


ORIGINAL ARTICLE

Attributions About Self-Harm: A Comparison Between Young People's Self-Report and the Functions Ascribed by Preservice Teachers and School Counsellors

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Abstract

Globally, adolescent self-harm rates remain high, while help-seeking behaviour remains low. School staff are in a position to facilitate access to appropriate care for young people who self-harm (YPS-H), but little is known about gatekeepers' attributions of self-harm or whether these attributions influence the support they provide. This study investigates the perceived functions of self-harm reported by potential gatekeepers and examines how these compare to the self-reported functions of self-harm in young people; 386 students from postgraduate teaching ($n = 111$), school counselling ($n = 37$), and undergraduate psychology ($n = 238$) programs completed a survey regarding their beliefs about YPS-H, which included the Inventory of Statements about Self-Harm. Responses were compared to those of 281 young people attending treatment at a suicide prevention program who completed the same measure. Preservice teachers, school counsellors and psychology students endorsed all functions of self-harm at a higher rate than treatment-seeking young people themselves. In particular, they endorsed interpersonal functions to a greater extent than the clinical reference group. The potential effect of greater endorsement of interpersonal influence as a function of self-harm gatekeeper's responding to YPS-H is discussed.

Keywords: Mental health; self-harm; schools; gatekeepers

Self-harm rates among young people in Australia are high, with approximately one in ten adolescents reporting that they have engaged in self-harm behaviour (Lawrence et al., 2015; Wyman et al., 2008). Prevalence estimates from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing indicate that in any 12-month period, 8% of all 12- to 17-year-olds report engaging in non-suicidal self-injury, with this estimate increasing with age to 11.6% in 16- to 17-year-olds (Zubrick et al., 2016). Lifetime prevalence rates are 11.6% to 16.6% for young people aged 15 to 19 years, and 18.1% to 24.4% for young people aged 20 to 24 years (Martin et al., 2010). These rates are similar to international findings (Lim et al., 2019; Muehlenkamp et al., 2012). A meta-analysis of international data from articles published between 1989 to 2018 found that the aggregate lifetime and 12-month prevalence of nonsuicidal self-injury in children and adolescents was 22.1% and 19.5% respectively (Lim et al., 2019). Not only are these young people at risk of severe injury and accidental death, but continued engagement in self-harm is associated with an increased acquired capacity to complete suicide (Grandclerc et al., 2016; Hawton et al., 2020; van Orden et al., 2010; Zahl & Hawton, 2004). More specifically, it has been found that 'suicide risk increased further with multiple repeat episodes of

deliberate self-harm' (Zahl & Hawton, 2004, p. 70). Additionally, Gordon et al. (2010) found that repetition of self-harm was associated with greater reports of self-harm's reinforcing properties (e.g., emotional regulation, soothing, relief, and feeling calmer following self-harm). These findings make it clear that early identification and intervention strategies are essential.

Substantial research has highlighted the importance of an across-setting approach to intervention that includes relevant health, community and education service providers (Kern et al., 2017; Robinson et al., 2016). These initiatives attempt to link and facilitate partnerships between mental health professionals, educators, young people and their families (e.g., School Link; NSW Ministry of Mental Health, 2015; Salmon & Kirby, 2008). These programs support early identification and intervention opportunities with the aim to increase access to specialist mental health services for young people. Schools are identified as key gateways or referral pathways that can either facilitate or impede young people's access to specialist mental health providers (Evans & Hurrell, 2016; Gulliver et al., 2010; Lewis et al., 2020). Individuals who facilitate identification and referral of young people into appropriate services are often referred to as gatekeepers. Gatekeepers are typically individuals who routinely engage directly with community members as part of their role or regular activities (Burnette et al., 2015). Within school communities, teachers, school counsellors and professional staff are recognised as appropriate gatekeepers (Luthar & Mendes, 2020; Mo et al., 2018). The capacity for school staff to serve as key facilitators of access to mental health services was demonstrated in a study of 134 parents accompanying their adolescent child to public sector Child and Family Mental Health Services in Australia. Approximately one quarter of parents indicated that they were the first to notice their young person's mental health problems, but another 25% indicated that the problems were first identified by school personnel (Iskra et al., 2015). School counsellors are a particularly important link in the help-seeking process. The ability of teachers and school counsellors to identify young people who are at risk of mental health problems and self-harm is an essential component in getting them the help they need. However, in identifying young people who require assistance, there may be beliefs and attitudes that are potential barriers to the gatekeeper role (Hatton et al., 2017). For instance, it has been found that mental health professionals hold a combination of positive and negative attitudes towards people who self-harm. A survey of 195 hospital staff found that 51% agreed that 'Patients use self-harm as a way to get sympathy and/or attention' (Gibb et al., 2010, p. 716). Such beliefs about the function of self-harm can be problematic if they result in a dismissive response from gatekeepers. Causal attributions (such as the function of a behaviour) can affect beliefs and affective responses towards others, resulting in rejecting behaviour such as avoidance and withholding of help (Corrigan et al., 2003). Further, Lewis and colleagues (2020) argue that lack of knowledge regarding the nature of self-harm can result in a range of inappropriate responses to disclosures and missed opportunities to facilitate access to appropriate supports. There is a need to clarify how gatekeepers in schools understand the different functions of self-harm (e.g., to regulate emotional distress or elicit care from others; Klonsky, 2009) and how these perceptions align with the reasons reported by YPS-H.

Inaccurate information about self-harm function may contribute to ineffective gatekeeper responses. School staff who report poor knowledge of self-harm also tended to report more negative feelings towards the young person and felt less effective in the management of self-harm (Timson et al., 2012). These findings reinforce the need to better understand gatekeeper factors that might influence whether YPS-H access appropriate professional services. Multiple studies have found that attributions made about the motivations for self-harm behaviour (e.g., socially vs. internally motivated) inform assessments of risk and seriousness, and shape teachers' responses to the self-harm behaviour (Carlson et al., 2005; Heath et al., 2011; Knowles et al., 2013; Newton & Bale, 2012). For example, in a sample of teachers across three high schools, 63% endorsed adolescent self-harm as 'attention seeking', and 57% of participants endorsed adolescent self-harm behaviour as a 'minor problem' (Carlson et al., 2005, p. 26). Although numerous studies have found that young people self-harm for a variety of reasons (Edmondson et al., 2016; Klonsky, 2007; Nock & Prinstein, 2004), there is comparatively little information regarding what reasons gatekeepers ascribe to self-harm behaviour. If staff

Table 1. Demographic information of participants

		Preservice teachers	Preservice school counsellors	Undergraduate students
		<i>n</i> = 97 (26.3%)	<i>n</i> = 36 (9.2%)	<i>n</i> = 238 (64.5%)
Age (years)	18–24	68 (70.1)	0 (0)	213 (89.5)
	25–34	19 (19.6)	20 (55.6)	15 (6.3)
	35–44	7 (7.2)	12 (33.3)	8 (3.4)
	44+	3 (3.1)	4 (11.1)	2 (0.8)
Gender	Female	68 (70.1)	30 (83.3)	167 (70.2)
	Male	29 (29.9)	6 (16.7)	71 (29.8)

believe self-harm behaviour is ‘attention seeking’ (e.g., Carlson et al., 2005), there is a risk that such behaviour may not be viewed as requiring mental health service attention.

This study aims to determine the functions of self-harm endorsed by preservice teachers, preservice school counsellors and psychology students and to compare these with the functions endorsed by a sample of young people in treatment at an outpatient suicide prevention service.

Methods

Participants

All participants were recruited from the University of Wollongong, Australia. The study was approved by the University of Wollongong Human Research Ethics Committee (HE2016/042). Participants were chosen to reflect three distinct groups. Preservice teaching and school counsellor students were included to reflect a sample about to begin their careers as teachers and school counsellors. In terms of prior experience, participants from the preservice teacher sample had completed a minimum of 560 hours of professional experience (i.e., working directly in school environments in a supervised teaching role). Participants from the preservice school counsellor students were accredited teachers pursuing a pathway to school counsellor accreditation. These samples were selected since once employed they will be potential gatekeepers for young people in schools. Given the recency of their training, their responses provide access to a teacher and school-counsellor sample with the most up-to-date training. Trainee teachers were invited to participate during their final semester’s orientation week. Trainee school counsellors were invited to participate during their final training workshop. Participation was voluntary and no incentives were provided. Undergraduate students studying a first-year psychology unit were chosen as a convenience comparison sample, allowing comparison of attitudes and beliefs between those with specific teacher and school-counselling training and those without. Undergraduate psychology students elected to participate in their study as a partial credit towards their course requirements. Participants comprised 238 undergraduate psychology students, 111 postgraduate teaching students, and 37 school counsellor trainees. Table 1 contains the demographic information for participants.

Design

The study was a cross-sectional, questionnaire-based survey. It used a correlational design to compare the self-report data of a clinical youth sample drawn from an archival data bank of young people participating in an outpatient suicidal prevention program, with survey data of trainee teachers, school counsellors and psychology students.

Measures

Inventory of Statements about Self-Harm (ISAS; Klonsky & Glenn, 2009)

The ISAS contains 39 items that represent 13 potential functions of deliberate self-harm: Affect Regulation, Interpersonal Boundaries, Self-Punishment, Self-Care, Anti-Dissociation/Feeling-Generation, Anti-Suicide, Sensation-Seeking, Peer-Bonding, Interpersonal Influence, Toughness, Marking Distress, Revenge, and Autonomy. Each function is captured by three items rated on a 3-point scale as 0 (*Not relevant*), 1 (*Somewhat relevant*), or 2 (*Very relevant*). Thus, cumulative scores for each function can range from 0 to 6. The 13 functions can further be collated into the two subgroups of intrapersonal (i.e., self-harm undertaken for reasons focused on the self, which includes functions such as affect regulation and self-punishment) and interpersonal functions (i.e., self-harm undertaken for reasons focused on the social environment, including functions such as interpersonal influence and peer bonding), by averaging the scores from relevant subscales (Klonsky et al., 2015). The two-factor structure of the ISAS has shown strong internal consistency across studies with reported coefficient alphas for the intrapersonal and interpersonal scales being .80 and .88 respectively (Klonsky & Glenn, 2009; Kortge et al., 2013). The ISAS function scales also have good test-retest reliability with a median correlation of .59 across the 13 individual functions, .60 for the intrapersonal scale, and .82 for the interpersonal scale (Glenn & Klonsky, 2011; Klonsky & Glenn, 2009). Originally, the ISAS was designed for participants who reported self-harm to endorse the functions of their own self-harm behaviour. In the current study, participants were asked to respond to each item in relation to their perceptions of others' self-harm. The original version's wording: 'When I self-harm, I am ...' was modified to 'When others self-harm, they are ...'. Reliability analyses were conducted on the altered scales to assess for internal consistency. These analyses showed acceptable internal reliability, with the overall scale having a Cronbach's alpha of .92. The two subscales of the ISAS (interpersonal and intrapersonal) also showed strong internal consistency with Cronbach's alphas of .90 for the interpersonal scale and .86 for the intrapersonal scale.

Procedure

The study followed an approved ethics protocol that included anonymity and the right to withdraw from the study at any time. Informed consent was obtained from all individual participants included in the study. A total of 401 participants, aged between 18 and 51 years, were invited to complete questionnaires regarding their beliefs and attitudes regarding nonsuicidal self-harm behaviour. Participants from the undergraduate psychology sample provided their responses via a computer survey in groups of 20. Participants from the preservice teacher and school counsellor samples were invited to provide their responses via an online survey.

Fourteen (12.6%) students from the postgraduate teaching sample, and 1 (2.7%) student from the preservice school counsellor sample started the survey but then discontinued and their responses were subsequently removed from the analysis. Participant dropout in online surveys is not uncommon, nor does the current dropout rate or profile exceed that of studies of similar length and response format (Hoerger, 2010). To compare the attitudes of these participants with YPS-H, we utilised the responses from a sample of 281 young people attending an outpatient suicide prevention program delivered by a primary health organisation (Rankin, 2016). This sample was relevant in that it was derived from a similar geographical area to the university participants (i.e., the Greater Sydney and Illawarra area). Participants from this program were aged between 12 and 25 years ($M = 16.95$, $SD = 2.80$), and all had reported a current or historical experience of 10 or more episodes of non-suicidal self-injury. Of these participants, 37.01% had reported at least one historical suicide attempt.

Data Analysis

All analyses were conducted using IBM SPSS V 21 (IBM Corp., 2016). Participants whose responses contained missing data were omitted from the analyses. There were no univariate or multivariate

Table 2. Means and standard deviations of endorsed functions of self-harm, across participants of a local suicide prevention program, preservice teaching students, preservice school counsellors, and undergraduate psychology students

	Clinical sample (<i>n</i> = 281)		Preservice teachers (<i>n</i> = 97)		Preservice school counsel- lors (<i>n</i> = 36)		Psychology students (<i>n</i> = 238)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Interpersonal functions ^a	0.86	0.80	2.11	1.06	2.16	1.03	1.78	0.94
Intrapersonal functions ^a	3.41	1.13	4.05	1.02	4.17	0.97	4.13	1.02

Note: ^aCorresponding to the subscales of the Inventory of Statements About Self-harm (ISAS).

outliers, and assumptions of normality, homogeneity of variance-covariance matrices, and linearity were satisfactory. A paired samples *t* test was conducted to examine differences across groups between endorsement of intrapersonal versus interpersonal functions of self-harm. To examine differences in endorsements between the three groups, between groups analyses of variance (ANOVAs) were conducted. To examine the difference between the self-reported endorsement of self-harm functions of the clinical sample, and endorsements ascribed by the trainee teacher, school-counsellor, and psychology students, a series of independent *t* tests were conducted based on summary data (i.e., mean, *SD* from Rankin, 2016) and calculated using GraphPad QuickCals software.

Results

Table 1 contains demographic information across groups, including participants' reported past help-seeking behaviour.

Perceived Functions of Self-Harm

Across the three groups (preservice teachers, school counsellors, and undergraduate students), 99.7% of participants endorsed intrapersonal functions compared to 85.2% endorsing interpersonal functions. A paired samples *t* test revealed that endorsement of intrapersonal functions ($M = 4.11$, $SD = 1.01$) was significantly higher than interpersonal functions ($M = 1.91$, $SD = .99$), $t(370) = 43.34$, $p \leq .001$, $r^2 = .84$, 95% CI [2.11, 2.31]. To compare differences between endorsement of intrapersonal and interpersonal functions across the three student groups, two one-way ANOVAs were conducted. Statistical significance was only found for the interpersonal subset, indicating that the groups differed significantly in their endorsement of interpersonal functions of self-harm, $F(2, 368) = 5.93$, $p = .003$. Due to the large difference in sample size between groups, Hochberg's GT2 was used for post-hoc comparisons to control for type 1 error (Field, 2009). Preservice teachers reported higher endorsement of interpersonal functions of self-harm behaviour when compared to undergraduate psychology students ($M_{diff} = .36$, $p = .007$, 95% CI [.08, .64]). There was no significant difference between preservice school counsellors' and preservice teachers' endorsements of interpersonal functions for self-harm behaviour.

Comparison of Perceived Functions With Clinical Sample

Differences between the participant groups' estimations of the reasons other people self-harm when compared to reasons reported by the clinical sample were examined descriptively. The ISAS items were totalled to calculate the interpersonal subscale and the intrapersonal subscale for each group to facilitate comparison to the clinical sample. It is noted that caution is advised in interpreting the comparisons here due to differences in wording of the measure provided to the clinical sample (Rankin, 2016) and the current study's participants. As seen in Table 2, endorsement across the student groups was

Table 3. Rank order of endorsement of Inventory of Statements about Self-Harm (ISAS) functions across groups

ISAS scale	Youth clinical (<i>n</i> = 281)		Preservice teachers (<i>n</i> = 97)		Trainee school counsellors (<i>n</i> = 36)		Psychology under- graduate (<i>n</i> = 238)	
	Rank	<i>M</i> (<i>SD</i>)	Rank	<i>M</i> (<i>SD</i>)	Rank	<i>M</i> (<i>SD</i>)	Rank	<i>M</i> (<i>SD</i>)
Affect Regulation	1	4.52 (1.42)	3	4.10 (1.20)	1	5.17 (1.06)	3	4.34 (1.37)
Anti-Dissociation	4	3.20 (1.81)	1	4.47 (1.44)	2	4.81 (1.37)	2	4.55 (1.40)
Anti-Suicide	3	3.33 (1.74)	5	3.49 (1.52)	7	2.83 (1.36)	5	3.26 (1.56)
Marking Distress	5	2.11 (1.87)	4	3.82 (1.42)	3	4.06 (1.49)	4	3.90 (1.61)
Self-punishment	2	3.91 (1.73)	2	4.36 (1.52)	4	4.00 (1.35)	1	4.62 (1.37)
Autonomy	10	0.76 (1.18)	12	1.16 (1.46)	12	1.39 (1.54)	12	1.10 (1.32)
Interpersonal Boundaries	7	1.27 (1.55)	9	2.24 (1.61)	8	1.86 (1.61)	7	2.50 (1.40)
Interpersonal Influence	11	0.74 (1.24)	6	2.91 (1.61)	6	3.19 (1.56)	8	2.47 (1.64)
Peer Bonding	12	0.27 (0.80)	13	0.94 (1.38)	11	1.61 (1.15)	13	0.52 (1.01)
Revenge	13	0.38 (1.02)	11	1.98 (1.83)	13	1.97 (1.32)	11	1.31 (1.65)
Self-care	6	1.54 (1.49)	7	2.68 (1.56)	5	3.50 (1.65)	6	2.74 (1.48)
Sensation-seeking	9	0.77 (1.21)	10	2.12 (1.41)	10	1.92 (1.52)	10	1.72 (1.52)
Toughness	8	1.14 (1.36)	8	2.26 (1.40)	9	1.81 (1.60)	9	1.86 (1.52)

Note: Ranks shown in bold type are the five highest rated functions for each group in terms of relevance. Ratings were on a 3-point Likert-type scale from 0 = *Not relevant at all*, 1 = *Somewhat relevant*, 2 = *Very relevant*.

observed to be higher for both subscales, in contrast to the clinical sample. Not only did participants in the student groups appear to over-endorse the functions of self-harm when compared to the clinical group, descriptively the magnitude of difference appeared greater in response to endorsement of interpersonal functions of self-harm in that participants across our studies appeared to over-endorse interpersonal functions to a greater extent than intrapersonal functions.

Data related to the endorsement of the 13 ISAS functions across groups were examined descriptively and are presented in Table 3. There appeared to be overall consistency in the rank importance of ISAS function endorsement among the five highest endorsed categories, with the exception of ‘Anti-suicide’ endorsement in the preservice school counsellor sample. The top five endorsed functions across groups were: Affect Regulation, Anti-Dissociation, Self-Punishment, Marking Distress, and Anti-Suicide. Endorsement of the remaining functions were consistent with the self-report of the clinical sample with the exception of the ‘Interpersonal Influence’ function that appeared to rank higher in endorsement across the school counsellor and teacher student groups (rank 6) compared to the clinical sample (rank 11). With the exception of the Affect Regulation and Anti-Suicide subscales, participants endorsed the different functions of self-harm at higher levels than did the clinical sample.

Discussion

Across all groups (preservice teachers, preservice school counsellors, undergraduate psychology students), participants endorsed items related to intrapersonal functions significantly higher than interpersonal functions. This finding indicates that respondents typically strongly attributed others’ self-harm to occur for reasons related to the person’s internal experiences. Affect regulation, antidissociation and self-punishment were strongly endorsed intrapersonal functions of self-harm. These findings are consistent with previous research assessing the reported functions of self-harm with adolescent clinical samples, suggesting that in terms of relative importance, participants in the current study

endorsed functions in a similar rank order to YPS-H at least for the top five functions (Klonsky, 2009; Nock & Prinstein, 2004). When group differences were examined, preservice teachers endorsed interpersonal reasons more highly than psychology students. When participants' responses were compared with the summary data obtained from a clinical group of adolescents attending a local suicide prevention program (Rankin, 2016), all groups endorsed both intrapersonal and interpersonal functions higher than the clinical reference group. It is worth noting that while Rankin's (2016) study was drawn from participants who were receiving treatment from a suicide prevention program, and all participants in the comparison sample had engaged in self-harm behaviours, suicidality is not synonymous with self-harm. However, when comparing the extent of over-endorsement across groups, interpersonal functions were more strongly over-endorsed than intrapersonal functions. These findings suggest that when ascribing functions to young peoples' self-harm behaviour, our participants not only showed a pattern of endorsing both types of functions to self-harm behaviour greater than the clinical reference sample, but that the degree of over-endorsement appeared disproportionately greater for interpersonal functions.

Although overall participants endorsed all functions more strongly than the clinical youth sample, the relative order of endorsement was similar. One exception was the ranking of interpersonal influence, which was ranked 11th by the clinical reference group but ranked 6th by both preservice teaching and school counsellor groups. Interpersonal influence items comprised 'Letting others know the extent of my emotional pain', 'Seeking care or help from others', and 'Keeping loved ones from abandoning me'. Preservice teachers and school counsellors seem to view self-harm behaviours being driven by these calls for help from others as higher order than do young people experiencing suicidality. As long as these calls for help are viewed as legitimate then this is unlikely to interfere with gatekeeper responses; however, there is some evidence that when reasons for self-harm are thought to be attention-seeking they are not taken as seriously (Gibb et al., 2010; Lewis et al., 2020). Evans and Hurrell (2016) further put forward that beliefs related to self-harm as attention seeking can impact support provision to young people at the institutional level, encouraging secrecy and discouraging help-seeking. Knowles and colleagues (2013) suggest that perceptions of self-harm as socially motivated (i.e., self-harm behaviour with an interpersonal function) results in self-harm behaviour being either dismissed or seen as less serious than when it is perceived to be intrapersonally motivated. Therefore, when self-harm behaviours by young people are deemed to be socially (i.e., interpersonally) motivated, there is a risk they may miss out on receiving support because their problems may be mistakenly considered to be less severe. Such concerns are also reinforced by prior research that found teachers' endorsement of adolescent self-harm behaviour as 'attention seeking' is greater than reported by young people who self-harm (Carlson et al., 2005). Our findings regarding the relatively higher ranking of interpersonal influence among preservice teachers and school counsellors is of particular significance and requires additional research to clarify whether attributing self-harm behaviour to interpersonal influence affects the support they provide for young people to seek help.

Implications for School Counsellors and Psychologists

The current findings may have implications for school-based interventions and, in particular, highlight the need to understand attributions of self-harm among staff, in order to address any negative misconceptions. Lewis and colleagues (2020) outline how inadequate knowledge and responding to self-harm from school staff can result in greater stigmatisation of young people and missed opportunities to facilitate access to necessary supports. The current findings lend weight to the authors' calls for schoolwide professional development aimed at challenging common misconceptions and providing training in appropriate responding to disclosures of self-harm. Specifically, the higher order ranking of 'Interpersonal Influence' as a function of self-harm and the apparent strength of endorsement of interpersonal functions are particularly noteworthy if such beliefs are related to dismissive or stigmatising responses to young people engaging in self-harm. Such training might include reinforcing that self-harm that is in part driven by a call for help carries just as much risk and should be taken seriously,

and requires every effort to support the young person to get help. Gatekeeper training programs in some areas have already begun addressing stigmatising attitudes or attributions. A training program for teachers and school staff — for example, Project Air Strategy's (2016) 'Working with Young People with Complex Mental Health Issues' — not only targets mental health literacy, but also attitudinal beliefs about self-harm specifically in adolescent populations.

Limitations

The ISAS measure is a well-validated self-report measure of the functions that people ascribe to their own self-harm (Klonsky, 2009). However, there is no prior research regarding the validity of its use as a measure of the attributions made about another's self-harm. Instead of asking participants to endorse functions pertaining to their own self-harm behaviour, participants were asked to endorse the attributions they ascribe to another's self-harm behaviour. Although the preservice teachers and school counsellors had some practical experience, it is unclear whether the results would generalise to teachers and school counsellors who were more experienced and had been working in schools. It is also noted that data on primary or secondary school specialisation was not collected; therefore, group differences by specialisation were not able to be examined. A final limitation relates to comparisons using the clinical sample who were attending a suicide prevention program since suicidality is not the equivalent of self-harm behaviour. However, there were very high rates of self-harm in this sample that involved self-harm behaviour with or without suicidal intent.

Prior research provides preliminary evidence that the attributions made about self-harm shape public stigma and helping behaviour towards people with mental illness and self-harm behaviours (Knowles et al., 2013; Law et al., 2009; Lewis et al., 2020). Given that increasing knowledge alone is not sufficient to create help-seeking behavioural change in young people or gatekeepers, future studies should aim to understand how different attributions can influence responses to young people who are engaging in self-harm behaviour.

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Ethics approval and consent to participate. All procedures performed in studies involving human participants were in accordance with the ethical standards of the Institutional and/or National Research Committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. This study was approved by the University of Wollongong Human Research Ethics Committee, reference number: HE14/378.

Conflict of interests. None.

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