

**Self-harm and Secondary School Students: The Attitudes and Understandings
of Teachers, Psychologists and Chaplains**

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I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary educational institution.

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Abstract

Although school staff are on the front line of dealing with adolescent self-harm, very little research has explored their experiences of this concerning behaviour. The aims of this study were to explore the attitudes and understandings of secondary school staff towards student self-harm and identify gaps that may be addressed with training. School psychologists, chaplains and teachers ($N=174$) completed an on-line survey. In line with expectations, significant differences in attitudes were found between staff groups. In combination, understanding, empathy, and, having appropriate counselling and risk assessment skills, powerfully separated groups, and showed positive correlations with both confidence and effectiveness in managing the behaviour. Contrary to expectations, knowledge of self-harm was not found to be significantly different between groups, nor was it associated with attitudes. Further training to manage the behaviour was requested, is warranted, and should focus on staff response to self-harm, including countering the unfounded and unhelpful notion that self-harm is carried out “for attention.” The internet’s role in introducing and maintaining the behaviour amongst students, and the implementation of school policy around the issue, also require specific consideration.

Key words: self-harm, adolescents, school, staff, attitudes, knowledge

Self-harm and Secondary School Students: The Attitudes and Understandings of Teachers, Psychologists and Chaplains

Secondary school staff are on the front line of managing adolescent deliberate self-harm (DSH), a concerning behaviour that is now a significant public health issue worldwide. DSH can be defined as an act with a non-fatal outcome in which an individual deliberately initiates behaviour (such as cutting or burning) with the intention of causing harm to themselves with or without suicidal intention (Crawford, Geraghty, Street, & Simonoff, 2003). The usual onset of DSH is between 12 and 14 years (Nock, 2010), with links to the onset of puberty (Hawton, Saunders, & O'Connor, 2012). Secondary school staff are in close and regular proximity to adolescents, and thus their knowledge of and attitudes towards DSH are important for effective management of this behaviour (Toste & Heath, 2010). However, very little research has been conducted within this population, despite rates of adolescents engaging in DSH being very worrying.

In 2004, Australian research showed self-harm prevalence rates of 7% amongst adolescents and 19% amongst those diagnosed with anxiety and depression (De Leo & Heller, 2004), while figures for non-suicidal self-injury (NSSI; the terminology used for self-injury in the US and Europe) in the US have been quoted as 15% to 20% (Toste & Heath, 2010). A recent Belgian study of a community adolescent population found 27% had engaged in self-injury in one or more ways at least once (Baetens, Claes, Willem, Muehlenkamp, & Bijttebier, 2011), with other research reporting a figure as high as 44% of young adults having engaged in DSH at least once in their life (Muehlenkamp, Claes, Havertape, & Plener, 2012).

In Western Australia (WA) there has been an increase in DSH behaviour among young people in recent years. In 2013, WA Emergency Departments treated almost 1,800 children for DSH injuries, a rate of almost treble the figure for 2007 (Department of Health, 2014). This increasing trend of adolescent DSH has also been reported in overseas studies of adolescent DSH where it has been described as reaching epidemic levels (Shapiro, 2008; Walsh, 2012). The concern around adolescent DSH arises not just from the obvious physical damage inflicted as a result of the behaviour, but also because it is one of the strongest predictors of completed suicide (Joiner Jr, 2002; Muehlenkamp & Kerr, 2010), with repeated episodes resulting in suicides more frequently than single episodes (Zahl & Hawton, 2004). The significance of the behaviour is reflected by its inclusion in the recently published Diagnostic and Statistical Manual of Mental Health Disorders, fifth edition (American Psychiatric Association, 2013).

For adolescents in particular, early intervention from adults, including school staff, is imperative. This need for additional focus in the area of student DSH at this time has been reinforced at the state government level in WA by the inclusion of self-harm prevention amongst students as one of the key focus areas for 2014 and 2015 by the WA Education Department (Department of Education, 2013; 2014). The current study seeks to contribute to this effort by focusing on school staff knowledge and attitudes towards student DSH, the identification of any existing gaps, and how these may be addressed.

School Staff Attitudes and Understandings Toward DSH

In the small amount of research that does exist amongst school psychologists, teachers and other pastoral care staff, it appears that knowledge of and attitudes towards DSH influence the management of students who engage in this behaviour (Berger, Hasking, & Reupert, 2014a; Best, 2006; Heath, Toste, Sornberger, & Wagner, 2011). One avenue for exploring the link between knowledge, attitudes and behaviour as they relate to student DSH is the Public Discrimination Model (PDM; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). PDM posits that familiarity and knowledge of self-harm behaviour mediates attitudes and behaviour towards those who self-harm, with more familiarity and more knowledge resulting in more positive attitudes due to a reduction in the stigma that is often attached to self-harming, leading to better outcomes for the client (Corrigan et al., 2003). PDM further states when a caregiver believes a client is responsible for their self-harm (i.e., has a negative view of those who self-harm), they show less positive feelings towards them and less willingness to help, resulting in poorer outcomes for the client.

Research into how we process information about people and form impressions of them, has indicated that cognitive elements of social processing can be overridden by affective information (Edwards & von Hippel, 1995). This potential bias is relevant for studies of DSH because the behaviour (and particularly the sight of wounds) has been found to elicit extreme emotion in school staff, including shock, panic, anxiety and horror (Best, 2006). Thus, it is likely that these negative emotions could override knowledge of DSH in the formation of attitudes and behavior towards students who self-harm. Additionally, the Theory of Planned Behaviour says positive attitudes, perceived behavioural control and behaviour are linked (Ajzen, 2011) and move in a

positive direction. Thus, applied to DSH, more positive attitudes should result in more positive behavior.

Empirical research with secondary school staff on their attitudes towards and understandings of students who self-harm has been scant. One study found that even though teachers were willing to have contact with students who engaged in NSSI, less than a third felt knowledgeable about the behaviour and less than half felt they knew how to respond (Heath et al., 2011). Interestingly, male teachers were more negative than females regarding NSSI, believing that those who self-injure are just trying to get attention and are manipulative. Another study with 501 secondary school staff (Berger, Hasking, and Reupert; 2014b) found those with training in DSH were both more confident with students who self-injured than those without training, and had higher self-perceived knowledge of NSSI than those without training. They also found mental health workers were more confident than teachers in dealing effectively with students who self-injured. Interestingly, a negative correlation between knowledge and age was found, with younger colleagues having more knowledge and more self-perceived knowledge than their older colleagues. In a qualitative study with 34 teachers and other pastoral care staff, Best (2006) found teachers had overall negative emotional reactions to DSH including anxiety, horror, panic and revulsion. A feeling of “horror” towards NSSI was also reported from teachers in Heath et al. (2011).

In a comparative study of knowledge, attitudes and training needs in the UK, Timson, Priest, and Clark-Carter (2012) found that teachers and Accident and Emergency (A&E) staff had less knowledge, felt less effective and were more negative towards those who self-harmed than Child and Adolescent Mental Health (CAMHs)

workers. Studies have also reported that school staff's poor knowledge and negative attitudes towards DSH can result in poorer quality of treatment of students who self-harm, particularly around timely referral of students to appropriately trained staff (Best, 2006; Roberts-Dobie & Donatelle, 2007). Staff who knew more about DSH, and had more positive attitudes towards the behaviour, were more likely to refer students for treatment than those with less knowledge and less positive attitudes.

Studies of attitudes towards DSH have also been carried out with medical staff who treat those who self-harm. These staff often exhibit negative attitudes including anger, frustration and feelings that those who self-harm are time wasters and attention-seekers (McAllister, Creedy, Moyle, & Farrugia, 2002; McHale & Felton, 2010; Patterson, Whittington, & Bogg, 2007a). Furthermore, as in studies conducted with school staff, negative attitudes amongst health workers have been found to lessen the quality of care provided to patients (Gagnon & Hasking, 2012). House, Owens, and Storer (1992) found that hospital staff who thought DSH was attention-seeking and manipulative also thought their treatment of DSH patients was ineffective. However, negative attitudes towards those who self-harm (particularly that they are attention-seekers and manipulative) are not borne out by the evidence around why adolescents self-harm, as discussed below.

Why Adolescents Engage in DSH

In a school-based survey across seven countries, including Australia, Scoliers et al. (2009) investigated reasons for adolescent DSH and found two main dimensions, describing them as “a cry for help” i.e., largely externally directed and help-seeking (e.g., “to show someone how desperate I was feeling”), and, “a cry for pain” i.e., largely

internally directed and a sign of deeper psychological disturbance (e.g., “to get relief from a terrible state of mind”). They found the “cry for help” motive was less prominent than the “cry of pain”, a finding which goes against the frequently held view within the community that adolescents predominately self-harm for attention (Scoliers et al., 2009).

Nock (2008) similarly described a two-dimensional model to explain reasons for DSH: for intrapersonal reasons (in line with the “cry of pain” theory) or interpersonal reasons (in line with the “cry for help” theory). This model explains the interpersonal dimension of DSH as an automatic act, an attempt to regulate emotion. The emotions range from high anxiety (where DSH has a calming effect on the person) to feeling numb (where DSH enables the person to experience pain and, as a result, feel connected to the world around them). The interpersonal function conceptualises DSH as being socially driven, to get help from others to manage the overwhelming emotion they are feeling. According to Nock, DSH may begin for intrapersonal reasons for an individual, and later transition to interpersonal reasons when regulation of emotions is no longer possible. He discusses how humans are social animals and, like in the animal kingdom, actions often speak louder than words in getting our message across. In this respect, DSH can be a form of communication. Indeed, an earlier study (Anderson, Standen, and Noon, 2005) found that doctors and nurses saw DSH as a powerful form of communication, and that establishing effective communication with people who self-harm was viewed as an essential part of preventing further DSH and suicide.

Additionally, it is widely acknowledged that individual characteristics play a major role in adolescent DSH. Genetic, biological, social, psychological, psychiatric and

cultural factors can complexly combine, resulting in DSH for some individuals (Hawton et al., 2012), particularly when experiencing stress (the diathesis-stress model; Evans, Hawton, & Rodham, 2004).

Help-Seeking for DSH

Adding to the evidence for a largely intrapersonal explanation of DSH is that adolescents often do not disclose their behaviour. It is well documented that most adolescent DSH is conducted in private (Nock & Prinstein, 2005), with those engaging in this behaviour going to some lengths to cover the evidence of their DSH (Fortune, Sinclair, & Hawton, 2008). A recent systematic review of help-seeking and adolescent self-harm research found 50% of adolescents who self-harm do not seek any help for the issue (Rowe et al., 2014). Of the 50% who do seek help, the majority disclose to family or friends with very few seeking professional help (Rowe et al., 2014). These high rates of non-disclosure may explain why school staff have underestimated the prevalence of DSH amongst students in past studies (Heath et al., 2011; Toste & Heath, 2010).

Although disclosing only to friends is developmentally appropriate, this finding is concerning, because a strong association between individual and peer self-harm has been found (Evans et al., 2004). Moreover, low numbers of adolescents present to hospital after DSH episodes, e.g., 13% in a large English school study (Hawton et al., 2012) and 10% in a comparative Australian school study (De Leo & Heller, 2004). Adolescents report barriers to help-seeking as including: fear of negative reactions, fear of being seen as attention-seeking, and fear of confidentiality being breached (McHale & Felton, 2010).

In line with studies with medical staff, research with school staff has found poor outcomes for students are due to the formation of barriers to student help-seeking; if students disclose to a school staff member and get a negative response, they are unlikely to disclose again (Toste & Heath, 2010). If students do disclose to a school staff member, it is often to a teacher whom they trust (Heath et al., 2011). Critically, referral by school staff is linked to appropriate treatment being received for students who DSH (Roberts-Dobie & Donatelle, 2007). However, unfortunately, teaching staff are the least likely to identify at-risk students and appropriately refer them to school mental health colleagues in order that they get the help they need (Roberts-Dobie & Donatelle, 2007). Considering that DSH is a strong predictor of future suicide (Muehlenkamp, Walsh, & McDade, 2010), with one study finding people who presented to hospital with DSH within a one-year period were 66 times more likely to die from suicide than the general public (Hawton, Zahl, & Weatherall, 2003), these apparent barriers to help-seeking, in medical and school settings, are particularly concerning.

Training in DSH Management

An important avenue for removing barriers to help-seeking for DSH is the provision of adequate training for caregivers to more effectively manage the behaviour. A literature review of 19 studies to ascertain factors affecting attitudes towards adolescent DSH amongst doctors, nurses, and child and adolescent mental health workers found negative attitudes to be associated with a lack of education and training, and positive attitudes associated with improved training as well as a greater understanding of experiences of DSH (McHale and Felton, 2010). Another review of 74 studies of the attitudes and knowledge of clinical staff towards DSH patients found

attitudes were generally negative and that active training led to improvements in attitudes and knowledge across all staff groups (Saunders, Hawton, Fortune, & Farrell, 2012). In a study with mental health nurses, Patterson, Whittington, and Bogg (2007b) found even short term, intensive training programs were associated with significantly improved staff attitudes and in turn, improved quality of care for clients.

Research with school staff overwhelmingly shows participants' belief that increased DSH training will improve student outcomes (Berger et al., 2014a, 2014b; Best, 2006; Heath et al., 2011; Timson et al., 2012; Toste & Heath, 2010). The improvements were largely anticipated to be around increased knowledge, and confidence in dealing with DSH; Berger et al. (2014a) found less than half of teachers who deal with student DSH felt confident doing so. They also found a strong positive correlation between training and effective interaction, but little interventional work has been done to test the effectiveness of training programs with school staff. In the one study I did find, a program developed for school welfare staff found training improved both knowledge of DSH and confidence dealing with students engaging in the behaviour (Robinson, Gook, Yuen, McGorry, & Yung, 2008). The relationship between knowledge and effectiveness in managing DSH has also been explored in some studies. For example, in the study with secondary school teachers, CAMHs workers and A&E staff, Timson et al. (2012) found a significant positive relationship between knowledge and effectiveness for teachers. Furthermore, school staff have indicated that education for parents and students to encourage them to seek professional help for DSH would be beneficial, as would the development and implementation of school policies to manage student DSH (Berger et al., 2014a).

The Contagion Effect

Adding to the concern around adolescent DSH is the widely held view that adolescent DSH is susceptible to a social contagion effect, defined as an individual engaging in DSH being copied by others (Walsh, 2012). Contagion occurs in a variety of ways: through friends (most common), entertainment media, and web sites/discussion boards (Richardson, Surmitis, & Hyldahl, 2012). Some have described DSH as becoming a cultural phenomenon over the past decade; it has featured on popular TV shows and movie stars (e.g., Angelina Jolie) have openly talked about their self-injury (Roberts-Dobie & Donatelle, 2007). In an examination of friendship influences on NSSI amongst Chinese community adolescents, it was found that an individual's friendship group engagement in NSSI significantly predicted the individual's NSSI (You, Lin, Fu, & Leung, 2013). The study also found that adolescents who engage in NSSI also leaned towards joining groups whose members engage in the behaviour.

The contagion effect may be compounded by internet usage; self-harm information can spread very effectively via this medium, particularly in the heavy-using adolescent population (Richardson et al., 2012). This is largely due to its accessibility, affordability and the fact that it is largely unmonitored (Daine et al., 2013). Figures for internet usage amongst American 12-17 year olds are as high as 93%, with two thirds of adolescents on-line daily (Richardson et al., 2012). For those engaging in DSH, connecting with others who engage in DSH is simple; in a study documenting self-injury message boards on-line, more than 500 such sites were found (J. Whitlock, Lader, & Conterio, 2007). The authors concluded that the appeal of the internet for those who self-harm is

its anonymity for those feeling shame and isolation. Adolescents reported sharing non-judgmental support, methods of self-injury, and fears relating to disclosure. Concerningly, graphic DSH images that are common on these sites, may act as triggers for further self-harm for some, and work to prevent disclosure for others (J. Whitlock et al., 2007). General internet use has been correlated with increased risk of self-harm (and more violent methods of DSH), depression and suicidal ideation (Daine et al., 2013). Although some research has been carried out with adolescents who visit DSH internet sites, and others have reviewed the content of internet message boards (J. L. Whitlock, Powers, & Eckenrode, 2006), very little research has been done with care-givers of DSH clients, including teachers and pastoral care staff in schools, in terms of their understandings of the effect of the internet on adolescent DSH. Considering secondary school students are extensive users of internet technology, and are therefore vulnerable to DSH contagion via this medium, more research in this area is sorely needed.

School Chaplains

Despite being members of school pastoral care teams, to our knowledge, school chaplains have not been surveyed as a group in relation to student DSH. In 2006, the Australian Government initiated the National Schools Chaplaincy Programme, with responsibilities including: promoting student wellbeing; encouraging reflection about spirituality; educating in the areas of beliefs, values, morals, ethics and religion; and helping students who are suffering from bereavement, family breakdown or other crisis situations connect with the school and wider community (James & Forwards, 2014). The program has been expanded and now provides funding for chaplains to 2900 primary and secondary schools (National School Chaplaincy Association, 2015). School

chaplains are trained to a “nationally recognised standard in how to recognise mental health issues in young people and to refer appropriately to other care professionals” (James & Forwards, 2014, p. 3). Thus, considering their direct role in promoting students’ well-being, it is important to investigate chaplains’ attitudes and knowledge of DSH.

The Current Study

The aims of this study are:

1. To measure attitudes and knowledge regarding student DSH amongst secondary school teachers, psychologists and chaplains,
2. To ascertain how demographic factors (e.g., gender, years of experience and training) affect attitudes and knowledge of student DSH, and
3. To investigate relationships between knowledge and attitudes in the whole sample and within groups.

The measurement instrument will be used to identify where the gaps in attitudes and knowledge of participants exist, so that, if warranted, possible future training initiatives can be targeted in these areas.

Consistent with evidence that more knowledge of DSH is associated with more positive attitudes (Patterson et al., 2007b; Robinson et al., 2008), it is hypothesised that there will be a positive relationship between knowledge and attitudes across the whole sample such that more knowledge of DSH will result in more positive attitudes. It is further hypothesized that school psychologists, due to their specialist mental health training, and considering results of past research (Berger et al., 2014a; Gagnon & Hasking, 2012; Timson et al., 2012) will have more knowledge and more positive

attitudes towards students who self-harm than teachers. To our knowledge, there is no prior data available on the knowledge and attitudes of school chaplains, so our research with this group is considered exploratory. Finally, it is hypothesised that those participants with prior training in DSH management will have more knowledge and more positive attitudes than those participants with no prior DSH management training (Robinson et al., 2008; Timson et al., 2012).

Method

Participants

A total of 193 secondary school staff completed the survey. Eighteen people were represented in the “other occupation” secondary school staff category (e.g., school nurses and youth workers) who had roles that were deemed too disparate from each other and so were excluded from further analysis. One hundred and seventy-five participants remained (46 male; aged 25 to 66 years; $M = 42.48$, $SD = 12.10$) (129 females; aged 22 to 69 years, $M = 41.69$, $SD = 12.14$). Participants were teachers ($n = 62$), psychologists ($n = 57$) and chaplains ($n = 56$). Participants were mainly from metro schools (72%), with regional schools representing 25.7% and remote schools 2.3% of the sample. Government schools made up 54.2% of the sample, Catholic Schools 22.9% and Independent schools 22.9%. Years of experience ranged from less than 1 year to 20+ years, $M = 6-10$ years.

Materials

Survey development. Survey development began with an extensive literature review of existing scales and measures of DSH. As previously mentioned, although some scales exist to measure knowledge of DSH (Jeffery & Warm, 2002) and attitudes

towards DSH (Crawford et al., 2003; McAllister et al., 2002) and have been used in other DSH and NSSI studies (Timson et al., 2012), these were developed primarily for use in the health arena and, therefore, are not entirely appropriate for use with school personnel. The Teachers' Knowledge and Beliefs about Self-Injury questionnaire (Heath et al., 2011) was designed specifically for use with teachers, however, its internal consistency has been found to be relatively low (Berger et al., 2014b), making it difficult to adequately assess staff attitudes and understandings. In 2013 Murdoch University psychology students developed a measure of DSH knowledge and attitudes for use with community groups that incorporated elements from a range of existing measures, including Crawford et al. (2003), Jeffrey and Warm (2002) and McAllister et al. (2002). Results from this community sample were screened and subjected to factor analysis as part of a study by a second group of Murdoch University Psychology students in 2014. This refined survey, in addition to items pertaining specifically to school personnel that were developed for this study or found through the literature search, became the measurement instrument employed in the current study. Appendix B outlines the source of survey items. Appendix C contains the final survey.

Pilot testing. The survey was pilot tested on four people from the population of interest using Murdoch University's SCORED (Social and Community On-line Research Database) system that was also utilised during the study. Feedback from this group resulted in changes to the Likert scale options, the addition of questions and the modification of others.

The final survey. The questionnaire was divided into five sections:

Part A – Demographics. Items included gender, age, occupation, location, experience, frequency of contact with students who self-harm, whether or not DSH training had been received, and if participants would benefit from further training.

Part B – Experiences with students who self-harm. This section gathered data on attitudes towards self-harm using a six point Likert scale: from 1 (Never) – 5 (Always) and including 6 (Unable to Judge) via 17 items e.g., “I feel confident interacting with students who self-harm.” (Note, 6 items: B3, B13, B15, B20, B21 and B23, were gathered for use in concurrent Murdoch University research and were not included in the final analysis).

Parts C, D and E – Knowledge of student DSH, Opinions of self-harm, and Knowledge about how the internet affects self-harm (respectively). These sections gathered participants’ knowledge of self-harm using a six point Likert scale: from 1 (Strongly Disagree) to 5 (Strongly Agree) and including 6 (Unable to Judge). Section C had 16 items, e.g., “Students self-harm to relieve stress and anxiety,” Section D had 11 items, e.g., “Students who self-harm are actually trying to kill themselves,” and, Section E had 4 items, e.g., “I think students who self-harm learn how to self-harm through websites and social networking sites.” (Note: items were removed from each section due to a large number of Unable to Judge (UTJ) responses; this action is further discussed later in the thesis. These items were: C8, E3 and E4. Items D2 – D6 were removed before analysis because they were assessed as being attitude and not knowledge items). Cronbach’s alpha was used to assess the internal reliability for a knowledge scale using the remaining 23 items. During the reliability analysis, two further items, “Students self-harm as a manipulative act” (C6) and “Students self-harm

to get attention” (C16) were removed as the alpha level was improved as a result. Final alpha was an acceptable .74 with 21 items (see Table 2).

Open-ended responses. Additionally, three open-ended questions allowed participants to express additional views about: roles they have held that may have been relevant to managing student self-harm; training requests; and whether they had any additional comments or concerns about the survey or the topic of DSH generally.

Procedure

Ethics approval was gained from Murdoch University Human Research Ethics Committee (MUHREC No. 2014/108), The Evaluation and Accountability Directorate - Department of Education WA (Ref: D14/0462537), and The Catholic Education Office of WA (CEOWA) to conduct the study in WA schools (see Appendices: D1; D2; and D3 respectively). The study employed an anonymous on-line survey about experiences of staff who have contact with students who self-harm. The survey was approximately 10-15 minutes in duration and could be completed at any computer at the participant’s workplace or home. The study was conducted during school term four (mid-October to mid-December) 2014.

Selection of participants. Invitations to participate were sent to 127 secondary schools in metro, regional and rural WA. The schools were chosen because they were either relatively large (had over 500 students) and, therefore, likely to be broadly representative of the WA student population, or because they were located in a regional or remote area. School principals were contacted by email explaining the study and inviting their participation. Emails were tailored to school category i.e., Government,

Catholic or Independent (See Appendix E1 for example). If interested in participating, principals were emailed a more detailed Principal's Information Letter (Appendix F), and a Participant's Information Letter (that included a URL link to the survey) to forward to psychologists, chaplains, teachers and other pastoral care staff at the school (Appendix G). In line with CEOWA and DOE research policy guidelines, principals at Catholic and Government schools were required to complete a participation consent form and return it by email before access to the on-line survey was forwarded (Appendix H). Two weeks later, a second email was sent to those principals who had not responded, and two weeks following that a final email invitation was sent to those who had not responded to the previous invitations (Appendices E2 and E3).

Participants were also recruited via associations with whom they held membership (i.e., the School Psychologists Association WA and the Independent Schools Counsellors' Association WA), and via notifications from their employers (i.e., The Education Department WA's School Psychology office and YouthCARE, WA - managers of the state's school chaplaincy program).

On-line data collection. Thirty-eight school principals indicated their interest, but three did not return consent forms, leaving 35 schools being forwarded a URL link to access the survey and submit data, representing a 27.3% participation rate from schools invited to participate. Participants recruited via associations and employers' groups were sent a different URL link from those recruited directly from schools, so any differences in demographics between the two groups could be identified prior to analysis.

Results

Preliminary Analyses

Data screening.

Analysis of two data sets. SPSS version 22 for Windows (2013) was used for data analysis. Before the two data sets collected from separate URL links were merged, chi-square analysis was performed on psychologists' and chaplains' data collected from each link to test for sampling bias around the key demographics of gender, occupation and years of experience. (Teachers were not included as only one teacher responded via the association link). No gender difference was found, but significant differences were found for both occupation and length of experience between psychologists and chaplains responding via the two links. However, upon closer inspection it became clear that this was likely due to so few chaplains being recruited via schools ($N=6$) compared with the associations link ($N=47$) (with respective figures for psychologists being $N=17$ and $N=40$), rendering the occupation comparison meaningless. The low response for chaplains in schools was probably due to the chaplains' part-time status and reduced opportunity to respond via a school link, as opposed to the ease of participating via the personal email sent from YouthCARE WA. The chaplains may have also felt more comfortable responding to an email from their employer, given the recent controversy surrounding the chaplaincy program across Australia (James & Forwards, 2014). Regarding differences in length of experience, this was most likely due to the chaplaincy program being in its infancy (nine years old) compared with the well-established school psychology program. Thus, it was deemed there were no meaningful

differences between the school and associations data sets on gender, length of experience and occupation. The data sets were combined for all further analysis.

Consolidation of participants' groups. Only three counsellors participated, so their responses were collapsed into the psychologists' data set, as they were regarded to be closest to psychologists in terms of their training and role in a school. Seven participants were collapsed from the "Other Occupation" category into the Teachers' category as they were regarded to be similar enough to the other participants in that category, e.g., "Heads of Department" were included with the teachers. Two participants did not include their age and were removed from analysis involving this demographic.

Normality and outlier checks. All attitude and knowledge items showed significant Shapiro-Wilk tests indicating non-normality. However, as this test is extremely sensitive, the result was not considered problematic (Tabachnick & Fidell, 2007). Visual inspection of the histograms found nine attitude items (Section B: 5, 6, 7, 9, 12, 14, 16, 19 and 22) and two knowledge items (C7 and D1) were not normally distributed. Log10 transformations were run on these items, however, only five attitudes items and no knowledge items were successfully transformed. As analysis was to include differences between variables as well as relationships between variables, it was not appropriate to transform some items and not others (Field, 2013). Thus, original data was retained and analysis was conducted taking this partial non-normality into account. A multivariate outliers check resulted in one participant being removed due to leverage. One hundred and seventy-four participants were included in the remainder of the analysis. In line with Timson et al. (2012) who compared knowledge and attitudes

of self-harm amongst teachers, A&E staff and CAMHs workers using a Multivariate Analysis of Variance (MANOVA), a priori power analysis with alpha of .05 and power at 80% resulted in a necessary sample size of 132 for our study (fewer than the 174 participants recruited).

Treatment of “unable to judge” (UTJ) responses. To reduce the impact of UTJ responses on the study’s power, it was decided to treat all UTJ responses as missing data as recommended by Tabachnick and Fidell (2007). Analysis of missing values was run by group and as a result, three knowledge items that had over 45% of missing data in at least one group (Items: C8, E3 and E4) were excluded from further analysis. Multiple Imputations using the expectation maximisation procedure were run on the remaining items and missing data was replaced after five imputations.

Relevant experience. To contextualize the data, additional description of the experience and training by group is presented (See Appendix I for summary table). Psychologists had the most contact with students who self-harm, with 40.3% of them seeing three or more students with this behaviour each week, compared with 30.4% for chaplains and 24.6% for teachers, but the difference between teachers and psychologists in this contact frequency was not significant, $\chi^2(1, N=118) = 3.35, p = .07$. Chaplains and psychologists were more likely to refer students externally to some degree, with chaplains referring most often. Psychologists had the most DSH training followed by chaplains and then teachers. The majority of each group felt they would benefit from more training, however, almost a third of teachers were unsure if more training would be beneficial.

Main Analyses

Firstly, the underlying structure of the attitudes towards self-harm measure is explored. A principal component factor analysis, descriptive statistics for both attitudes and knowledge items and subscales are presented, followed by relationships between variables, as measured using Kendall's tau-b method, for the whole sample and by group. A MANOVA is used to examine whether the groups differentiated along a combination of knowledge and the most influential attitude subscale, followed by a descriptive discriminant analysis to determine how the dependent variables discriminated the groups.

The data for the attitudes towards self-harm measures were subjected to an exploratory factor analysis. Item loading identified three factors that are described as: "self-efficacy" (a feeling of personal efficacy towards managing students who self-harm) containing 4 items; "worry" (displaying feelings of anxiety about students who self-harm) containing 6 items; and "negativity" (feeling negative towards students who self-harm) containing 2 items (See Table 1). The self-efficacy sub-scale had an acceptable Cronbach's alpha of .73. However, the "negativity" and "worry" attitudes sub-scales yielded a Cronbach's alpha of .49 and .61 respectively, which were both deemed too low to infer adequate internal consistency and were excluded from further analysis. For the remainder of this thesis, "self-efficacy" will refer to the self-efficacy attitude subscale extracted from the factor analysis. The total amount of variance accounted for by self-efficacy, worry and negativity was: 20.41%, 13.73% and 9.93%, respectively, indicating self-efficacy was the most influential attitude factor across the sample.

Table 1

Orthogonally Rotated Factor Loadings of the Attitudes to DSH Survey Items

Attitude item	Factor		
	1 Self-efficacy	2 Worry	3 Negativity
B8. I can empathise with students who self-harm	.680		
B18. I understand why students self-harm	.764		
B10. I have the appropriate counselling skills to help students who self-harm	.659		
B11. I can identify those students at increased risk of more serious self-harm	.759		
B9. I worry I will be blamed for what might happen to students who self-harm		.410	
B2. Students who self-harm make me feel anxious		.573	
B4. I feel confident interacting with students who self-harm		-.543	
B16. I feel critical of students who self-harm		.503	
B19. I have felt panic when interacting with students who self-harm		.745	
B22. Students' self-harm injuries make me physically ill		.642	
B5. Students who self-harm make me feel angry			.778
B7. Students who self-harm make me feel frustrated			.793
Eigenvalue	3.27	2.20	1.59
Percentage of total variance accounted for	20.41	13.73	9.93
α	.73	.61	.49

Note. Item numbers correspond to the item numbers in the survey.

Table 2 displays the descriptive knowledge statistics for each group. Encouragingly, 19 items (from the total of 23) had means above the midpoint in all groups, indicating more accurate than inaccurate knowledge of those items.

Table 2

Descriptive Statistics for School Psychologists', Chaplains' and Teachers' Knowledge of Student DSH

Knowledge item	Psychologists n=57	Chaplains n=56	Teachers n=61	Total N=174	α
	M (SD)	M (SD)	M (SD)	M (SD)	
Knowledge Scale (21 Items)	3.75 (.28)	3.64(.31)	3.60 (.38)	3.66 (.33)	.74
C1. Release Anger	3.84 (.73)	3.76 (.66)	3.67 (.92)	3.75 (.78)	
C2. Self-Punishment	3.67 (.72)	3.65 (.83)	3.75 (.94)	3.69 (.83)	
C3. Friends who DSH	3.44 (.78)	3.58 (.84)	3.22 (.90)	3.41 (.85)	
C4. Relieve Stress & Anxiety	4.53 (.50)	4.18 (.66)	4.08 (.76)	4.26 (.68)	
C5. Question Sexuality	3.43 (.90)	3.02 (.95)	3.00 (1.03)	3.15 (.98)	
C7. Coping Strategy	4.73 (.64)	4.50 (.54)	4.17 (.56)	4.46 (.62)	
C9. Greater Suicide Risk	3.50 (1.02)	3.57 (.86)	3.57 (.92)	3.55 (.93)	
C10. Control Emotion	4.25 (.65)	3.95 (.75)	3.85 (.87)	4.01 (.78)	
C11. Substance Abuse	2.50 (.74)	2.22 (.78)	2.34 (.77)	2.36 (.77)	
C12. Express Emotional Pain	4.44 (.60)	4.43 (.54)	4.30 (.56)	4.39 (.57)	
C13. Copy DSH	3.62 (.67)	3.80 (.64)	3.38 (.93)	3.59 (.78)	
C14. Escape Depression	3.95 (.64)	3.86 (.53)	3.77 (.86)	3.86 (.69)	
C15. Practice Risky Sex	2.66 (.76)	2.51 (.73)	2.53 (.90)	2.57 (.80)	
D1.Should Seek Professional Help	4.35 (.67)	4.27 (.92)	4.37 (.90)	4.33 (.83)	
D9. Disconnected from Family	3.57 (.79)	3.32 (.87)	3.33 (.92)	3.41 (.87)	
D8. Disconnected from Friends	3.61 (.86)	3.55 (.98)	3.42 (1.01)	3.52 (.95)	
D10. Seeking Acceptance	3.72 (.79)	3.75 (.78)	3.77 (.85)	3.75 (.80)	
E1.Seek Advice from Internet	3.70 (.88)	3.43 (1.07)	3.16 (.88)	3.70 (.96)	
E2.Learn DSH from Internet	3.33 (1.00)	3.36 (.99)	3.58 (.98)	3.43 (.99)	
D7. DSH is Suicide Attempt (R)	4.28 (.53)	4.14 (.62)	4.21 (.78)	4.21 (.65)	
D11. DSH is for Sympathy (R)	3.56 (.87)	3.54 (.74)	3.41 (.86)	3.5 (.82)	
Other knowledge items^a					
C16.DSH is for Attention (R)	3.23 (.98)	3.13 (.88)	2.72 (.89)	3.02 (.94)	
C6.DSH is Manipulating (R)	3.68 (1.02)	3.57 (.93)	3.16 (.99)	3.47 (1.00)	

Note. Item numbers correspond to the item numbers in the survey.

^a Items removed because scale reliability was improved without them.

(R) Items that have been reversed for ease of comparison with other items.

Boldface scores are those below the mid-point of 3 on the Likert scale indicating more negative than positive knowledge of that item.

Across groups, the mean of the items, “Students who self-harm usually have substance abuse problems” (C11) and “Self-harm is more common amongst students who practice risky sex” (C15) was less than the midpoint of 3, indicating relatively poor

knowledge for these items. The mean of “Self-harm is more common amongst students who question their sexuality” (C5) was exactly 3.00 for teachers, and only very slightly above for chaplains (3.02), but 3.43 for psychologists, indicating that teachers and chaplains had relatively low knowledge of this item. Teachers were the only group who thought it was more likely than not that, “Students self-harm to get attention” (C16; $M = 2.72$). However, apart from the “risky sex” and “substance abuse” items, the “attention” item was the least well understood item across all the groups: chaplains, $M = 3.13$, and psychologists, $M = 3.23$.

Table 3

Descriptive Statistics for School Psychologists', Chaplains' and Teachers' Attitudes Toward Student DSH

Attitude item	Psychologists n=57 M (SD)	Chaplains n=56 M (SD)	Teachers n=61 M (SD)	Total N=174 M (SD)	α
Self-Efficacy Subscale	3.91 (.47)	3.62 (.66)	2.63 (0.83)	3.37 (.87)	.73
B18. Understand why DSH	3.82 (.71)	3.56 (.86)	2.80 (1.08)	3.38 (1)	
B8. Can empathise	4.21 (.72)	3.89 (1.09)	3.06 (1.42)	3.71 (1.22)	
B10. Have appropriate counselling skills	3.77 (.83)	3.49 (1.15)	2.14 (1.22)	3.11(1.3)	
B11. Have appropriate skills to identify future DSH risk	3.82 (.76)	3.52 (1.01)	2.53 (1.17)	3.27 (1.14)	
Worry Subscale	4.43 (.44)	4.49 (.32)	4.32 (.49)	4.42 (.48)	.61
B4. Feel confident interacting (-)	4.19 (.67)	4.02 (.77)	3.74 (1.14)	3.98 (.91)	
B2. Feel anxious (R)	4.02 (.81)	4.23 (.74)	3.90 (.97)	4.05 (.86)	
B9. Worry I'll be blamed (R)	4.16 (.93)	4.45 (.89)	4.31 (1.04)	4.3 (.96)	
B19. Feel panic (R)	4.51 (.60)	4.65 (.48)	4.62 (.59)	4.59 (.56)	
B22. Feel physically ill (R)	4.86 (.48)	4.80 (.40)	4.77 (.53)	4.81 (.47)	
B16. Feel Critical (R)	4.84 (.41)	4.81 (.52)	4.62 (.59)	4.8 (.48)	
Negativity Subscale	4.66 (.41)	4.71 (.37)	4.59 (.58)	4.65 (.47)	.49
B5. Feel angry (R)	4.89 (.31)	4.87 (.34)	4.87 (.39)	4.88 (.35)	
B7. Feel frustrated (R)	4.42 (.71)	4.55 (.57)	4.32 (.87)	4.43 (.73)	
Other Items^a					
B1. Feel interaction is effective	3.53 (.74)	3.54 (.79)	3.14 (.92)	3.40 (.84)	
B6. Can debrief	4.18 (1.09)	4.14 (1.18)	3.92 (1.40)	4.08 (1.23)	
B14. Feel compelled to help	4.39 (.86)	4.43 (.93)	4.12 (1.14)	4.31 (.99)	
B12.DSH students waste time (R)	4.96 (.19)	4.96 (.19)	4.90 (.44)	4.94 (.30)	

Note. Item numbers correspond to the item numbers in the survey.

^a Items that did not hang together with other items in the analysis.

(R) Items that have been reversed for ease of comparison with other items.

Boldface scores are those below the mid-point of 3 on the Likert Scale indicating a more negative than positive attitude towards that item.

Table 3 displays the descriptive attitude statistics for each group. Reassuringly, all items, apart from three, had a mean above the midpoint, which indicates a more positive than negative attitude towards those items across the three groups. The lower means were reported by teachers on self-efficacy items (i.e., Understand why students self-harm, Have appropriate counselling skills, and, Have appropriate skills to identify future self-harm

risk) indicating a relatively low endorsement of these items.

Psychologists felt on average more confident than teachers or chaplains, however, they also felt more likely to be blamed for what might happen to students who self-harm and more feelings of panic than the other two groups. Psychologists also felt: more frustrated than chaplains but not as frustrated as teachers; and slightly less effective than chaplains but more effective than teachers.

Relationships between Knowledge and Attitudes

Whole sample correlations. A correlation of demographics, knowledge, self-efficacy and items pertaining to confidence, effectiveness and whether students self-harm for attention or to be manipulative, was completed for the whole sample (Table 4). As there was some non-normality for items indicated by significant Shapiro-Wilk tests, Kendall's tau-b method of correlation was used as it tends to provide a better estimate of the population correlation for non-normal data (Allen & Bennett, 2010).

Significant positive relationships ranging from medium to small effect size include those between: self-efficacy and: occupation, $\tau = .49$; training, $\tau = .41$; effectiveness, $\tau = .32$, and confidence, $\tau = .28$, and, between training and: effectiveness, $\tau = .24$; and occupation, $\tau = .46$, and, between confidence and effectiveness, $\tau = .19$. All $ps = <.01$.

Table 4

Kendall's tau-b Correlations Between Demographics, Knowledge and Attitudes for the Whole Sample

	1	2	3	4	5	6	7	8	9	10	11
1. Gender	-										
2. Experience	.13	-									
3. Age	.03	.43**	-								
4. Occupation	.54**	-.03	-.15*	-							
5. No. per week	-.20	.11	-.06	.13	-						
6. Training	-.18	-.03	0	.46**	-.01	-					
7. Effectiveness	-.14*	-.08	-.06	.16*	-.01	.24**	-				
8. Confidence	.06	.20**	.08	.13	.18*	.08	.19**	-			
9. Manipulation	.25**	-.01	-.01	-.19**	.01	-.13	-.17**	-.16*	-		
10. Attention	.18**	-.07	-.06	-.21**	.01	-.17*	-.12	-.16*	.43**	-	
11. Self-efficacy Scale (4 items)	-.18**	.02	-.07	.49**	.10	.41**	.32**	.28**	-.25**	-.28**	-
12. Knowledge Scale (21 Items)	-.16**	-.11	-.12*	.14*	.17**	-.06	-.02	-.10	.12*	.13*	.07

Note. ** $p < .01$, * $p < .05$

Correlations within groups. Correlations were then completed to inspect relationships within the three groups (Appendices: J, K and L). Significant positive correlations were investigated. The relationship between training and self-efficacy was significant and positive for teachers, $\tau = .28, p = <.05$, indicating more training leads to higher self-efficacy. The correlation between self-efficacy and effectiveness was significant for all groups; teachers, $\tau = .23, p = <.05$; chaplains, $\tau = .31, p = <.01$; and psychologists, $\tau = .35, p = <.01$. Training and effectiveness were not significantly correlated at the group level. Self-efficacy and confidence were significantly correlated for chaplains; $\tau = .39, p = <.01$, but not for teachers and psychologists.

Group Differences in Knowledge and Attitudes

A multivariate of variance (MANOVA) was used to examine the differences between teachers, chaplains and psychologists on self-efficacy and knowledge. Before conducting the MANOVA the data were examined to ensure the underlying assumptions were met. Although Shapiro-Wilk tests indicated non-normality in the data, visual inspection of boxplots indicated univariate normality could be assumed (Allen & Bennett, 2010). Box's test of equality of covariance matrices was used to check the assumption of homogeneity of covariance across groups. The test was significant, $p < .001$, violating the assumption. Due to this violation, Pillai's Trace test was used to analyse the MANOVA as it is considered robust and not highly linked to assumptions of normality of data distribution (Tabachnick & Fidell, 2007). Pillai's Trace test was significant; $F(4,342) = 22.87, p < .001$, Partial $\eta^2 = .21$ indicating

significant differences in the three groups on a combination of self-efficacy and knowledge with a medium to large effect size.

Examination of group differences amongst variables. Following the MANOVA, a descriptive discriminant analysis (DDA) was conducted to ascertain where the group differences existed amongst the variables. The knowledge subscale (see Table 2) and the three attitude subscales; self-efficacy, worry, and negativity (see Table 3) were included in the analysis. Although the worry and negativity subscales did not have high internal consistency as measured by Cronbach's alpha, their inclusion in the DDA is justified due to their influence on group membership in other studies. For example, Timson et al. (2012) extracted three similar factors; worry, negativity and effectiveness when comparing attitudes towards DSH between teachers, A&E staff and CAMHs workers. Box's M was significant: $F(20, 103848.55) = 62.23, p < .001$ indicating that the homogeneity of variance assumption was not met. However, since the overall sample size was large ($N=174$) and the group sizes were close to equivalent, this violation was not considered problematic (Allen & Bennett, 2010). In examining the canonical discriminant functions, there was only one large canonical correlation (.643) on Function 1 with an effect size of $R^2_c = 41.3\%$. There was a second Function but it was small (.116) with a small effect size of $R^2_c = 1.3\%$. The full model test of functions 1 to 2 was statistically significant at $p < .001$. However, the test of Function 2 was not statistically significant ($p = .510$) and was thus excluded from subsequent analysis. Table 5 represents these findings.

Table 5

Wilks's Lambda and Canonical Correlation for Teachers, Chaplains and Psychologists

Function	Wilks's Lambda	X^2	df	p	R_c	R_c^2
1-2	.578	92.860	8	.000	.643	41.3%
2	.986	2.316	3	.510	.116	1.3%

Standardized discriminant function coefficients and structure coefficients were examined to determine which variables contributed to the group differences. Table 6 represents coefficients for the analysis. Self-efficacy was primarily responsible for group differences, with knowledge, negativity and worry each having a very small influence.

Table 6

Standardised Discriminant Function and Structure Coefficients for Teachers, Chaplains and Psychologists

Scale	Coefficient	r_s	r_s^2
Knowledge	.131	.192	3.7%
Negativity	-.044	-.102	1.04%
Worry	.103	-.176	3.1%
Self-efficacy	1.005	.984	96.8%

Regarding the group centroids (see Table 7), psychologists scored highest on the function followed by chaplains who in turn scored higher than teachers, with the scores spread equal distances apart across the three groups, not concentrated in one group above or below the other two.

Table 7

<i>Group Centroids</i>	
Function 1	
Group	
Teachers	-1.103
Chaplains	.353
Psychologists	.833

Discussion

This study's first hypothesis that there would be a positive relationship between knowledge and attitudes, that is, more knowledge of DSH would result in more positive attitudes, was not supported. Contrary to expectations, a positive relationship between knowledge of and attitudes towards DSH was not found. There were no significant positive correlations between knowledge and positive attitudes (i.e., self-efficacy, confidence interacting with students who self-harm, or effectiveness of interaction).

Our findings were contrary to those found in another study with school personnel (Robinson et al., 2008) and studies with medical personnel (Jeffery & Warm, 2002; McCann, Clark, McConnachie, & Harvey, 2007; Patterson et al., 2007b). The difference between what this study found, when compared to others, might be due to the extreme emotions student DSH elicits in school staff, particularly teachers, who are relatively inexperienced in dealing with such a confronting mental health issue, as discussed by Best (2006). Perhaps the idea of self-mutilation was so foreign to this group, that the expected positive relationship between knowledge and attitudes that has been found in other studies was overridden by emotions like panic, anxiety and worry about being blamed (Edwards & von Hippel, 1995). Furthermore, there were also

methodological differences between studies; Robinson et al. (2008) measured knowledge before and after a specific training intervention, whereas we measured knowledge at one time point by asking a series of general questions about self-harm.

In this study, it was not knowledge, but self-efficacy (comprising of understanding student DSH, having empathy towards those students who self-harm, having the appropriate counselling skills to help students who self-harm, and the ability to identify those students at future risk of DSH), that powerfully differentiated the groups (as seen in the results of the DDA, Table 6). It was also self-efficacy that was positively correlated with other positive attitude items, i.e., confidence and effectiveness (see Table 4). Closer examination of self-efficacy is warranted here. Although the four items that combined to form self-efficacy are certainly correctly classified as attitudes, it is impossible to extricate them entirely from knowledge, because one certainly needs a certain level of knowledge of self-harm to understand it, feel able to counsel those engaging in the behaviour, assess those at increased risk of future self-harm, and have empathy for those experiencing it. This inherent intertwining of knowledge and attitudes is supported by the breadth of research examining the relationship between the two. As previously discussed; knowledge influences attitudes which in turn influences behaviour (Ajzen, 2011; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003).

Perhaps one way of describing what self-efficacy represents is *knowledge in practice*; it is when staff *implement* this particular knowledge/attitude set face-to-face with students in *response* to DSH that other positive attitudes towards DSH are more likely to follow. For example, significant and positive correlations with self-efficacy

were found for: effectiveness (for the whole sample and within each group) and confidence (in the whole sample and for chaplains). This finding was supported by those of Berger et al. (2014b) who found staff feeling effective was highly correlated with their confidence. Further to this, the majority of requests for future training in the current study centered around how to respond to DSH. One chaplain said,

Last time there was a panel of experts talking about self-harm, I didn't find this helpful as they were telling us all the different reasons why people do it. The students already tell us the reasons. I would like to hear some more ways to manage the student in between being referred to a more suitable support person.

In summary, we found higher knowledge of DSH alone is not indicative of more positive attitudes towards the behaviour (e.g., feeling more confident or effectively managing student DSH), but self-efficacy, or *knowledge in practice*, is.

The second hypothesis that school psychologists would have more knowledge and more positive attitudes towards students who self-harm than teachers was supported. As expected, psychologists did have a higher mean for knowledge (although not significantly so), were less likely to think that students self-harm for attention or that DSH was manipulative, had a higher mean for positive attitudes (i.e., self-efficacy, confidence and effectiveness items), and a lower mean on negative attitude items than teachers e.g., "Students who self-harm make me feel frustrated" and "I feel critical of students who self-harm" (see Table 3). These findings are consistent with Berger et al. (2014a) who found mental health workers were more likely than teachers to feel confident and effective in response to student DSH, and, those of Timson et al. (2012)

who found CAMHs staff had more knowledge and more positive attitudes than teachers and A&E staff.

This study found psychologists were more knowledgeable, more positive and less negative towards student DSH than chaplains, with the exception of the frustration item; psychologists felt slightly more frustration with student DSH than chaplains. This latter result may be due to the average length of time each group has spent in their roles; 58% of chaplains had less than 5 years' experience in their role, compared with 39% of psychologists, whereas 30% of psychologists had spent between 11 and 20 years in their role compared with only 11% of chaplains (see Appendix I). Heath et al. (2011) found a significant positive relationship between experience and agreement with the item that students self-harm to "manipulate" other people, and surmised the attitude was linked to a feeling of ineffectiveness; if efforts do not lead to improvement in self-harm behaviour for students over time, staff feel ineffective and in turn less tolerant. This process could be at play with psychologists; longevity of tenure is leading to frustration via ineffectiveness. In support of this explanation, psychologists' mean effectiveness score was slightly lower than chaplains.

Nevertheless, chaplains' knowledge and attitude scores were higher than teachers, indicating they had more knowledge of, and more positive attitudes towards student DSH than teachers. Interestingly, psychologists felt the most panic of the three groups and also felt the most likely to be blamed for what might happen to students who self-harm. The higher mean for psychologists on the "worry will be blamed" item is consistent with Crawford et al. (2003) who found psychiatric doctors felt more worry than less qualified medical staff in relation to patients' DSH. The authors concluded

psychiatric doctors' higher level of worry reflected their higher level of responsibility, something that could well be at play with the psychologists in our sample. In summary, as hypothesised, psychologists did have more DSH knowledge than the other two groups, but not to a significant level. Psychologists had more positive attitudes than both teachers and chaplains and significantly so. Chaplains had significantly more positive attitudes than teachers.

The third hypothesis that participants with training would have more knowledge and more positive attitudes than those without training was partially supported and will be discussed according to the two parts of the hypothesis. Firstly, training and knowledge were not significantly correlated for the whole sample or within groups. This was a surprising finding considering results of past studies. For example, Robinson et al. (2008) found one-day and two-day DSH training of school support staff increased their knowledge, but the training included numerous opportunities to explore appropriate responses to student DSH, including role-playing counselling students, risk management planning and challenges working with families. This type of training was frequently requested by participants in our study.

Active training was also found to lead to an increase in knowledge of DSH in a systematic review of medical staff's attitudes and knowledge (Saunders et al., 2012). One possible explanation for the difference in findings between these studies and the present one might be found in the characteristics of our sample. The majority (71%) of the whole sample had previous training in DSH, leaving 29% with no formal training; perhaps the sample sizes were just too disparate to identify any significant correlations with knowledge. We might have expected a difference between training and knowledge

within the teachers' group, since only 40% were trained (and they made up 73% of the non-trained group), so any existing differences might have been picked up more easily than for psychologists and chaplains, where 91% and 84%, respectively, had training, but this was not the case. Another explanation for the lack of correlation might be that the content of previous training did not add to knowledge as measured on the knowledge subscale. Many knowledge items were of a general nature and such DSH information is available in the public domain, particularly on the internet. Thus, participants might have gained this knowledge outside of formal training, possibly even through experience with friends and family. It is interesting to note that 77% of psychologists and 82% of chaplains said they would benefit from more training, compared with 66% of teachers (see Appendix I), even though teachers' knowledge and attitudes levels were the lowest of the three. One possible explanation for teachers being less likely to regard further training as beneficial is they do not see management of students who self-harm as their role, as was found in Berger et al. (2014a). This was highlighted in our study by comments such as the following provided by a teacher:

Teachers are expected to be able to deal with mental health issues which we just aren't equipped to do. Sending teachers on a 3 day course is like applying a bandaid to a shark attack victim. Psychologists with years of training and experience are unable to help in most cases, so why expect teachers to be able to deal with these issues. Mental health issues in schools are increasing and teachers are starting to break under the pressure of dealing with these students. Take the burden off teachers and let them get back to what they are trained to do... teach.

In summary, we found those with previous training in DSH did not have more DSH knowledge than those without training. However, this might well have been due to sample characteristics. Importantly, the majority of participants felt they would benefit from more DSH training.

The second part of the hypothesis, that those with training would have more positive attitudes towards DSH than those without training, was partially supported. Correlations across the whole sample showed a significant positive correlation between training and both self-efficacy and effective interaction, indicating that more training led to higher self-efficacy and feeling more effective in their interactions with students who self-harm. However, within groups, it was discovered that the correlation with self-efficacy was significant only for teachers, and there were no significant correlations for training and effective interaction within groups. The latter finding will be discussed first.

Our finding of no correlation between training and effective interaction was contrary to Berger et al. (2014a) who found a strong positive correlation between training and effectiveness for teachers. I discuss three possible reasons for these findings. Firstly, the training received by the school staff groups might not have included information that enabled them to respond to students who self-harm in a way that made them feel effective. This conclusion is reinforced by participants' comments regarding requests for more training and by recent previous research, e.g., "Perhaps more on the daily managing of students – when they come in and talk – how we harm minimize – best way to deal with the students and their interactions with others" (teacher). That participants wanted more of this type of training was also found by

Berger et al. (2014a); 65.3% of their sample wanted more information about how to counsel students, 56.9% about risk assessment, and 56.3% about student referral. Perhaps training that involves role-playing or other opportunities for practicing responding to student DSH might be a useful avenue to explore or expand on.

Secondly, staff might not be aware of the outcomes for students they have had interactions with (in terms of their ongoing DSH behaviour), and thus find it difficult to judge the effect of their interactions. That is, it may not be training per se that is reflected in these findings, but rather the management of students who self-harm in the school environment. Walsh (2012) emphasised the importance of DSH policy in schools that include “feedback loops” so staff know whether internal referral resulted in professional intervention. It is suggested that this idea be explored further at a local level.

Thirdly, it might be that the length of staff tenure was influential in the training and effectiveness interaction relationship such that the longer teachers were in their role, the more likely they were to feel ineffective. We also found teachers who were in their role for 11 years and over were more likely to have been trained, adding weight to the relevance of the interaction between training and experience for this group (Appendix M). Specific instruction for longer-serving teaching staff who have been in roles longer might be warranted to combat ingrained views of feeling ineffective in managing DSH. Somewhat unusually though, teachers and chaplains with 0-5, and, 11 plus years’ experience had a higher percentage of those with training than their colleagues with 6-10 years’ experience (see Appendix M). This finding is somewhat puzzling with no obvious explanation. That the teachers and chaplains in the middle

experience level might have missed training opportunities offered to newer and older recruits needs to be investigated.

An explanation of the significant positive correlation of self-efficacy and training for teachers, but not chaplains or psychologists, may be found in the make-up of our sample. The group sizes of those trained and untrained in DSH were more equal for teachers (approximately 40% and 60%, respectively, compared with 91% and 9% for psychologists, and, 84% and 16% for chaplains), thus significant correlations in the teachers group were more likely to be identified. In summary, teachers with training had more positive attitudes than those without training, but this was not true for psychologists and chaplains.

In addition to consideration of our hypotheses, there are two other findings worthy of discussion. Firstly, consideration of the item “Students self-harm to get attention,” (C16). This was the third least understood of 23 knowledge items in the total sample (after the Sexuality (C5) and Substance abuse (C11) items). Teachers were more likely than not to think students self-harm for attention, with psychologists’ and chaplains’ means falling closest to the neutral midpoint. The attention item, along with the manipulation item (C6), was not included in the knowledge subscale as their exclusion raised the subscale’s reliability. That these items behaved differently to other knowledge items, and received relatively low endorsement from participants, is likely reflective of the misconceptions around students self-harming for attention and being manipulative that have also prevailed in other studies (Patterson et al., 2007a; Scoliers et al., 2009). These labels insinuate that DSH is a negative behaviour, with adolescents seeking more than their fair share of caregivers’ time, and that it is unnecessary to be

approaching caregivers for assistance, if they are “doing it for attention.” As discussed previously, the evidence shows most adolescent DSH is conducted in private and never disclosed. The practical implications of these misconceptions will be discussed below.

Secondly, knowledge of students learning how to self-harm through websites and social networking sites was consistently low across groups. As mentioned previously, two internet knowledge items had to be removed from analysis because they recorded too many UTJ responses. Considering the strength of evidence showing the significant role on-line sites play in informing this behaviour, including DSH’s susceptibility to social contagion via the internet (Richardson et al., 2012; J. Whitlock et al., 2007; J. L. Whitlock et al., 2006), this finding is concerning.

Practical Implications

Several findings arising from this study have practical implications for schools, staff, students and the wider community. Firstly, given the finding that self-efficacy powerfully and significantly differentiated staff groups, and was also positively correlated with other positive attitudes like effectiveness and confidence, training in self-efficacy needs to be implemented and evaluated. Furthermore, the development of school policy that includes consideration of self-efficacy elements (particularly counseling skills and the identification of future self-harm risk) for different staff groups, how staff are to respond when approached by students who self-harm, and when referral should occur, would be worthwhile. While such policy does exist in some Australian schools, it is not mandatory nor widespread. The surveillance gatekeepers’ model, as discussed in Berger et al., (2014b), is an example of a DSH program that found training increased confidence, enabling appropriate response to student DSH. As

limited resources for additional programming is often constraining for schools, Heath et al. (2011) suggested training staff who already engage in interactions with students who self-harm, as they are the most likely to be approached, e.g., form teachers, Heads of Year, and Heads of House. This might be a good starting point for Australian schools looking to develop such programs.

Secondly, even though teachers were considerably less likely than psychologists or chaplains to feel they would benefit from more student self-harm management training, perhaps because they do not see student self-harm management as their role, studies have shown teachers are the *most* likely to be approached by students who self-harm and, at present, are the *least* likely equipped to deal with their needs (Roberts-Dobie & Donatelle, 2007). Therefore, their role in managing the issue needs to be addressed and more clearly delineated.

Thirdly, all staff groups showed evidence of poor understanding of students' reasons for self-harm in respect to attention-seeking. This was particularly so for teachers who were more likely than not to believe that DSH is attention-seeking behaviour. The implications of these misconceptions are particularly concerning, considering findings reported by McHale and Felton (2010) that adolescents being seen as "attention-seeking" was a major barrier to their help-seeking. The concern is further raised by evidence that if students do disclose, and are confronted by negative attitudes, such as being labeled attention-seeking, they are likely not to disclose again (Toste & Heath, 2010), leading to an increased risk of future suicide attempts (Muehlenkamp et al., 2010). In the current study, male participants were significantly more likely to think DSH was for attention than females (as was found by Heath et al. (2011); a finding that

needs to be addressed in the development of future training initiatives. Training for all school staff that focuses on: adolescent DSH being mostly for intrapersonal (internal) not interpersonal (external) reasons; the majority of DSH behaviour never being disclosed; adolescents being seen as “attention-seeking” as a major barrier to help-seeking and; the link between repeat DSH and suicide, is warranted to reduce the stigma associated with DSH.

Finally, there was relatively poor understanding amongst staff regarding the influence of websites and social networking sites on student self-harm. This finding is particularly concerning, given the growing evidence that social media use among adolescents has increased the incidence and maintenance of DSH behaviours through easily accessible DSH related material, and that DSH is susceptible to a social contagion effect (Richardson et al., 2012). The internet is an inescapable, powerful and growing influence over youth worldwide, and school staff need education to better understand how students are using it in relation to DSH to better assist them to manage the behaviour.

Strengths, Limitations and Future Research

The robust sample size ensured the study had more than adequate power, however, the study was self-selected so participants may have held particular interest in student DSH which, coupled with the survey being self-report, could have led to some bias within the sample. An UTJ option was included for participants without experience on certain items to distinguish between no experience and a neutral attitude towards items. However, due to UTJ knowledge items being treated as missing data and replaced with imputed scores, in order to preserve other data in the analysis, the knowledge data from

this study must be treated with some caution, particularly since 57.2% of the missing values that were imputed came from teachers (chaplains = 32.1% and psychologists = 10.7%) suggesting there are differences in at least *self-perceived* knowledge between groups. However, as items with more than 45% of missing data were excluded from analysis, the remaining data used in the analysis is considered robust.

In light of calls by authors including Berger et al., (2014b) to validate instruments to measure student DSH, the current study utilised a survey developed by modifying an existing community survey and incorporating the results of a wide literature review. Three attitudes factors of self-efficacy, worry and negativity were identified, in line with findings by Timson et al. (2012), who extracted effectiveness, negativity and worry factors, adding to the evidence for the validity of these subscales in exploring school staff attitudes towards student DSH. However, we found only the self-efficacy subscale was internally reliable ($\alpha = .73$); negativity and worry items need further refinement in future studies to improve scale reliability.

Concluding Statements

In conclusion, this study demonstrated that knowledge of student DSH alone was not related to more positive attitudes towards the behaviour amongst school staff. Rather, a combination of understanding, empathy, and, having appropriate counselling and risk assessment skills (labelled “self-efficacy” for the purposes of this study), was the factor that powerfully differentiated staff groups, and showed positive correlations with both confidence and effectiveness in managing the behaviour. Self-efficacy essentially represents an individual’s *response* to student DSH, and thus it is suggested future training for these groups should be focused on opportunities to improve response

skills. Additionally, specific focus on the internet's role in student DSH, and that students do not self-harm for attention, would be beneficial inclusions in future training initiatives for school staff. Implementation of policy at school level is required as a framework that staff, students and parents can work within as they strive together to manage this very concerning behaviour.

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- Disclosure of potential conflicts of interest
- Research involving Human Participants and/or Animals
- Informed consent

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When reporting studies that involve human participants, authors should include a statement that the studies have been approved by the appropriate institutional and/or national research ethics committee and have been performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

If doubt exists whether the research was conducted in accordance with the 1964 Helsinki Declaration or comparable standards, the authors must explain the reasons for their approach, and demonstrate that the independent ethics committee or institutional review board explicitly approved the doubtful aspects of the study.

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Ethical approval: “All applicable international, national, and/or institutional guidelines for the care and use of animals were followed.”

If applicable (where such a committee exists): “All procedures performed in studies involving animals were in accordance with the ethical standards of the institution or practice at which the studies were conducted.”

If articles do not contain studies with human participants or animals by any of the authors, please select one of the following statements:

“This article does not contain any studies with human participants performed by any of the authors.”

“This article does not contain any studies with animals performed by any of the authors.”

“This article does not contain any studies with human participants or animals performed by any of the authors.”

Informed consent

All individuals have individual rights that are not to be infringed. Individual participants in studies have, for example, the right to decide what happens to the (identifiable) personal data gathered, to what they have said during a study or an interview, as well as to any photograph that was taken. Hence it is important that all participants gave their informed consent in writing prior to inclusion in the study. Identifying details (names, dates of birth, identity numbers and other information) of the participants that were studied should not be published in written descriptions, photographs, and genetic profiles unless the information is essential for scientific purposes and the participant (or parent or guardian if the participant is incapable) gave written informed consent for publication. Complete anonymity is difficult to achieve in some cases, and informed consent should be obtained if there is any doubt. For example, masking the eye region in photographs of participants is inadequate protection of anonymity. If identifying characteristics are altered to protect anonymity, such as in genetic profiles, authors should provide assurance that alterations do not distort scientific meaning.

The following statement should be included:

Informed consent: “Informed consent was obtained from all individual participants included in the study.”

If identifying information about participants is available in the article, the following statement should be included:

“Additional informed consent was obtained from all individual participants for whom identifying information is included in this article.”

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Appendix B

Original Items	New/Amended Items
I deal effectively with deliberate self-harm clients (McAllister et al., 2002)	B1. My interaction with students who self-harm is effective
	B2. Students who self-harm make me feel anxious
	B3. Students with learning difficulties are more likely to self-harm than other students*
	B4. I feel confident interacting with students who self-harm
These children usually make me feel angry (Crawford et al., 2003)	B5. Students who self-harm make me feel angry
I have someone at work with whom I can discuss these children (Crawford et al., 2003)	B6. I am able to debrief with someone about students who self-harm
	B7. Students who self-harm make me feel frustrated
I can empathise with parents/carers of children who self-harm (Crawford et al., 2003)	B8. I can empathise with students who self-harm
I am worried that I am going to be blamed for what might happen to these children (Crawford et al., 2003)	B9. I worry I will be blamed for what might happen to students who self-harm
I have the appropriate knowledge in counselling skills to help deliberate self-harm clients (McAllister., 2002)	B10. I have the appropriate counselling skills to help students who self-harm
Risk assessment is an important skill for me to have (McAllister et al., 2002)	B11. I can identify those at increased risk of more serious self-harm
Dealing with self-harm clients is a waste of the health care professional's time (McAllister et al., 2002)	B12. Students who self-harm waste my professional time
	B13. Students who are high achievers are at greater risk of self-harm than other students*
	B14. I feel compelled to help students who self-harm

Original Items	New/Amended Items
<p>I feel critical towards self-harming clients (Patterson et al., 2007)</p> <p>I rarely find myself thinking about young people who have self-harmed when I am not at work (Crawford et al., 2003)</p>	<p>B15. Students who are bullied are at greater risk of self-harm than other students*</p> <p>B16. I feel critical of students who self-harm</p> <p>B17. I think about the students who have self-harmed when I am away from school</p>
	<p>B18. I understand why students self-harm</p> <p>B19. I have felt panic when interacting with students who self-harm</p> <p>B20. Group activities at school (Eg., sport, theatre) protect students from self-harm *</p> <p>B21. Academic stress is a significant contributor to student self-harm*</p> <p>B22. Students' self-harm injuries make me feel physically ill</p> <p>B23. Students who skip school are more likely to self-harm than other students*</p>
<p>Self-harm is a release for anger (Jeffery & Warm, 2002)</p>	<p>C1. Students self-harm to release feelings of anger</p> <p>C2. Students self-harm as a form of self-punishment</p> <p>C3. Students who self-harm usually have friends who self-harm</p>
<p>For some individuals, self-harm can be a way of relieving tension (Patterson et al., 2007)</p> <p>Gay young men are no more likely to self-harm than the general population (Crawford et al., 2003)</p> <p>Self-harm is a manipulative act (Jeffery & Warm, 2002).</p> <p>Self-harm is a coping strategy (Jeffery & Warm, 2002).</p>	<p>C4. Students self-harm to relieve stress and anxiety</p> <p>C5. Self-harm is more common amongst students who question their sexuality</p> <p>C6. Students self-harm as a manipulative act</p> <p>C7. Students self-harm as a coping strategy</p> <p>C8. Students who self-harm usually have a family member who self-harms</p>
Original Items	New/Amended Items

People who self-harm have an increased likelihood of committing suicide in the future (Crawford et al., 2003)	C9. Students who self-harm are at greater risk of suicide
Self-harm provides a way of staying in control (Jeffery & Warm, 2002)	C10. Students self-harm to help stay in control of emotion C11. Students who self-harm usually have substance abuse problems
Self-harm expresses emotional pain (Jeffery & Warm, 2002)	C12. Students self-harm as an expression of emotional pain C13. Some students copy self-harm behaviour from other students
Self-harm provides escape from depression (Jeffery & Warm, 2002)	C14. Students self-harm to provide an escape from depression C15. Self-harm is more common amongst students who practise risky sex
Self-harm is attention-seeking (Jeffery & Warm, 2002)	C16. Students self-harm to get attention
Self-harming clients do not respond to professional care (Patterson et al., 2007)	D1. Should seek professional help
People who self-harm lack solid religious convictions (Patterson et al., 2007)	D2. Lack religious convictions D3. Are overly sensitive to their emotions
Self-harm is a serious moral wrongdoing (Patterson et al., 2007)	D4. Commit a serious wrongdoing
People who self-harm have poor communication skills and low self-esteem (Crawford et al., 2003)	D5. Have low self-esteem D6. Have poor social skills
Self-harm is a failed suicide attempt (Jeffery & Warm, 2002)	D7. Are actually trying to kill themselves D8. Feel disconnected from their friends D9. Feel disconnected from their family

Original Items

New/Amended Items

People who self-harm are usually trying to get sympathy from others (Patterson et al., 2007)

D11. Are trying to get sympathy from others

E1. Are likely to seek help and advice from the internet rather than a medical professional

E2. Learn how to self-harm through websites and social networking sites

E3. Use self-harm chat rooms to seek approval for their self-harm

E4. Use the internet to follow celebrity role models who self-harm

*Items were included in survey to gather data for simultaneous research at Murdoch University and were not analysed in this study.

Appendix C

Information and Consent

Information about completing the survey

The following survey is divided into 5 sections (labelled A-E) covering different aspects of student self-harm. Participants are asked to complete all sections as instructed. Items marked with an * require an answer. In order that responses remain completely anonymous, please do not write your name, your school's name, students' names or refer to specific examples in any of your answers.

Consent Conditions

- I have read and understood the information letter about the project, or have had it explained to me in language I understand.
- I have taken up the invitation to ask any questions I may have had, and am satisfied with the answers I have received.
- I understand that participation in the project is entirely voluntary.
- I am willing to become involved in the project, as described.
- I understand I am free to withdraw my participation (before submitting my data) without affecting my relationship with staff at the school where I am employed, the Department of Education WA/Catholic Education Office/Association of Independent Schools WA, or Murdoch University.
- I understand that once my data has been submitted I am no longer able to withdraw from the study as all information provided is entirely anonymous and will not be able to be individually identified.
- I understand that the data gathered may be re-analysed for use in future studies.
- I give permission for my contribution to this research to be reported on Murdoch University's website, in reports sent to participating schools, and for its potential publication in a journal provided that I or the school is not identified in any way.
- I understand that I can request a summary of findings once the research has been completed.

If you agree with these conditions, select, "I agree" and click the "Next" button. If you do not agree click the "Cancel" button.*

I agree

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CANCEL

PART A - This section asks you to provide information about you and your occupation. Please mark the appropriate boxes or provide information as required.

N.B. For the purposes of this survey, "self-harm" is defined as acts of harming oneself with or without suicidal intent (eg. cutting or burning) with a non-fatal outcome.

1. What is your gender?*

- Male
- Female

2. What is your age?*

3. What is your occupation?*

- Deputy Head
- Head of House
- Head of Year
- Teacher
- School Chaplain
- School Counsellor
- School Psychologist
- Other, please specify _____

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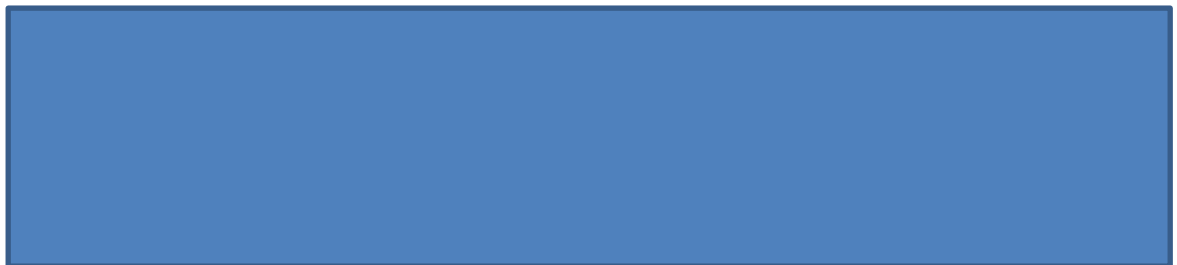
CANCEL

4. Where is your school located?*

- Perth (CBD or suburb of Perth)
- Regional
- Remote

5. How many years of experience do you have in your current role?*

- Less than 1
- 1 to 5
- 6 to10
- 11 to 20
- 20 +

6. Are there any other roles you have held that are relevant to managing students who self-harm? Please explain.**7. Where did you obtain your qualifications and training?***

- Australia
- Overseas
- Both

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8. On average, how frequently do you come into contact with students who self-harm?*

- Daily
- Weekly
- Fortnightly
- Monthly
- Less than monthly

9. In an average week, how many students who self-harm do you come into contact with?*

- 1-2
- 3-5
- 6-8
- 9-10
- More than 10

10. How frequently do you refer students who self-harm to external services?*

- Never
- Occasionally
- Usually
- Always

11. Have you received any training regarding the management of student self-harm (either as stand-alone training or as part of a broader training package)?*

- Yes
- No (go to question 13)

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12. When did you receive this training?

- Within the last 6 months
- 6-12 months ago
- 13-24 months ago
- Over 2 years ago

13. Do you think you would benefit from further training and/or education on the subject of self-harm?*

- No
- Yes
- Not sure

14. If you answered "Yes" to question 13, what type of education and/or training would you find useful?



PART B -This section is about your experiences with students who self-harm. When completing this section, please keep in mind the majority of students with whom you meet. *In my experience.....*

1. My interaction with students who self-harm is effective*

Never Sometimes About half the time Most of the time Always Unable to Judge

2. Students who self-harm make me feel anxious* *

Never Sometimes About half the time Most of the time Always Unable to Judge

3. Students with learning difficulties are more likely to self-harm than other students*

Never Sometimes About half the time Most of the time Always Unable to Judge

4. I feel confident interacting with students who self-harm*

Never Sometimes About half the time Most of the time Always Unable to Judge

5. Students who self-harm make me feel angry**

Never Sometimes About half the time Most of the time Always Unable to Judge

6. I am able to debrief with someone about students who self-harm*

Never Sometimes About half the time Most of the time Always Unable to Judge

7. Students who self-harm make me feel frustrated**

Never Sometimes About half the time Most of the time Always Unable to Judge

8. I can empathise with students who self-harm*

Never Sometimes About half the time Most of the time Always Unable to Judge

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9. I worry I will be blamed for what might happen to students who self-harm* *

Never Sometimes About half the time Most of the time Always Unable to Judge

10. I have the appropriate counselling skills to help students who self-harm *

Never Sometimes About half the time Most of the time Always Unable to Judge

11. I can identify those students at increased risk of more serious self-harm*

Never Sometimes About half the time Most of the time Always Unable to Judge

12. Students who self-harm waste my professional time**

Never Sometimes About half the time Most of the time Always Unable to Judge

13. Students who are high achievers are at greater risk of self-harm than other students*

Never Sometimes About half the time Most of the time Always Unable to Judge

14. I usually feel compelled to help students who self-harm*

Never Sometimes About half the time Most of the time Always Unable to Judge

15. Students who are bullied are at greater risk of self-harm than other students*

Never Sometimes About half the time Most of the time Always Unable to Judge

16. I feel critical of students who self-harm**

Never Sometimes About half the time Most of the time Always Unable to Judge

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17. I think about the students who have self-harmed when I am away from school*

Never Sometimes About half the time Most of the time Always Unable to Judge

18. I understand why students self-harm*

Never Sometimes About half the time Most of the time Always Unable to Judge

19. I have felt panic when interacting with students who self-harm**

Never Sometimes About half the time Most of the time Always Unable to Judge

20. Group activities at school (e.g., sport, theatre) protect students from self-harm*

Never Sometimes About half the time Most of the time Always Unable to Judge

21. Academic stress is a significant contributor to student self-harm*

Never Sometimes About half the time Most of the time Always Unable to Judge

22. Students' self-harm injuries make me feel physically ill**

Never Sometimes About half the time Most of the time Always Unable to Judge

23. Students who skip school are more likely to self-harm than other students*

Never Sometimes About half the time Most of the time Always Unable to Judge

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PART C - In this section you are asked whether you agree or disagree with statements regarding student self-harm, and why students may self-harm. Again, please keep the majority of students with whom you meet in mind as you complete this section.

1. Students self-harm to release feelings of anger*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

2. Students self-harm as a form of self-punishment*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

3. Students who self-harm usually have friends who self-harm*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

4. Students self-harm to relieve stress and anxiety*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

5. Self-harm is more common amongst students who question their sexuality*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

6. Students self-harm as a manipulative act**

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

7. Students self-harm as a coping strategy*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

8. Students who self-harm usually have a family member who self-harms*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

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9. Students who self-harm are at greater risk of suicide*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

10. Students self-harm to help stay in control of emotion*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

11. Students who self-harm usually have substance abuse problems*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

12. Students self-harm as an expression of emotional pain*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

13. Some students copy self-harm behaviour from other students *

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

14. Students self-harm to provide an escape from depression*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

15. Self-harm is more common amongst students who practise risky sex*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

16. Students self-harm to get attention**

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

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PART D - This section is about your opinions of students who self-harm. Please complete the section keeping the majority of students with whom you meet in mind. *In my opinion, students who self-harm.....*

1. Should seek external professional help*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

2. Lack religious convictions*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

3. Are overly sensitive to their emotions*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

4. Commit a serious moral wrong doing*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

5. Have low self-esteem*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

6. Have poor social skills*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

7. Are actually trying to kill themselves**

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

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8. Feel disconnected from their friends*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

9. Feel disconnected from their family*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

10. Are seeking acceptance and understanding*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

11. Are trying to get sympathy from others**

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

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**Items for which scores were reversed when calculating knowledge and attitude subscales.

PART E - This section is about how the internet and social networking websites (e.g. chat rooms & discussion forums) affect student self-harm. Please keep the majority of students with whom you meet in mind as you respond. *I think students who self-harm.....*

1. Are likely to seek help and advice from the internet rather than a medical professional*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

2. Learn how to self-harm through websites and social networking sites*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

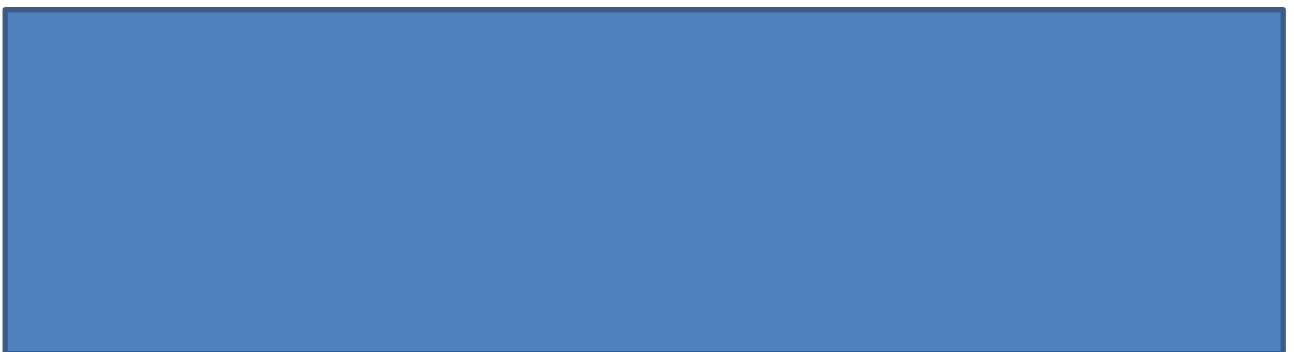
3. Use self-harm chat rooms to seek approval for their self-harm*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

4. Use the internet to follow celebrity role models who self-harm*

Strongly Disagree Disagree Neutral Agree Strongly Agree Unable to Judge

5. Do you have any additional comments, questions or concerns you would like to share (e.g., on the topic of self-harm, the survey etc.)?



If you experience any anxiety as a result of completing the survey, you can access support services from Lifeline on 13 11 14, or Beyondblue on 1300 2246 36.

Thank you for taking the survey!

Appendix D1



Division of Research & Development
Research Ethics and Integrity Office

Monday, 14 July 2014

Dr Suzanne Dziurawiec
School of Psychology and Exercise Science
Murdoch University

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Telephone: (08) 9360 6677
Facsimile: (08) 9360 6686
human.ethics@murdoch.edu.au

www.murdoch.edu.au

Dear Suzanne,

Project No. 2014/108
Project Title High school teachers', school psychologists' and school chaplains' understandings and attitudes toward deliberate self-harm amongst adolescents

Thank you for addressing the conditions placed on the above application to the Murdoch University Human Research Ethics Committee. On behalf of the Committee, I am pleased to advise the application now has:

OUTRIGHT APPROVAL

Approval is granted on the understanding that research will be conducted according to the standards of the **National Statement on Ethical Conduct in Human Research (2007)**, the **Australian Code for the Responsible Conduct of Research (2007)** and **Murdoch University policies** at all times. You must also abide by the **Human Research Ethics Committee's standard conditions of approval (see attached)**. All reporting forms are available on the Research Ethics and Integrity web-site.

I wish you every success for your research.

Please quote your ethics project number in all correspondence.

Kind Regards,

A handwritten signature in black ink, appearing to read "E. von Dietze".

Dr. Erich von Dietze
Manager
Research Ethics and Integrity

cc: Ms Amy Cleator and Diana McGrath

Appendix D2



Government of **Western Australia**
Department of **Education**

Your ref :
Our ref : D14/0462537
Enquiries :

Ms Diana McGrath
5 Davies Crescent
KARDINYA WA 6163

Dear Ms McGrath

Thank you for your application received 1 September 2014 to conduct research on Department of Education sites.

The focus and outcomes of your research project, *The Attitudes and Understandings of Secondary School Teachers, Psychologists, Chaplains and Counsellors About Deliberate Self-harm Amongst Students*, are of interest to the Department. I give permission for you to approach principals to invite their participation in the project as outlined in your application. It is a condition of approval, however, that upon conclusion the results of this study are forwarded to the Department at the email address below.

Consistent with Department policy, participation in your research project will be the decision of the schools invited to participate and individual staff members. A copy of this letter must be provided to principals when requesting their participation in the research. Researchers are required to sign a confidential declaration upon arrival at the Department of Education site.

Responsibility for quality control of ethics and methodology of the proposed research resides with the institution supervising the research. The Department notes a copy of a letter confirming that you have received ethical approval of your research protocol from the Murdoch University Human Research Ethics Committee.

Any proposed changes to the research project will need to be submitted for Department approval prior to implementation.

Please contact Dr Adriaan Wolvaardt, Research and Evaluation Officer, on (08) 9264 5512 or researchandpolicy@education.wa.edu.au if you have further enquiries.

Very best wishes for the successful completion of your project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Alan Dodson'.

ALAN DODSON
DIRECTOR
EVALUATION AND ACCOUNTABILITY

14 October 2014

Appendix D3



CATHOLIC EDUCATION
OFFICE OF WESTERN AUSTRALIA

EXECUTIVE DIRECTOR OF CATHOLIC EDUCATION

17 September 2014

Dr Suzanne Dziurawiec
Murdoch University
School of Psychology and Exercise Sciences
90 South Street
MURDOCH WA 6150

Dear Dr Dziurawiec

**RE: THE ATTITUDES AND UNDERSTANDINGS OF SECONDARY SCHOOL TEACHERS,
PSYCHOLOGISTS, CHAPLAINS AND COUNSELLORS AND DELIBERATE SELF-HARM
AMONGST STUDENTS**

Thank you for your completed application received 1 September 2014, whereby this project aims to assess understandings of and attitudes towards adolescent self-harm amongst teachers, psychologists, counsellors and chaplains working in Government, Catholic and Independent secondary schools in metropolitan, regional and rural WA, as these staff are likely to come in contact with students who self-harm.

I give in principle support for the selected secondary Catholic schools in Western Australia to participate in this valuable study. However, consistent with the Catholic Education Office of Western Australia (CEOWA) policy, participation in your research project will be the decision of the individual principal and staff members. A copy of this letter must be provided to principals when requesting their participation in the research.

Responsibility for quality control of ethics and methodology of the proposed research resides with the institution supervising the research. The CEOWA notes that Murdoch University Human Research Ethics Committee has granted permission for the duration of this research project (Reference Number: 2014/108).

Any changes to the proposed methodology will need to be submitted for CEOWA approval prior to implementation. The focus and outcomes of your research project are of interest to the CEOWA. It is therefore a condition of approval that the research findings of this study are forwarded to the CEOWA.

Further enquiries may be directed to Jane Gostelow at gostelow.jane@ceo.wa.edu.au or (08) 6380 5118.

I wish you all the best with your research.

Yours sincerely

Dr Tim McDonald

EXECUTIVE DIRECTOR OF CATHOLIC EDUCATION
50 Ruislip Street, Leederville WA 6007 | PO Box 198, Leederville WA 6903
T (08) 6380 5210
E mcdonald.tim@ceo.wa.edu.au W ceo.wa.edu.au

Appendix E1

Attention: School Principal**Adolescent self-harm is concerning and on the rise.**

Dear

The onset of adolescent self-harm is between the ages of 12 and 14, and managing this behaviour has become an issue for staff in secondary schools worldwide. During this fourth school term, Murdoch University is conducting research into the understandings and attitudes of secondary school staff towards adolescent self-harm across WA under the supervision of Dr. Suzanne Dziurawiec. We are interested in hearing from **teachers, counsellors, psychologists and chaplains** at your school regarding their experiences with adolescents who self-harm via an on-line, 10-15 minute survey. **The anonymity of participants is guaranteed as no identifying information about schools, staff or students is collected.** This research is timely, as self-harm prevention amongst students is one of the six key focus areas for the WA Education Department this year, specifically, "Work with school psychologists and other interagency partners on student mental health issues including suicide and self-harm prevention" (Focus 2014, *Education Department, WA, 2013*). To our knowledge, this is the first time in Australia this staff group has been surveyed on this topic. It is anticipated the findings will provide a foundation to improve the education and training needs of current and future staff, so that they may be supported to assist this at-risk and growing group of adolescents.

Schools were selected on the basis of one of two criteria; either having relatively large student numbers (over 500), or being in a regional or remote location. **Your school is one of 127 Government, Independent and Catholic Schools selected statewide to participate in this research.** All participating schools will receive a report of the results in June 2015. The research has been approved by the WA Department of Education and The Catholic Education Office of WA.

If you would like your staff to participate, or would like more information about the survey, please contact me by return email. Participation is straightforward. You will be emailed: the official approval from the WA Education Department, a more detailed Principal's Information Letter, and an electronic Consent Form to sign and return. Once I have received your consent, you will be emailed a Participants' Information Letter (including a link to the survey) to forward to your relevant staff members. They can complete the survey from any computer at school or at home. You are not required to do anything else. Please contact me if you have any queries. I hope you will support this timely research. Thank you for your time.

Kind regards,



Diana McGrath
Bachelor of Psychology (Hons) student
School of Psychology and Exercise Science
Email: D.McGrath@murdoch.edu.au, Ph: 0405361393



Murdoch
UNIVERSITY

Appendix E2

Attention: School Principal

Dear

Earlier this term I sent you an email inviting your school staff to participate in Murdoch University's Adolescent Self-harm Research (please see below). The anonymous survey is being conducted until the end of this term. The response has been encouraging but we need more participants to better represent the experiences of WA secondary school staff with students who self-harm. Our pilot work indicates that staff want to have a better understanding of students who self-harm and want to make a difference in these students' lives, so your help in facilitating this research is valued. If you would like: any further information, a copy of the survey, or to participate, please contact me by return email. Thank you for your time.

Diana McGrath

Adolescent self-harm is concerning;**I in 6 high school students have self-harmed.**

The onset of adolescent self-harm is between the ages of 12 and 14, and managing this behaviour has become an issue for staff in secondary schools worldwide. During this fourth school term, Murdoch University is conducting research into the understandings and attitudes of secondary school staff towards adolescent self-harm across WA under the supervision of Dr. Suzanne Dziurawiec. We are interested in hearing from **teachers, counsellors, psychologists and chaplains** at your school regarding their experiences with adolescents who self-harm via an on-line, 10-15 minute survey. **The anonymity of participants is guaranteed as no identifying information about schools, staff or students is collected.** This research is timely, as self-harm prevention amongst students is one of the six key focus areas for the WA Education Department this year, specifically, "Work with school psychologists and other interagency partners on student mental health issues including suicide and self-harm prevention" (Focus 2014, *Education Department, WA*, 2013). To our knowledge, this is the first time in Australia this staff group has been surveyed on this topic. It is anticipated the findings will provide a foundation to improve the education and training needs of current and future staff, so that they may be supported to assist this at-risk and growing group of adolescents.

Schools were selected on the basis of one of two criteria; either having relatively large student numbers (over 500), or being in a regional or remote location. **Your school is one of 127 Government, Independent and Catholic Schools selected statewide to participate in this research.** All participating schools will receive a report of the results in June 2015. The research has been approved by the WA Department of Education and The Catholic Education Office of WA.

If you would like your staff to participate, or would like more information about the survey, please contact me by return email. Participation is straightforward. You will be emailed: the official approval from the WA Education Department, a more detailed Principal's Information Letter, and an electronic Consent Form to sign and return. Once I have received your consent, you will be emailed a Participants' Information Letter (including a link to the survey) to forward to your relevant staff members. They can complete the survey from any computer at school or at home. You are not required to do anything else.

Please contact me if you have any queries. I hope you will support this timely research. Thank you for your time.

Kind regards,



Diana McGrath
Bachelor of Psychology (Hons) student
School of Psychology and Exercise Science
Email: D.McGrath@murdoch.edu.au
Ph: 0405 361 393



Murdoch
UNIVERSITY

Appendix E3

Dear

This is a final invitation for your school staff to participate in Murdoch University's Adolescent Self-harm Research (please see below). The anonymous survey is being conducted until the end of this term. The response has been encouraging but we need more participants to better represent the experiences of WA secondary school staff with students who self-harm. Our pilot work indicates that staff want to have a better understanding of students who self-harm and want to make a difference in these students' lives, so your help in facilitating this research is valued. If you would like: any further information, a copy of the survey, or to participate, please contact me by return email. Thank you for your time.

Diana McGrath

Adolescent self-harm is concerning;

I in 6 secondary school students have self-harmed.

The onset of adolescent self-harm is between the ages of 12 and 14, and managing this behaviour has become an issue for staff in secondary schools worldwide. During this fourth school term, Murdoch University is conducting research into the understandings and attitudes of secondary school staff towards adolescent self-harm across WA under the supervision of Dr. Suzanne Dziurawiec. We are interested in hearing from **teachers, counsellors, psychologists and chaplains** at your school regarding their experiences with adolescents who self-harm via an on-line, 10-15 minute survey. **The anonymity of participants is guaranteed as no identifying information about schools, staff or students is collected.** This research is timely, as self-harm prevention amongst students is one of the six key focus areas for the WA Education Department this year, specifically, "Work with school psychologists and other interagency partners on student mental health issues including suicide and self-harm prevention" (Focus 2014, *Education Department, WA*, 2013). To our knowledge, this is the first time in Australia this staff group has been surveyed on this topic. It is anticipated the findings will provide a foundation to improve the education and training needs of current and future staff, so that they may be supported to assist this at-risk and growing group of adolescents.

Schools were selected on the basis of one of two criteria; either having relatively large student numbers (over 500), or being in a regional or remote location. **Your school is one of 127 Government, Independent and Catholic Schools selected statewide to participate in this research.** All participating schools will receive a report of the results in June 2015. The research has been approved by the WA Department of Education and The Catholic Education Office of WA.

If you would like your staff to participate, or would like more information about the survey, please contact me by return email. Participation is straightforward. You will be emailed: the official approval from the WA Education Department, a more detailed Principal's Information Letter, and an electronic Consent Form to sign and return. Once I have received your consent, you will be emailed a Participants' Information Letter (including a link to the survey) to forward to your relevant staff members. They can complete the survey from any computer at school or at home. You are not required to do anything else.

Please contact me if you have any queries. I hope you will support this timely research. Thank you for your time.

Kind regards,



Diana McGrath
Bachelor of Psychology (Hons) student
School of Psychology and Exercise Science
Email: D.McGrath@murdoch.edu.au
Ph: 0405 361 393



Murdoch
UNIVERSITY

Appendix F

**School of Psychology and Exercise Sciences**

Murdoch University
 South Street campus
 90 South Street
 Murdoch
 Western Australia 6150

Principal's Information Letter

***The Attitudes and Understandings of Secondary School Teachers,
 Psychologists, Chaplains and Counsellors About Deliberate Self-harm Amongst Students***

My name is Diana McGrath and I am writing to you on behalf of Murdoch University. I am conducting a research project that aims to explore the understandings and attitudes of secondary school teachers, school psychologists, school counsellors and school chaplains in Western Australia regarding self-harm amongst adolescent students. To our knowledge, this study is the first in Australia to survey this particular group of staff in relation to student self-harm. It appears this research is timely, as self-harm prevention amongst students is one of the six key focus areas for the WA Education Department, specifically, "Work with school psychologists and other interagency partners on student mental health issues including suicide and self-harm prevention" (Focus 2014, *Education Department, WA, 2013*).

It is envisaged that data collected will provide a foundation to improve the education and training needs of current and future staff so that they may be supported to assist this risky, and unfortunately increasing behaviour amongst adolescents. The project is being conducted as part of a Bachelor of Psychology (Honours) project at Murdoch University, supervised by Dr. Suzanne Dziurawiec.

I would like to invite your school to take part in the project. This is because either: your school is one of the larger senior campuses in the state and is therefore more likely to experience a broad range of student behavioural issues, including self-harm, or, your school is located in a major regional centre and we want to ensure the experiences of regional and remote staff, not just those working in metropolitan areas, are surveyed. Your school is one of 127 Government, Independent and Catholic schools in metropolitan, regional and rural areas of Western Australia approached for their participation.

What does participation in the research project involve?

I seek access to school psychologists, school counsellors, school chaplains, and teachers (including Deputy Heads, Heads of House and Heads of Year) who may have contact with students who self-harm or consider self-harming. These staff will be invited to participate in a single, on-line survey of 10-15 minutes duration.

I will keep your school's involvement in the administration of the research procedures to a minimum. However, it will be necessary for you to sign the attached consent form and email it back to me. I will then email you a Participants Information Letter for you to forward to your relevant staff members. The letter provides a link to the secure Murdoch University SCORED survey site, and staff can complete the survey in breaks or after hours. Staff consent is provided on-line.

To what extent is participation voluntary, and what are the implications of withdrawing that participation?

Participation in this research project is entirely voluntary. If any participant decides to participate and then later changes their mind, they are able to withdraw their participation at any time before they submit their data. Because the survey is entirely anonymous, and all survey data comes directly and anonymously to the School of Psychology and Exercise Science's password protected website at Murdoch University, once the survey is submitted data will not be able to be withdrawn.

There will be no consequences relating to any decision by an individual or your school regarding participation, other than those already described in this letter. Decisions made will not affect the relationship with the research team or Murdoch University.

What will happen to the information collected, and is privacy and confidentiality assured?

The anonymity of participants is guaranteed because no identifying personal information or information about schools is collected. During the study, data can only be accessed by the Principal Researcher and the Associate Researcher responsible for coordination of the study. Following the study, data will be stored on a USB flash drive for 5 years in a locked cabinet in the School of Psychology and Exercise Science at Murdoch University. After this time, it will be disposed of in accordance with university guidelines.

To ensure the survey functions as effectively as possible to assess understandings and attitudes towards self-harm, we may re-analyse data from this study to refine the survey before it is used in future studies in other locations. However, as the data is completely anonymous, individual participants' names and schools will never be identified. Consistent with Department of Education policy, a summary of the research findings will be made available to the participating site(s) and the Department. You can expect this to be available from June 2015.

Is this research approved?

The research has been approved by Murdoch University's Human Research Ethics Committee, approval number 2014/108, and has met the policy requirements of the Department of Education as indicated in the attached letter.

Who do I contact if I wish to discuss the project further?

If you would like to discuss any aspect of this study with a member of the research team, please contact me on the number provided below. If you wish to speak with an independent person about the conduct of the project, please contact Dr. Erich von Dietze, Manager, Research Ethics and Integrity, Murdoch University on 9360 6677.

How do I indicate my willingness for my school to be involved?

If you have had all questions about the project answered to your satisfaction, and are willing for your school to participate, please complete the Consent Form on the following page.

This information letter is for you to keep. Thank you very much for your time and I do encourage you to support this research into this concerning area of student behaviour.

Yours sincerely,



Diana McGrath
Bachelor of Psychology (Hons) student
School of Psychology and Exercise Science
Email: D.McGrath@murdoch.edu.au
Phone: 0405361393

Appendix G



School of Psychology and Exercise Sciences

Murdoch University
 South Street campus
 90 South Street
 Murdoch
 Western Australia 6150

Participant's Information Letter

The Attitudes and Understandings of Secondary School Teachers, Psychologists, Chaplains and Counsellors About Deliberate Self-harm Amongst Students

Nature and Purpose of the Study

Self-harm has become more common in the general population, especially amongst adolescents, but the factors underlying the causes and maintenance of this behaviour are not always clear. It is particularly important to understand the experiences of staff in secondary schools who come in contact with students who self-harm as 12-14 years of age is the usual time of onset for this behaviour. The primary aim of this research is to explore the understandings and attitudes of teachers (particularly Deputy Heads, Heads of Year and Heads of House or other teachers providing pastoral care), school psychologists, school counsellors and school chaplains in Western Australia (metropolitan, regional and rural areas) regarding self-harm amongst students. Such understandings will provide a foundation to improve the education and training needs of current and future staff so that they may be supported to assist this at-risk group of adolescents. We invite you to participate in this study. Your school is one of 127 schools in Western Australia approached for this project. This research project is part of a Bachelor of Psychology (Honours) project at Murdoch University, supervised by Dr. Suzanne Dziurawiec.

What the Study will involve? If you decide to participate in this study:

- You will be asked to complete an online questionnaire (10-15 minutes in duration).

Voluntary Participation, Withdrawal from the Study and Confidentiality

Participation in this project is completely voluntary. There are no consequences relating to any decision you make regarding participation. If you choose to participate, you may withdraw without consequence before you submit your data. Once data is submitted, because it is entirely anonymous, it will not be able to be withdrawn. **The anonymity of participants is guaranteed** as no identifying personal information or information about schools is collected. All survey data comes directly and anonymously to the School of Psychology and Exercise Science's password protected web site at Murdoch University and all data will be compiled at Murdoch University. To ensure the survey functions as effectively as possible to assess understandings and attitudes towards self-harm we may re-analyse data from this study to refine the survey before it is used in future studies in other locations. At no time will any former participants be able to be identified. Following the study, data will be stored on a USB flash drive for 5 years in a locked cabinet in the School of Psychology and Exercise Science at Murdoch University. After this time, it will be disposed of in accordance with university guidelines.

Informed Consent and Instructions for Participation

- If you wish to participate in the study, please follow this link:
<http://scored.murdoch.edu.au/survey/TakeSurvey.aspx?SurveyID=n24MII2>
 You will be required to check the box on the page 1 to confirm you agree with the listed consent conditions. You may then begin the questionnaire. In the unlikely event that you experience any anxiety as a result of completing the survey, you can access support services from Lifeline on 13 11 14, or Beyondblue on 1300 2246 36.

Results of the study

A summary of the de-identified collected data may be presented to the Department shortly after the surveys have been completed and consistent with Department of Education policy, a summary of the research findings will also be made available to the participating schools and the Department. You can expect this to be available from June 2015. An overview of the study and its findings will also be published on the Murdoch University School of Psychology and Exercise Science Research Results webpage and can be assessed at: <http://www.murdoch.edu.au/School-of-Psychology-and-Exercise-Science/Research/Psychology-Research/Research-results/>

Thank you for your time and we hope you will choose to participate in this research project. If you would like to discuss any aspect of this study, please contact the student researcher or Chief Investigator using the contact details provided below.

Diana McGrath

Bachelor of Psychology (Hons) student
School of Psychology and Exercise Science
Email: D.McGrath@murdoch.edu.au
Phone: 0405361393

Dr Suzanne Dziurawiec

Chief Investigator
School of Psychology and Exercise Science
Email: S.Dziurawiec@murdoch.edu.au
Phone: (08) 93602388

This study has been approved by the Murdoch University Human Research Ethics Committee (Project number: 2014/108). If you have any reservations or complaints about the ethical conduct of this research and would like to talk with an independent person, please contact Murdoch University's Research Ethics Office (Ph. 08 9360 6677 (for overseas studies, +61 8 9360 6677) or e-mail ethics@murdoch.edu.au). Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

Appendix H

**School of Psychology and Exercise Sciences**

Murdoch University
 South Street campus
 90 South Street
 Murdoch
 Western Australia 6150

***The Attitudes and Understandings of Secondary School Teachers, Psychologists, Chaplains
 and Counsellors About Deliberate Self-harm Amongst Students***

Consent Form

I have read the Principals Information Letter and understand the aims, procedures, and risks of this project, as described within it.

For any questions I may have had, I have taken up the invitation to ask those questions, and I am satisfied with the answers I received.

I am willing for this school to become involved in the research project, as described.

I understand that participation in the project is entirely voluntarily.

I understand that this school is free to withdraw its participation at any time, without affecting the relationship with the research team or Murdoch University.

I understand that because the survey is entirely anonymous, and all survey data comes directly and anonymously to the School of Psychology and Exercise Science's password protected website at Murdoch University, once the survey is submitted data will not be able to be withdrawn.

I understand that overviews of the study and its findings will be published on the Murdoch University School of Psychology and Exercise Science's Research Results webpage in June 2015. Results may also be published in a scientific journal. However, at no time will participants or participating schools be identified in any way.

I understand that this school will be provided with a copy of the findings from this research upon its completion.

Name of School: Enter School Name

Name of Principal (printed): Enter Principal's Name

Signature: (Insert Electronic Signature)

Date: Click here to enter a date.

Please complete this form electronically and email it back as an attachment to:

D.McGrath@murdoch.edu.au. Thank you for your participation.

Appendix I

Table II

Description of experience and training by group

	Psychologists n=57	Chaplains n=56	Teachers n=61	Total N=174
Experience (years) n (% of group)				
5 & Under	22 (38.6%)	32 (57.2%)	23 (37.7%)	77 (44.3%)
6-10	18 (31.6%)	18 (32.1)	17 (27.9%)	53 (30.4%)
11 & over	17 (29.8%)	6 (10.7%)	21 (34.4%)	44 (25.3%)
Weekly contact with DSH students n (% of group)				
0-2	34 (59.6%)	39 (69.6%)	46 (75.4%)	119 (68.4%)
3-8	21 (36.8%)	16 (28.6%)	13 (21.3%)	50 (28.7%)
9 & Over	2 (3.5%)	1 (1.8%)	2 (3.3%)	5 (2.9%)
Refer students				
Externally n (% of group)				
Never	0	0	18 (29.5%)	18 (10.3%)
Occasionally	15 (26.3%)	10 (17.8%)	20 (32.8%)	45 (25.9%)
Usually	27 (47.4%)	23 (41.1%)	12 (19.7%)	62 (35.6%)
Always	15 (26.3%)	23 (41.1%)	11 (18%)	49 (28.2%)
Training				
Yes: n (% of group)	52 (91.2%)	47 (83.9%)	24 (39.3%)	123 (70.7%)
No: n (% of group)	5 (8.8%)	9 (16.1%)	37 (60.7%)	51 (29.3%)
When Trained n (% of group)				
Untrained	5 (8.8%)	9 (16.1%)	37 (60.7%)	51 (29.3%)
Within last 6 Months	8 (14%)	9 (16.1%)	3 (4.9%)	20 (11.5%)
6-12 Months	14 (24.6%)	21 (37.5%)	9 (14.8%)	44 (25.3%)
13-24 Months	18 (31.6%)	12 (21.4%)	4 (6.6%)	34 (19.5%)
Over 2 years ago	12 (21.1%)	5 (8.9%)	8 (13.1%)	25 (14.4%)
Benefit from more Training				
Yes: n (% of group)	44 (77.2%)	46 (82.2%)	40 (65.6%)	130 (74.8%)
No: n (% of group)	3 (5.3%)	4 (7.1%)	3 (4.9%)	10 (5.7%)
Unsure: n (% of group)	10 (17.5%)	6 (10.7%)	18 (29.5%)	34 (19.5%)

Appendix J

Table J1

Kendall's tau-b Correlations Between Demographics, Knowledge and Attitudes Towards Self-harm for Teachers

	1	2	3	4	5	6	7	8	9	10
1.Gender	-									
2.Experience	.14	-								
3.Age	.06	.37**	--							
4.No. per week	-.24	.04	-.10	-						
5.Training	.08	-.14	-.08	.06	-					
6.Effectiveness	-.01	-.28**	-.13	-.12	.14	-				
7.Confidence	.07	.30**	.10	.10	.08	.07	-			
8.Manipulation	.33**	.03	-.01	-.04	.04	-.14	-.23*	-		
9.Attention	.10	-.14	-.15	.08	.21	-.06	-.25*	.33**	-	
10.Self-efficacy Scale (4 Items)	-.03	.002	-.10	.01	.28*	.23*	.16	-.25**	-.08	-
11.Knowledge Scale (21 Items)	-.19	-.19	-.09	.19	-.19	.08	-.10	.06	.32**	.16

Note. ** $p < .01$, * $p < .05$

Appendix K

Table K1

Kendall's tau-b Correlations Between Demographics, Knowledge and Attitudes Towards Self-harm for Chaplains

	1	2	3	4	5	6	7	8	9	10
1.Gender	-									
2.Experience	-.03	-								
3.Age	-.10	.39**	-							
4.No. per week	-.21	.10	-.17	-						
5.Training	-.08	-.03	-.15	.13	-					
6.Effectiveness	-.19	.20	.17	-.13	.19	-				
7.Confidence	.09	.19	.16	.09	-.01	.36**	-			
8.Manipulation	.14	-.09	-.11	-.03	-.08	-.23*	-.20	-		
9.Attention	.18	-.03	-.02	-.06	.18	-.19	-.19	.34**	-	
10.Self-efficacy Scale (4 Items)	-.10	.31**	.18	-.03	.21	.31**	.39**	-.04	-.32**	-
11.Knowledge Scale (21 Items)	-.12	-.08	-.14	.27*	-.14	-.16	-.21*	.28**	-.004	.08

Note. ** $p < .01$, * $p < .05$

Appendix L

Table L1

Kendall's tau-b Correlations Between Demographics, Knowledge and Attitudes Towards Self-harm for Psychologists

	1	2	3	4	5	6	7	8	9	10
1.Gender	-									
2.Experience	.10	-								
3.Age	-.03	.61**	-							
4.No. per week	-.07	.16	.15	-						
5.Training	.04	-.11	-.10	-.01	-					
6.Effectiveness	-.15	.10	-.09	.19	.18	-				
7.Confidence	.16	.11	-.11	.35**	-.09	.21	-			
8.Manipulation	.10	-.01	-.02	.17	-.06	-.13	-.004	-		
9.Attention	.12	-.10	-.11	.12	-.05	-.08	.03	.54**	-	
10.Self-efficacy Scale (4 Items)	-.07	-.10	-.07	.25*	.21	.35**	.22	-.24*	-.20	-
11.Knowledge Scale (21 Items)	-.19	-.07	-.05	-.02	.13	.17	-.07	.21*	.14	-.15

Note. ** $p < .01$, * $p < .05$

Appendix M

Table M1

Description of Participants who have Received Training Combined with Experience Level by Group

	Psychologists n (% of group)	Chaplains n (% of group)	Teachers n (% of group)	All N (% of group)
Experience (years)				
0 - 5	19 (86.4%)	27 (84.4%)	8 (34.8%)	54 (70.1%)
6-10	17 (94.4%)	14 (77.8%)	14 (23.5%)	35 (66%)
11 +	16 (94.1%)	6 (100%)	11 (52.4%)	33 (75%)

