself in and found her lying on the sofa. When her mother approached, she noticed medication packages on the floor and coffee table. The mother immediately called for an ambulance and her daughter was taken to hospital and discharged the next day.

Appendix C

Measures

Instruction: Please answer the following by reading each question carefully and then circling the number that best reflects your response.

Question One

To what extent do you think the woman wanted to die from her overdose?

0	1	2	3	4	5	6	7	8	9	10
Definitely did not want to die										Definitely wanted to die

Question Two

As much as you can, imagine how you would feel towards the woman when you found out she had overdosed. Please circle the number that best reflects what your response would be for each of the following:

	Strongly Disagree						**Strongly Agree**
I would feel angry	0	1	2	3	4	5	6
I would feel disgust	0	1	2	3	4	5	6
I would feel sympathy	0	1	2	3	4	5	6
I would feel concern	0	1	2	3	4	5	6
I would feel pity	0	1	2	3	4	5	6
I would feel sorrow	0	1	2	3	4	5	6

Question Three

To what extent would you be willing to help the woman? That is, being available to listen when she needs some one to talk to, visiting her to see how she is managing and helping out when needed.

0	1	2	3	4	5	6	7	8	9	10
No, I definitely would not help										Yes, I definitely would help

Question Four

Why do you think the woman overdosed? Please circle the number that best reflects what your response would be for each of the following:

	Not a Reason	Minor Reason	Major Reason
To make people understand how desperate she was feeling	0	1	2
To get relief from a terrible state of mind	0	1	2
To make people sorry for the way they treated her; frighten or get someone back	0	1	2
To try to influence someone or get them to change their mind	0	1	2
To escape for a while from an impossible situation	0	1	2
To show how much she loved someone	0	1	2
To find out whether someone really loved her or not	0	1	2
Due to a mental illness	0	1	2
To get help from someone	0	1	2
To die	0	1	2

Question Five

What do you think is the likelihood of this woman taking another overdose?

0	1	2	3	4	5	6	7	8	9	10
Most unlikely					Don't Know					Most likely

Appendix D

Second Scenario

Instruction: Please read the following update.

The next day, you bump into your friend's mother whilst at a bus station. You make general chit chat for a while until your friend's mother starts telling you about the overdose. Finally, before the bus arrives, your friend's mother states she is worried because her daughter has done this sort of thing before. On the bus, you retreat into your thoughts and you think about what your close friend's husband has told you and just now, her mother. Please answer the following questions. Do not look at you previous answers until you have completed answering this section.

Appendix E

Repeated Measures and Demographics

Instruction: Please answer the following by reading each question carefully and then circling the number that best reflects your response.

Question One

As much as you can, imagine how you would feel towards the woman when you found out she had overdosed. Please circle the number that best reflects what your response would be for each of the following:

	Strongly Disagree						**Strongly Agree**
I would feel angry	0	1	2	3	4	5	6
I would feel disgust	0	1	2	3	4	5	6
I would feel sympathy	0	1	2	3	4	5	6
I would feel concern	0	1	2	3	4	5	6
I would feel pity	0	1	2	3	4	5	6
I would feel sorrow	0	1	2	3	4	5	6

Question Two

To what extent would you be willing to help the woman? That is, being available to listen when she needs some one to talk to, visiting her to see how she is managing and helping out when needed.

0	1	2	3	4	5	6	7	8	9	10
No, I definitely would not help										Yes, I definitely would help

Question Three

Why do you think the woman overdosed? Please circle the number that best reflects what your response would be for each of the following:

	Not a Reason	Minor Reason	Major Reason
To make people understand how desperate she was feeling	0	1	2
To get relief from a terrible state of mind	0	1	2
To make people sorry for the way they treated her; frighten or get someone back	0	1	2
To try to influence someone or get them to change their mind	0	1	2
To escape for a while from an impossible situation	0	1	2
To show how much she loved someone	0	1	2
To find out whether someone really loved her or not	0	1	2
Due to a mental illness	0	1	2
To get help from someone	0	1	2
To die	0	1	2

Question Four

What do you think is the likelihood of this woman taking another overdose?

0	1	2	3	4	5	6	7	8	9	10
Most unlikely					Don't Know					Most likely

Demographic Information

Age (in years) _____

Instruction: Please answer the following questions by circling the response that best reflects your answer. Circle one number only for each question.

Sex

Female	0
Male	1

Enrolment status

Full-time student	1
Part-time student	2

Current Employment status

Full-time paid employment	1
Part-time paid employment	2
No employment	3

Current Relationship Status

Not in a current relationship	1
Married (and living together)	2
Defacto (and living together)	3
In a relationship but not living together	4

Previous Relationship

Previously married	1
Previously in a defacto relationship	2

Suicidal Experiences

To the best of your knowledge, have any of your close family members or close friends:

Attempted suicide in the past	1
Seriously contemplated suicide in the past	2
Had thoughts of suicide in the past	3
Had never considered suicide in the past	4

Have you ever

Attempted suicide in the past	1
Seriously contemplated suicide in the past	2
Had thoughts of suicide in the past	3
Had never considered suicide in the past	4