Frustrated and Concerned: Understanding Antipathy Towards Clients Who Engage in Nonsuicidal Self-Injury in Australian Mental Health Practitioners

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Frustrated and Concerned: Understanding Antipathy Towards Clients Who Engage in Nonsuicidal Self-Injury in Australian Mental Health Practitioners

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ABSTRACT

Background: Nonsuicidal self-injury (NSSI) involves harm towards one's own body tissue without suicidal intent. Mental health workers' attitudes towards consumer NSSI may impact clinical care. This study aimed to explore factors associated with worker attitudes and antipathy towards NSSI.

Method: A quantitative survey including demographics, professional background, confidence regarding NSSI, Inventory of Statements about Self-Injury and Self-Harm Antipathy Scale was distributed to mental health workers in Australia. Two hundred and forty-five participants completed the survey, including 174 psychologists, 34 social workers, 23 counsellors and 14 youth workers, with 216 women and 29 men aged 24–70 years old, working in a range of health care settings.

Results: Higher age was negatively correlated with exposure to and confidence working with NSSI. Participants in private and community services had the highest exposure, with exposure and training associated with higher confidence working with NSSI. Psychologists rated highest regarding antipathy to NSSI, followed by counsellors and social workers. Significant predictors of antipathy included professional background, level of experience, confidence in ability to manage the situation if a client needed immediate medical attention, the intrapersonal functions of affect regulation and self-punishment and the interpersonal function of toughness.

Conclusion: Findings suggest exposure to NSSI is prevalent across treatment settings. Differences exist between professions and people of different ages on exposure to, and confidence in working with NSSI. The results show predictors of antipathy are misconceptions about the functions of NSSI, professional background and confidence in working with NSSI. Further research is required to explore factors associated with professional orientation and antipathy to NSSI, alongside components of effective training.

1 | Introduction

Nonsuicidal self-injury (NSSI) has been defined as the direct and deliberate destruction of one's own body tissue that is not culturally sanctioned and is carried out without suicidal intent (Nock and Favazza 2009). Common forms of NSSI include cutting, burning, scratching, hitting and banging (Klonsky 2007). Terminology has lacked consistency over the years, with researchers and clinicians often using the term deliberate self-harm to refer to both nonsuicidal and suicidal acts (Cipriano et al. 2017). NSSI specifies that the person uses self-injury without intent to die and is the phenomenon considered in this report. NSSI has only recently started receiving empirical evaluation (Klonsky et al. 2014), with the DSM-5 including NSSI in Section-III as a condition that requires further study given the growing awareness and prevalence.

Summary

- Antipathy amongst Australian mental health practitioners is related to beliefs about the function (i.e., purpose) of NSSI.

- Younger mental health workers are increasingly exposed to more consumers who engage with NSSI.

- Age, gender, professional background and years of practice did not impact negative attitudes towards consumers who engage with NSSI.

- We can effectively improve mental health workers' attitudes and understanding of NSSI through training.

NSSI appears most prominent in adolescents and young adults, with an average age of onset around 12–14 years, although few studies have investigated children younger than 12 years (Cipriano et al. 2017). Prevalence rates range between 7.5% and 46.5% of adolescents, and although they drop with age, they have still been estimated to be between 4% and 23% of adults. Although typically associated with borderline personality disorder (BPD), people who use NSSI may not meet the criteria for BPD and some individuals with BPD do not use NSSI (In-Albon et al. 2013). There is also a significant association with posttraumatic stress disorder, dissociative disorder, conduct disorder, obsessive–compulsive disorder, substance use disorder and eating disorders (Cipriano et al. 2017).

The use of NSSI by consumers may be confronting for mental health workers, with nurses in emergency departments working with people who use NSSI reporting limited empathy and negativity towards these people (Rayner et al. 2019; Wilstrand et al. 2007). NSSI may be difficult to conceptualise given it runs contrary to survival instincts (Hooley et al. 2020) and may be perceived as 'morally injurious experience' (Stovall and Hansen 2020), compounding compassion fatigue. Staniland et al. (2021) outline a conceptual framework for how stigma develops associated with NSSI and indicate common misconceptions about the behaviour, including beliefs it is attention-seeking, manipulative, more prevalent amongst adolescent girls, suicidal or superficial. These beliefs contribute to the development of public, self, enacted and anticipated stigma. These forms of stigma can engender blame of the individual without consideration of precipitating reasons for NSSI, while stigmatising beliefs about its origin can inform poor treatment responses (e.g., denying analgesia to a person who has self-injured due to belief it was motivated by desire for pain).

Stigma regarding NSSI may generate the phenomenon of antipathy (Patterson et al. 2007). Antipathy is defined as a social attitude characterised by antagonism towards an individual or group as a stereotyped whole (Corsini 2002). Patterson et al. (2007) developed the Self-Harm Antipathy Scale (SHAS) as a means of assessing attitudes towards the use of NSSI, with higher overall scores indicative of antipathy. The scale includes six factors, including competence appraisal (empathy), care futility, consumer intent manipulation, acceptance and understanding, rights and responsibilities and needs function. Evaluating worker antipathy towards NSSI

is important, as antipathy may contribute to lower empathy and greater judgement, inhibiting a strong therapeutic relationship (Dickinson and Hurley 2012; Rogers 2007). This may in turn lead to negative interactions that reinforce shame, guilt and secrecy associated with NSSI, exacerbating this behaviour, which is associated with a higher risk of suicide (De Stefano et al. 2012; Gagnon and Hasking 2012; P. Patterson et al. 2007; Saunders et al. 2012). Additionally, antipathy towards NSSI may be compounded by compassion fatigue and burnout (Babic et al. 2020; Streeto and Phillips 2024).

Research regarding worker attitudes has largely focused on medical professionals (Anderson and Standen 2007; Crawford et al. 2003; Gibb et al. 2010), particularly those working in hospital emergency departments (ED) (Conlon and O'Tuathail 2012; Dickinson and Hurley 2012; Friedman et al. 2006; Hemmings 1999; Long and Jenkins 2010; Mackay and Barrowclough 2005; McAllister et al. 2002; McCann et al. 2006, 2007; McCarthy and Gijbels 2010). There has been less investigation of the attitudes of workers outside the medical domain who work with people who use NSSI, although this body of research has been growing (Crawford et al. 2003; Fox 2011; Gagnon and Hasking 2012; Law et al. 2009; Long and Jenkins 2010; Commons Treloar and Lewis 2008; De Stefano et al. 2012; Timson et al. 2012; Turp 1999). Karman et al. (2015) reported a systematic review of nurses' attitudes and found that general nurses held more negative attitudes than mental health nurses. Similarly, Saunders et al. (2012) reported findings from a systematic review of attitudes and knowledge of clinical staff regarding people who use NSSI. General hospital staff, especially doctors, were more critical of people who use NSSI, while psychiatric staff in community and hospital settings held more positive attitudes. Jeffery and Warm (2002) found that workers with psychological, social or community education had a more accurate understanding of NSSI than those in the medical profession, including psychiatrists. Likewise, Babič et al. (2020) demonstrated that in psychiatric nursing settings, those in therapeutic units held more positive attitudes than nontherapeutic units. These findings suggest that greater awareness and understanding of NSSI may facilitate improved therapeutic engagement.

There have been inconsistent findings regarding demographic factors associated with attitudes towards people who use NSSI. Some research indicates female workers hold more positive attitudes (Commons Treloar and Lewis 2008; Mackay and Barrowclough 2005; Moriarty et al. 2021; Muehlenkamp et al. 2013), while others found no gender effects (Crawford et al. 2003; Gibb et al. 2010). Studies have reported older staff at EDs had a greater understanding (Mackay and Barrowclough 2005) and lower antipathy than younger colleagues (Conlon and O'Tuathail 2012), although McCarthy and Gijbels (2010) reported younger nurses endorsed more positive attitudes. A number of other studies have found no age-related differences in empathy, negative attitudes and knowledge of NSSI (Dickinson and Hurley 2012; Gagnon and Hasking 2012; Gibb et al. 2010; Moriarty et al. 2021).

There is also contrasting evidence regarding exposure to people who use NSSI, with some research finding positive correlations between experience and positive attitudes (McCann et al. 2006), while others have found greater antipathy in

more experienced clinicians (Friedman et al. 2006; Patterson et al. 2007). A number of researchers have not found any associations between years of experience and attitudes towards NSSI HYPERLINK 'bookmark://_ENREF_14' (Dickinson and Hurley 2012; Gagnon and Hasking 2012; Gibb et al. 2010; Moriarty et al. 2021). This runs contrary to the possible impact of compassion fatigue leading to antipathy towards NSSI, as one might expect greater experience would lead to increased antipathy; however, this may be offset by a number of factors, including training.

Specific training has been shown to positively impact worker attitudes around NSSI (Commons Treloar and Lewis 2008; Dickinson and Hurley 2012; McCann et al. 2006; McCarthy and Gijbels 2010; Muehlenkamp et al. 2013). Indeed, training appeared to have a mediating effect on the anger experienced by nurses in Friedman and colleagues' study. Patterson et al. (2007) demonstrated the benefits of an educational intervention for workers focused on understanding causes, the functions of NSSI, preventive strategies, assessment and intervention and professional practice. The intervention was associated with lower antipathy scores maintained 18 months after intervention. Gibson et al. (2019) also reported a brief 45-min education intervention involving facts about NSSI, lived experience stories and focus on increasing understanding of NSSI was associated with significant decreases in antipathy scores in nurses.

Training generally appears to contribute to confidence in working with consumers who use NSSI (Friedman et al. 2006; Timson et al. 2012). In their multidisciplinary sample, Timson et al. (2012) reported the more effective staff felt working with people who use NSSI, the less negative they felt. Clinicians' perceptions of their effectiveness working with NSSI were also associated with less negative attitudes (Crawford et al. 2003). Karman et al. (2015) and Saunders et al. (2012) systematic reviews indicate that training and education may facilitate more positive attitudes towards NSSI. While the increase of confidence may be one mechanism of action for training, it may also assist with reducing compassion fatigue. Streeto and Phillips (2024) conducted a mixed methods study finding that higher burnout amongst nurses was associated with higher antipathy, suggesting educational interventions to help understand the function of NSSI may reduce burnout, compassion fatigue and antipathy. These findings indicate training that helps workers understand the functions of NSSI may promote more meaningful therapeutic engagement, although further investigation is required regarding effective components of training.

Attitudes towards NSSI are associated with beliefs workers hold regarding the function of the behaviour (Cipriano et al. 2017; Dickinson and Hurley 2012; Timson et al. 2012). NSSI serves multiple and varied functions, with several theories developed to understand its use and function (Kortge, Meade, and Tennant 2013; Klonsky 2007; Klonsky and Glenn 2009; Nock and Prinstein 2004). These have categorised NSSI as having either *intrapersonal* or *interpersonal* functions, although these functions are not mutually exclusive (Klonsky and Olino 2008; Nock and Favazza 2009; Nock and Prinstein 2004; Saraff and Pepper 2014). Intrapersonal functions are self-reinforcing and involve the use of NSSI to alter psychophysiological states (e.g., affect regulation). Interpersonal functions are socially reinforced, and NSSI is used to regulate or modify the individual's social environment (e.g., using NSSI to gain care) (Klonsky and Olino 2008; McKenzie and Gross 2014; Nock and Prinstein 2004). There is still considerable stigma associated with NSSI based on foundations in perceptions of its function (Hasking and Boyes 2018; Law et al. 2009; Warm et al. 2002). Workers endorsing perceptions of the interpersonal functions of NSSI as attention-seeking or manipulative are more likely to hold negative attitudes than workers who view it as having predominantly intrapersonal functions (Law et al. 2009; Warm et al. 2002). A recent systematic review and meta-analysis of distress tolerance and use of NSSI found no differences between interpersonal and intrapersonal functions when factoring in distress tolerance as a moderator (Akbari et al. 2024). Further research is needed to establish the impact on stigma and antipathy if clinicians understand its use within a distress tolerance framework.

Given the conflicting reports of factors associated with antipathy towards people who use NSSI, this study aimed to explore the relationship between mental health workers who do not work in medical settings and whether there is any relationship with age, gender, level of exposure working with NSSI, discipline, training regarding NSSI and beliefs about the function of NSSI.

This research had five main hypotheses to explore antipathy in mental health workers. The first hypothesis investigated whether demographic differences significantly impacted exposure to and antipathy towards NSSI behaviour in consumers. Hypothesis two related to identifying whether workers beliefs about the functions (i.e., purpose) of NSSI impacted levels of antipathy towards consumers who engaged in the behaviour. The third hypothesis investigated whether the level of experience in working with consumers who engaged in NSSI impacted confidence and antipathy. The fourth hypothesis investigated whether engaging with focused training on NSSI impacted confidence and antipathy towards consumers using NSSI. Finally, a range of identified predictors was utilised to create a predictive model of the most important factors contributing to antipathy towards consumers engaging in NSSI in mental health workers.

2 | Method

2.1 | Participants

The sample comprised 245 Australian psychologists ($n = 174$, 71.0%), social workers ($n = 34$, 13.9%), counsellors ($n = 23$, 9.4%) and youth workers ($n = 14$, 5.7%) who met the inclusion criteria of being employed in Australia as a mental health worker who had worked with at least one consumer who had engaged in NSSI. The sample included 216 women and 29 men (age range 24–70 years, M = 41.7, SD = 7.6). The number of years working as a mental health worker ranged from 1 to 42 years (M = 10.81 years, SD = 7.63). Participants were from a variety of workplaces including 31.8% private practice; 22% schools, education or academia; 16.3% community; 9.8%

psychiatric services; 6.9% forensic; 4.1% organisational; 4.1% in other areas of practice; 2.4% drug and alcohol; 0.8% in outreach; and 1.6% reporting that they were not currently working (e.g., family leave). Before commencement, the research was approved by the Victoria University HREC (approval number HRETH 11/141).

The inclusion criteria for the study involved participants identified as working as a mental health or community practitioner (i.e., they had to endorse if they were a psychologist, social worker or youth worker). Participants had to be over the age of 18 years and currently be working in their clinical/worker role. Participants also needed to endorse having worked with at least one consumer who they had identified as engaging in NSSI in the 12 months leading up to their survey participation.

2.2 | Materials and Method

2.2.1 | Demographics and Professional Background

A brief demographic questionnaire collected information on gender, date of birth, country of birth and country of residence of participants. This was followed by four items related to their profession within mental health, practice area, years of practice, number of consumers worked with who had engaged in NSSI and whether they had received formal training on NSSI. Finally, using a sliding scale from 0 to 100, workers were asked to rate 'How confident are you in your ability to initially recognise the signs of NSSI'.

2.2.2 | Inventory of Statements About Self-Injury (ISAS)

The researchers adapted the Inventory of Statements About Self-Injury (ISAS) (Klonsky and Glenn 2009; Klonsky and Olino 2008) for use with mental health practitioners. The questions were only altered to reflect the change from a self-report measure of self-injury to that of a measure of professional beliefs about the function of NSSI for clients, i.e., changing from 'when I self-harm, I am …' to 'when my patients self-harm, they are …' and changing tense from 'I' to 'they'. The ISAS comprises two distinct sections: Section I. Behaviours assesses the act of NSSI, while Section II. Functions measures the functions of behaviour (Klonsky and Olino 2008; Klonsky and Glenn 2009). Only the latter section was used in the present study.

The ISAS is a 39-item scale that assesses 13 functions of NSSI: affect regulation; anti-dissociation; anti-suicide; autonomy; interpersonal boundaries; interpersonal influence; marking distress; peer bonding; revenge; self-care; self-punishment; sensation seeking; and toughness. Scores on the 13 functions range from 0 to 6 (higher scores represented greater use of NSSI to manage function) (Glenn and Klonsky 2011; Klonsky and Glenn 2009; Klonsky and Olino 2008).

The structure of the functional scale of the ISAS displayed a robust, two-factor structure, with the first factor representing interpersonal functions (i.e., autonomy, interpersonal boundaries, interpersonal influence, peer-bonding, revenge, self-care, sensation seeking and toughness) and the second factor focusing on intrapersonal functions (i.e., affect regulation, anti-dissociation, anti-suicide, marking distress and self-punishment) (Klonsky and Olino 2008). Good internal consistency and construct validity were demonstrated by alpha coefficients of 0.88 and 0.80 for the interpersonal and intrapersonal functions, respectively. In the current study, the total ISAS scale had very good internal consistency, with Cronbach's alpha of 0.89. The intrapersonal and interpersonal factors of the ISAS also demonstrated good internal consistency, with respective Cronbach's alphas of 0.81 and 0.86, and the 13 function subscales ranged from 0.59 to 0.86.

2.2.3 | Self-Harm Antipathy Scale (SHAS)

The Self-Harm Antipathy Scale (SHAS) (Patterson et al. 2007) is a 29 item self-report measure of attitudes towards self-harming behaviours. However, it was modified to 28 items to improve the scale's reliability and validity in the current sample. Specifically, Cronbach's alpha reliability analysis indicated that item 10 *People who self-harm lack solid religious convictions* of the SHAS affected the scales veracity, specifically for the *Acceptance & Understanding Factor* (Cronbach's $\alpha = 0.23$). There was also a negative average covariance amongst items, violating reliability model assumptions. *Cronbach's Alpha if Item is Deleted* indicated α would increase ($\alpha = 0.52$) if item 10 of the SHAS was deleted. Each statement on the SHAS was rated on a 7-point Likert scale, ranging from 1 = *strongly disagree* to 7 = *strongly agree*. On this modified version, scores range from 28 to 196, with higher scores indicating a greater level of antipathy towards self-harming behaviour. The SHAS has six subscales: competence appraisal; care futility; consumer intent manipulation; acceptance and understanding; rights and responsibilities; and needs function. Cronbach's alpha of 0.89 indicated that the SHAS has good internal consistency with individual item correlations ranging from 0.22 to 0.68 (Patterson et al. 2007). With Cronbach's alpha of 0.78, the current study also found good internal consistency for the total antipathy score on the SHAS. Notably, there was wide variability in the subscale internal consistency scores, with competence appraisal, client intent for manipulation and rights and responsibilities subscales all demonstrating reasonable internal validity (0.80, 0.68 and 0.65 respectively) while care futility, acceptance and understanding and needs functions all showing low internal consistency (0.43, 0.28 and 0.33 respectively). Because of this variability, only the first three subscales were investigated alongside the total score in this investigation.

Participants were asked to rate their level of confidence with managing a range of issues around NSSI using a sliding scale from 0% to 100%. The measures of confidence related to confidence in ability to recognise the signs of self-harm, differentiate the risks of self-harm from the risks of suicide, counsel the client, manage the situation, should the client need immediate attention to their wounds, know when to inform the client's primary caregiver and know when to refer. Participants were further asked to endorse (yes or no) whether they had received or undergone formal training on self-harming behaviours generally, as well as in relation to the following six domains: assessing the risks of self-harm, counselling clients who self-harm, managing self-harm, managing my own feelings when working with individuals who self-harm, and training in suicide risk assessment.

2.3 | Procedure

The online survey was designed and administered in Qualtrics, an online secure survey platform that was licensed to Victoria University. A brief description and direct URL link for the study was advertised on the webpages of relevant professional bodies and mailing lists.

Participants were recruited via online study advertising with professional bodies (such as the Australian Psychological Society), via social media posts (unpaid) that were provided permission by Australian professional groups related to these professions and at the National Association of School Psychologists and Mental Health in Schools conferences. Convenience sampling was also employed to recruit participants via professional networks, word of mouth, and online social media within a 12-month period. Participation in this research was completely voluntary and anonymous, as described fully in the PICF. Participants who did not endorse voluntary informed consent were not directed to the survey body to complete; rather, they were diverted to the end of survey acknowledgement and thank you. Participants did not receive any form of reimbursement for their involvement in the project.

Data entered into the licenced Qualtrics software were securely stored in the academic's research drive at Victoria University in accordance with the data management plan approved by the HREC. Data collected in Qualtrics were directly exported to SPSS v26 to eliminate researcher data entry errors. Only the research team had access to the anonymous data in compliance with HREC ethical approval and guidelines.

2.4 | Statistical Analysis

Once imported into SPSS, scores for scales and subscales were calculated. Data were screened for outliers and descriptive statistics created. The data were analysed using a variety of inferential statistical procedures, including χ^2, t tests, ANOVA, biserial point correlations, bivariate correlations (PPMCC) and a multiple regression. For each statistical test utilised, appropriate normality testing and assumptions were tested and reported.

3 | Results

The data were analysed in SPSS version 26. Data were coded into categorical variables based on demographic characteristics (age and gender) and exposure to NSSI from minimal (1–10 consumers), moderate (11–40 consumers) and considerable (41+ consumers).

3.1 | Impact of Demographic Variables on Level of Exposure to NSSI

Before assessing antipathy, the level of exposure to consumers who engaged in NSSI based on demographic factors was conducted. Age and years of practice in mental health were assessed through point biserial correlations due to one continuous and

one categorical variable. The age results indicated that younger practitioners endorsed working with more NSSI consumers, $r_{pb} = -0.151$, $n = 237$, $p = 0.020$. In contrast, a second biserial correlation indicated that years of practice were not related to experience working with consumers who engaged in NSSI, $r_{pb} = -0.013$, $n = 245$, $p = 0.845$.

Associations between NSSI exposure and gender, profession and mental health setting were conducted using Chi^2 testing. The results indicated no impact of gender, $\chi^2_{(1)} = 0.990$, $p = 0.610$, $phi = 0.064$. Likewise, profession (psychology, social work, counselling or youth work) did not relate to exposure to consumers who engaged with NSSI, $\chi^2_{(4)} = 3.15$, $p = 0.533$, $phi = 0.113$. In contrast, mental health setting was significantly related to exposure to NSSI, $\chi^2_{(4)} = 33.824$, $p = 0.013$, Cramer's $V = 0.263$. Utilising a Cramer's V (df = 2) where small = > 0.07, medium > 0.3 and large = > 0.5, this result indicated a small effect size for this variable and is presented in Table 1.

Overall, these tests indicate significant, yet weak impacts of both age and area of practice on exposure to consumers who use NSSI.

3.2 | Impact of Background Demographics on Antipathy Towards Consumer NSSI

The mean total score for the SHAS was 56.18 (SD = 11.07), with scores ranging from 34 to 88 and a median of 56. According to Patterson et al. (2007), this indicates a moderate level of antipathy, as scores can range between 17 and 85, noting that the scale results in this study exclude question 10 so are between 1 and 7 points lower than the full-scale score. Normality testing was conducted on the SHAS total score, with results indicating satisfaction of skewness and kurtosis.

TABLE 1 | Participant employment setting and level of exposure to NSSI.

Employment setting	Minimal exposure (n = 128)		Moderate exposure (n = 36)		Considerable exposure (n = 81)	
	n	%	*n*	%	*n*	%
Psychiatric	2	8.3	16	66.7	6	25
Private Practice	35	44.9	26	33.3	17	21.8
Community	13	32.5	16	40.0	11	27.5
School, university, education	12	22.2	32	59.3	10	18.5
Forensic	3	17.6	7	41.2	7	41.2
Organisational	6	60.0	1	10.0	3	30.0
Outreach	1	50.0	1	50.0	0	0.0
Drug and alcohol	1	16.7	2	33.3	3	50.0
Other	6	42.9	5	35.7	3	21.4

Note: % = percentage of total level of exposure to clients who self-injured.
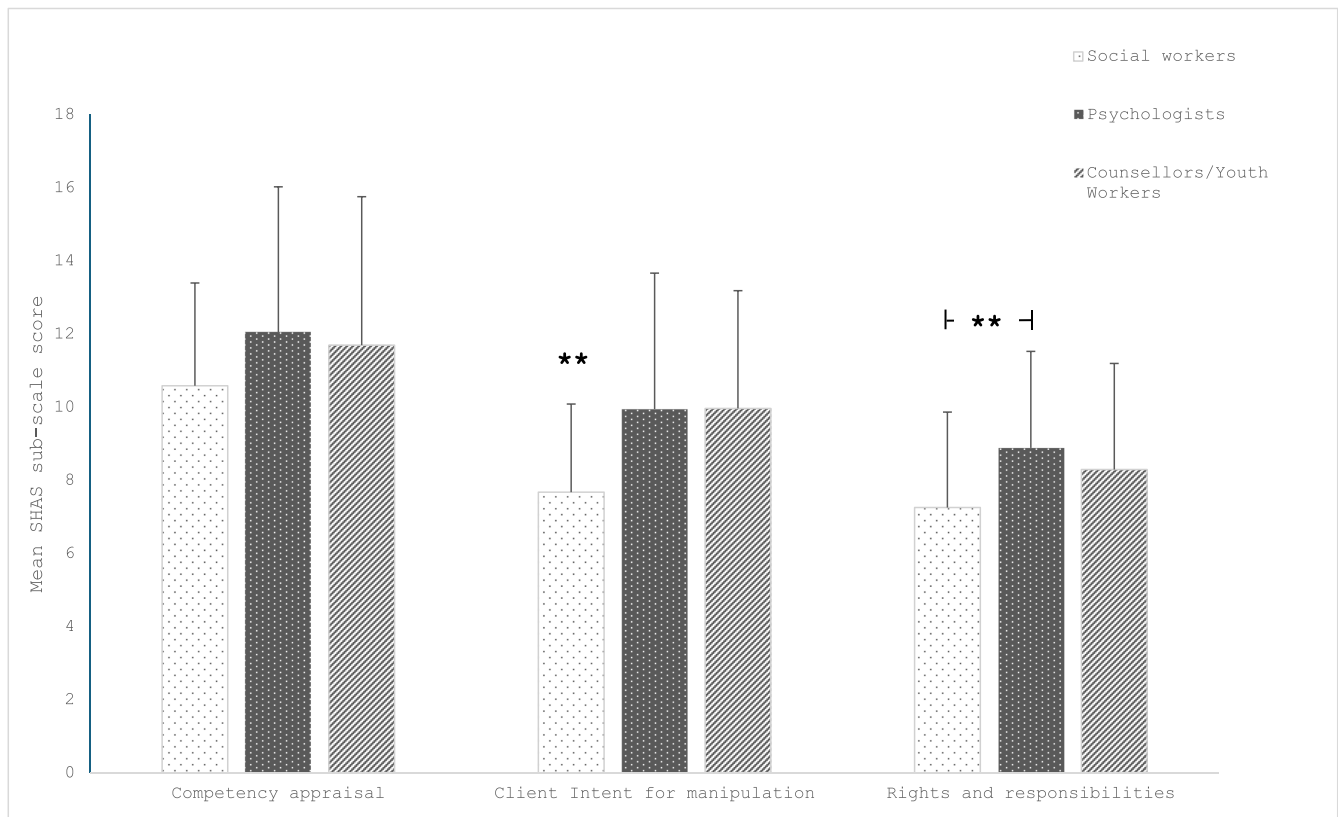
FIGURE 1 | Antipathy subscale score by profession (mean + SD). Note that ** denotes significant difference in Hochberg post hoc tests at $\alpha = 0.05$.

To assess the impacts of gender on antipathy, a two-tailed independent samples t test was conducted and revealed no significant difference in antipathy endorsed by male (M = 55.93, SD = 12.55) or female workers (M = 56.22, SD = 10.89), t(1, 245) = −0.13, $p = 0.89$. Preliminary Pearson's product–moment correlation coefficients indicated that age, years of practice and the overall number of consumers who had engaged in NSSI were also not significantly related to antipathy.

A one-way between-groups ANOVA explored possible difference in professional background and antipathy towards consumers who engaged in NSSI. Levene's test for homogeneity of variance indicated no violation of this assumption (Levene's $p = 0.345$) and the data were normally distributed. Workers from different professional backgrounds demonstrated significant differences in levels of antipathy, F(3, 241) = 13.40, $p < 0.001$, $\eta^2 = 0.11$. Hochberg's GT2 post hoc comparisons showed social workers (M = 49.9, SD = 9.2) had significantly lower antipathy scores (i.e., less negative) than psychologists (M = 57.5, SD = 11.11). Counsellors (including youth workers and school counsellors) had antipathy scores that were between these groups and were not significantly different to social workers or psychologists (M = 55.9, SD = 10.7).

Based on significant overall differences between professions, follow-up exploratory ANOVA's were conducted investigate the differences in workers' professional backgrounds across the three eligible subscales analysed (with sufficient internal consistency). The results indicated no significant differences between professions on 'competence appraisal' (F[1, 244] = 2.086, $p = 0.126$) but significant differences on

client 'intent for manipulation' (F[1, 244] = 6.196, $p = 0.002$, $\eta^2 = 0.049$) and 'rights and responsibilities' (F[1, 244] = 5.458, $p = 0.005$, $\eta^2 = 0.043$). These outcomes are presented in Figure 1.

Hochberg's GT2 post hoc tests were utilised to identify the nature of these differences, which showed social workers had lower client intent for manipulation scores than psychologists or counsellors and lower scores for rights and responsibilities than psychologists.

3.3 | Impacts of Worker Beliefs Around the Functions NSSI and Antipathy

The mean score on the ISAS was 32.11 (SD = 9.86), with scores ranging from 10 to 59, and a median of 32. Workers endorsed an average of 5.69 (SD = 2.09) different functions for their consumers NSSI. The functions of NSSI endorsed by workers in this sample are outlined in Figure 2.

Interpersonal and intrapersonal functions were calculated using Klonsky and Glenn's (2009) methodology (sum of item scores on either scale/number of questions for each function). Following satisfaction of normality testing, a paired-samples t test was conducted to assess the within-sample difference in worker ratings between the two ISAS factors (interpersonal and intrapersonal). Intrapersonal functions (M = 20.14, SD = 4.74) were endorsed significantly more than interpersonal functions (M = 11.96, SD = 6.62), t(245) = −21.47, $p < 0.001$. Furthermore, the magnitude between the differences (mean

difference $= -8.18$, 95% CI [−8.93, −7.42]) was large ($\eta^2 = 0.65$). The relationship between functions of NSSI and worker antipathy towards people who engage in NSSI was explored using a Pearson product–moment correlation coefficient. This analysis included an assessment of the relationship between total SHAS score with total ISAS total score, intrapersonal and interpersonal functions of NSSI and the competence appraisal, client intent for manipulation and rights and responsibilities subscales. The results of these correlations are presented in Table 2.

As demonstrated in Table 2, a weak negative correlation was found between the intrapersonal functions of NSSI and total antipathy amongst workers, indicating that workers ascribing internal reasons for NSSI endorsed less antipathy. While interpersonal functions were not significantly associated with overall antipathy, analysis of subscales indicated that interpersonal functions were moderately associated with client intent on manipulation and a lower, negative correlation with rights and responsibilities. Both of these subscales indicate negative antipathy associated with beliefs that NSSI is more interpersonally driven.
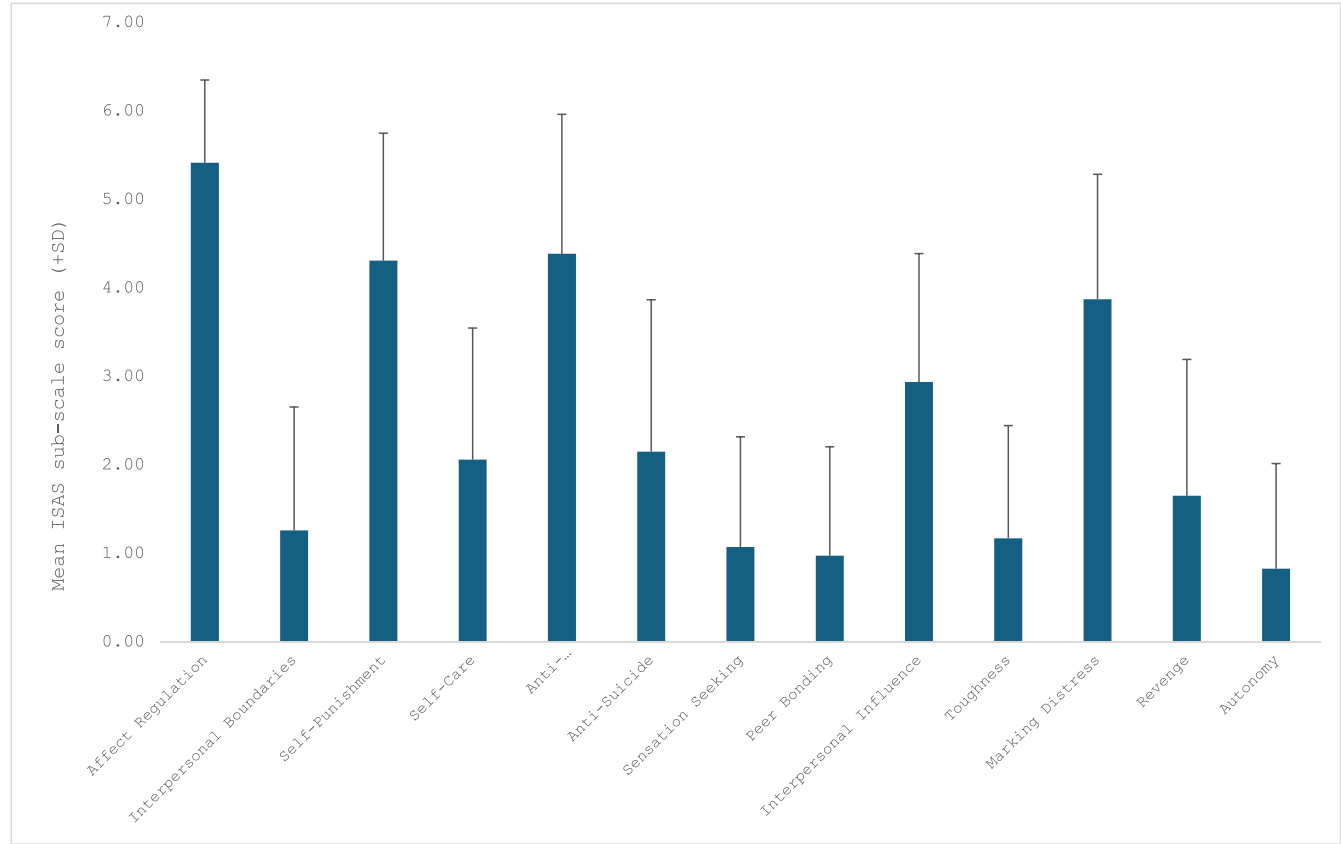
FIGURE 2 | Mean (+SD) scores on the ISAS functions workers believe underlie consumer NSSI behaviours.

TABLE 2 | Pearson product–moment correlations between the functions of NSSI and antipathy.

Scale	1	2	3	4	5	6
ISAS						
1 Interpersonal functions	—					
2. Intrapersonal functions	0.49**	—				
SHAS						
3. Antipathy total	0.03	−0.24**	—			
4. Competence appraisal	0.05	−0.09	0.79**	—		
5. Client Intent manipulation	0.33**	0.01	0.48**	0.18**	—	
6. Rights & responsibilities	−0.19**	−0.12	0.32**	0.07	−0.07	—

Note: *$p < 0.05$, **$p < 0.01$ (two-tailed). Care futility, acceptance and understanding and needs functions of the SHAS were not included for analysis as they did not satisfy minimum internal consistency requirements (Cronbach's $\alpha > 0.60$).

TABLE 3 | Comparison of practitioners' confidence in their abilities by level of exposure to NSSI.

Confidence in your ability to:	Minor exposure ($n=128$)		Moderate exposure ($n=36$)		Considerable exposure ($n=81$)		$F(6, 223)$	p	η_p^2
	M	**SD**	**M**	**SD**	**M**	**SD**			
Initially recognise NSSI	65.1[a]	19.1	72.6[a]	17.3	81.9[a]	16.0	14.49	<0.001**	0.112
Differentiate the risk of NSSI from suicide	69.8	22.0	76.5	18.6	83.9[b]	11.7	9.340	<0.001**	0.076
Counsel the client	69.8	18.8	76.0	19.6	83.3[b]	13.7	8.804	<0.001**	0.072
Manage situation should client req medical attention	64.1[b]	23.7	75.6	22.9	79.4	16.1	9.426	<0.001**	0.076
Know when to inform the primary caregiver	71.9	24.3	74.9	21.9	74.8	20.2	0.418	0.659	0.004
Know when to refer	80.5	21.9	82.1	18.1	86.0	14.5	1.444	0.238	0.013

Note: η_p^2 = partial eta squared. As multiple analyses were run, the Bonferroni adjusted alpha level of 0.008 was used. ** denotes significant difference at $\alpha = .001$.
[a]Post hoc difference between all three groups on Hochberg's GT2.
[b]Post hoc differences between this group and the other two groups on Hochberg's GT2.

3.4 | Impacts of Experience Working With NSSI on Confidence and Antipathy

A series of ANOVAs was performed to investigate the differences in the level of exposure to consumers who used NSSI and workers' confidence in responding and treating NSSI. The dependent variables were the six confidence variables (refer to Table 3), and the independent variable was the level of exposure to consumers who had engaged in NSSI over the past 5 years. Assessments of normality were satisfied in this ANOVA, but *Box's test* indicated that the assumption of homogeneity of variance–covariance matrices was not met in this analysis. However, it is largely agreed that *Box's test* is too conservative in large sample sizes (Field 2024). An examination of *Levene's F test* demonstrated that the assumption of homogeneity of variance was met for four of the six confidence variables (recognising the signs of NSSI and informing the primary caregiver). Given this violation, a Bonferroni adjusted alpha level of 0.008 was set (Field 2024). The results of these ANOVAs are presented in Table 3.

Overall, Table 3 highlights that increased experience working with consumers who engage with NSSI leads to increased confidence in recognising, differentiating NSSI risk from suicide risk, the ability to counsel consumers and the ability to manage the situation if immediate medical care is required.

A one-way between-groups ANOVA explored the difference in level of experience and antipathy towards consumers who engaged in NSSI. Levene's test for homogeneity of variance indicated no violation of this assumption (*Levene's p* = 0.110), and the data were normally distributed. The ANOVA showed level of experience working with consumers who engage in NSSI associated with antipathy, $F(2, 242) = 4.094$, $p = 0.018$, $\eta^2 = 0.033$. Post-hoc testing using Hochberg's GT2 indicated that individuals with minimal exposure (M = 58.4, SD = 12.0) had similar levels of antipathy as those with considerable exposure (M = 57.3, SD = 11.7)

TABLE 4 | NSSI professional development undertaken by practitioners.

Professional development	Total	
	n	**%**
Counselling clients who had self-injured	151	65.4
Managing NSSI	147	63.6
Assessing the risk of self-injury	169	73.2
Suicide risk assessment	208	90.4
Managing their own feelings when working with client who self-injure	138	60.0

but dissimilar to those with moderate exposure (M = 53.9, SD = 9.6).

3.5 | Impacts of Training on Confidence and Antipathy Towards NSSI

Most participants ($n = 169$, 68.9%) self-reported that they had received or attended formal training on NSSI. Table 4 details the number of workers who endorsed undertaking specific areas of training in various NSSI management areas.

A number of *t* tests were utilised to assess the relationship between training and confidence. Assumptions of *t* tests including normality (i.e., skewness and kurtosis) and random sampling were met. Analysis of confidence on various NSSI skills is summarised in Table 5.

The results of Table 5 indicate that targeted training led to increased confidence in three aspects of NSSI management, namely, differentiating the risks of NSSI from suicide, knowing when to inform caregivers and knowing when to refer.

TABLE 5 | Practitioners' confidence in their abilities based on targeted training.

Confidence in your ability to:	No training (n = 30)		Training (n = 201)		t	p	Cohen's D
	M	SD	M	SD			
Initially recognise NSSI	58.5	22.4	74.7	17.0	3.229	0.074	−0.904
Differentiate the risk of NSSI from suicide	58.8	24.9	78.8	17.1	8.395	0.004**	−1.123
Counsel the client	59.6	20.9	78.3	17.1	3.283	0.071	−1.060
Manage situation should client req. medical attention	60.8	25.6	74.7	21.5	1.653	0.200	−0.630
Know when to inform the primary caregiver	66.2	28.9	75.1	20.9	7.297	0.007**	−0.405
Know when to refer	74.2	25.8	83.8	17.1	8.264	0.004**	−0.522

Note: η^2 = eta squared. ** denotes significant difference at $\alpha = 0.001$.

TABLE 6 | Impact of training on antipathy towards NSSI on total SHAS (excluding item 10).

Training	No training		Training		t	p
	M	SD	M	SD		
Any formal training in managing NSSI	58.7	11.2	58.7	10.7	−2.56	0.916
Managing my own feelings when working with consumers who engage in NSSI	54.7	10.6	58.6	11.2	−2.636	0.364
Assessing the risk of NSSI	55.8	10.7	57.5	11.7	−1.039	0.487
Counselling consumers who use NSSI	55.6	11.0	57.7	10.9	−1.386	0.973
Managing risk of NSSI	54.9	10.7	58.7	11.2	−2.555	0.916
Suicide risk assessment	56.1	10.8	59.1	12.7	−1.216	0.568

A series of *t* tests were conducted to investigate the impacts of targeted training on antipathy towards NSSI. Total scores on antipathy were normally distributed, and testing satisfied the assumption of random sampling. The results of the *t* tests are presented in Table 6.

Overall, the outcomes indicate that targeted training on NSSI had no direct impact on antipathy levels.

3.6 | Prediction of Antipathy in Workers Towards Consumers Who Engage in NSSI

Following identification of a range of variables that are related, or predict, antipathy, a multiple regression was conducted to identify the most impactful predictors across demographics, beliefs about functions of NSSI, experience in working with NSSI and training. These factors were entered into a multiple regression. Assumption testing indicated satisfaction of the assumption of normality (P–P plot analysis), homoscedasticity (scatterplot) and multicollinearity (VF between 1.25 and 1.89). The results of this multiple regression are presented in Table 7.

The full model containing all 21 predictors was statistically significant, $F(21, 202) = 5.376$, $p = < 0.001$, with the model explaining 29% (adjusted $R^2 = 0.292$) of the variance in total antipathy. Of the 21 independent variables, seven, including professional background, level of experience, confidence to differentiate NSSI and suicide, confidence to manage immediate medical emergency, ISAS affect regulation, ISAS self-punishment and ISAS toughness, made a unique, statistically significant contribution to the model.

4 | Discussion

This study explored five hypotheses regarding factors associated with antipathy amongst Australian mental health workers towards clients who use NSSI. First, we hypothesised that demographic factors would be associated with levels of exposure to, and antipathy towards, NSSI. We found partial support for this hypothesis: Younger practitioners reported greater exposure to NSSI, particularly those working in youth, community or forensic settings; however, no significant associations were found between age, gender, years of practice and antipathy. Second, our hypothesis that practitioners' beliefs about the functions of NSSI would influence their levels of antipathy was supported. Workers who endorsed intrapersonal (emotion regulation) functions of NSSI reported significantly lower antipathy, while endorsement of interpersonal functions (e.g., manipulation) correlated with higher antipathy on specific subscales. Third, we predicted that more experience working with consumers who use NSSI would be associated with increased confidence and lower antipathy. Consistent with this, higher exposure was linked to greater confidence

TABLE 7 | Standard multiple regression to predict antipathy (total score excluding item 10).

Variable	*B*	SE	β	95% CI LL	95% CI UL	*p*
Age	−0.01	0.06	−0.01	−0.13	0.11	0.890
Professional background	−2.84	0.95	−0.19	−4.72	−0.96	0.003**
Level of experience	1.99	0.93	0.14	0.16	3.82	0.033*
Not received formal training on NSSI	3.80	2.05	0.12	−0.24	7.85	0.065
Confidence						
Recognise signs NSSI	−0.06	0.05	−0.10	−0.16	0.04	0.265
Ability to differentiate NSSI and suicide risk	−0.09	0.04	−0.15	−0.17	0.00	0.039*
Ability to counsel client	−0.07	0.05	−0.13	−0.17	0.02	0.124
Ability to manage situation if client needs immediate medical attention	−0.09	0.03	−0.19	−0.16	−0.03	0.006**
Functions of NSSI (from ISAS)						
Affect regulation	−2.23	0.75	−0.19	−3.71	−0.75	0.003**
Interpersonal boundaries	−0.24	0.53	−0.03	−1.28	0.80	0.651
Self-punishment	−1.23	0.51	−0.16	−2.23	−0.22	0.017*
Self-care	−0.69	0.49	−0.09	−1.65	0.28	0.163
Antidissociation	−0.78	0.49	−0.11	−1.74	0.18	0.110
Antisuicide	−0.17	0.43	−0.03	−1.02	0.68	0.695
Sensation seeking	−0.22	0.63	−0.02	−1.46	1.03	0.732
Peer bonding	0.22	0.57	0.03	−0.91	1.35	0.701
Interpersonal influence	0.83	0.58	0.11	−0.32	1.98	0.156
Toughness	1.66	0.64	0.20	0.40	2.91	0.010*
Marking distress	0.95	0.58	0.12	−0.20	2.11	0.104
Revenge	0.20	0.52	0.03	−0.83	1.23	0.704
Autonomy	−0.14	0.65	−0.01	−1.42	1.15	0.836

Abbreviations: CI = confidence interval; LL = lower limit; UL = upper limit.

in managing NSSI, although associations with antipathy were less clear. Fourth, we hypothesised that training would impact confidence working with NSSI and antipathy. Findings showed that training was associated with higher confidence in clinical decision-making (e.g., differentiating NSSI from suicide), but not directly with lower antipathy. Finally, our fifth hypothesis proposed a predictive model of antipathy. A multiple regression revealed seven variables—including professional background, confidence and specific beliefs about NSSI functions—significantly predicted antipathy, explaining 29% of the variance. Notably, although training was not associated with lower antipathy, it was predictive of increased confidence, which in turn was related to lower antipathy.

Our study diverges from prior literature on certain demographic variables. Although some studies (Commons Treloar and Lewis 2008; Muehlenkamp et al. 2013) reported female practitioners held more positive attitudes, the current study found no significant gender differences in antipathy. This may reflect

sampling limitations (i.e., a predominantly female sample) or changing attitudes across the profession. Similarly, while previous findings on age and antipathy have been mixed (e.g., Conlon, 2012; McCarthy and Gijbels 2010), the present study found no association between age and antipathy, though younger workers reported greater exposure and higher confidence in identifying NSSI, which aligns with Gagnon and Hasking's (2012) findings. In terms of exposure, this may reflect increasing prevalence of NSSI in younger populations or changing professional education, issues that warrant further exploration. Our findings may also indicate consumers who use NSSI feel more able to disclose this to younger workers, or the well-documented increasing prevalence of NSSI consistent with earlier meta-analyses (Lim et al. 2019).

We found a significant difference in workers' confidence in their ability to respond, manage and treat NSSI based on their age, although contrary to expectations. The two younger groups of workers reported more confidence in their ability to initially

recognise the signs of NSSI and differentiate NSSI from suicidal behaviour. Notably, age was not associated with antipathy towards NSSI but was related to workers' confidence. This is consistent with previous findings suggesting it could be attributed to a recency effect in the younger workers' education and training, or an increased presentation of self-injurious behaviours (Gagnon and Hasking 2012; Lim et al. 2019). This suggests that confidence may have a mediating role on the effects of age on NSSI and could be an avenue for further investigation and analyses.

Dickinson and Hurley (2012) contended that differences in antipathy scores between studies could be the result of workplace setting, and the type and severity of NSSI workers are exposed to. We found some evidence to support this, with workers across different employment settings being exposed to varying numbers of consumers who had engaged in NSSI. We did not find significant differences between professions (i.e., psychologists, social workers, counsellors or youth workers) and their level of exposure to consumers who had engaged in NSSI. These findings suggest that when individuals who used NSSI access mental health support, they are doing so through a range of workers across a variety of settings, but predominantly in private practice and community agencies. This offers further support that NSSI should be assessed and treated as a multidisciplinary issue (Turp 1999).

While most participants had received training related to NSSI, this was not directly associated with lower antipathy scores. This contrasts with earlier studies showing that training reduced negative attitudes (Gibson et al. 2019; Patterson et al. 2007), suggesting that not all training may be equally effective. Previous research has found that training and exposure to NSSI can improve practitioner confidence and attitudes (McAllister et al. 2002; Commons Treloar and Lewis 2008; Muehlenkamp et al. 2013). The current study extends these findings by highlighting it may not be training alone, rather training that enhances understanding of the function of NSSI and builds clinical confidence that is most protective against antipathy. Similarly, Patterson et al. (2007) educational interventions that address the functions of NSSI, particularly intrapersonal mechanisms such as affect regulation, appear to reduce negative judgements and increase empathy. Our data support this: Beliefs about intrapersonal functions were inversely related to antipathy, also consistent with Law et al. (2009) and Warm et al. (2002), who found that perceiving NSSI as manipulative (i.e., interpersonal) was associated with more negative attitudes. These findings align with emerging research suggesting a link between clinician burnout and increased antipathy towards clients who self-injure (Streeto and Phillips 2024; Babic et al. 2020). Burnout-related emotional exhaustion may diminish empathy and tolerance, leading to more judgmental or disengaged responses. One aspect that remains unclear is the impact on antipathy when NSSI is understood through its impact on distress tolerance (Akbari et al. 2024). However, our findings underscore the importance of workplace support and supervision, alongside training, in reducing antipathy.

As expected, workers who had undertaken professional development in counselling consumers who used NSSI or had completed suicide risk assessment training had greater confidence in counselling consumers who used NSSI and differentiating suicidal behaviour from NSSI, respectively. Statistically, only 4% of the variance in worker confidence in differentiating between NSSI and suicidal behaviour was explained by suicide risk assessment training. This suggests that educative programmes on NSSI should focus considerable attention on clinically differentiating between NSSI and suicidal behaviour, while highlighting the inimitably increased risk that NSSI poses for suicidal thoughts and behaviours (Guan et al. 2012; Hamza and Willoughby 2016; Klonsky et al. 2013; Whitlock et al. 2013).

Overall, scores on the antipathy scale were considerably lower in this study, indicating largely positive attitudes and empathy towards consumers who use NSSI. The current findings align with reports that mental health workers (as opposed to medical or emergency staff) tend to show more positive attitudes towards NSSI (Gagnon and Hasking 2012; Jeffery and Warm 2002; Muehlenkamp et al. 2013). However, our findings somewhat contrast with prior studies (e.g., Mackay and Barrowclough 2005; Gibb et al. 2010), which reported greater understanding amongst older and more experienced staff, while the current study found no such effects for age or years of practice on antipathy. This may reflect stronger therapeutic orientation or more advanced training in mental health-specific workers.

Interestingly, our study adds nuance by identifying professional background differences within the mental health field: social workers reported significantly lower antipathy than psychologists and counsellors, particularly in the domains of consumer intent regarding manipulation and rights and responsibilities. Our findings may be due to a significantly larger group of psychologists than social workers in the study, representing a broader diversity of understanding and experience of antipathy amongst psychologists. Social work and psychology have similar but distinct theoretical and philosophical foundations, including their focus on systems-based thinking. Further research is therefore needed to establish whether these differences may be related to training or type of engagement with consumers using NSSI. For example, it is unclear from our data whether psychologists, due to the nature of their role, may have experienced greater burnout leading to higher antipathy. Despite these small differences, it is notable that workers in our study still responded more positively overall to antipathy subscales in comparison to other studies (Patterson et al. 2007).

Consistent with McCann et al.'s (2006) findings, workers in our study reported an increased level of confidence with greater professional exposure to NSSI. Even when a more stringent alpha was set, this remained universal across their confidence in all abilities under investigation, except for when to inform the primary caregiver. Interestingly, there was a significant difference in workers' confidence in knowing when to refer consumers between those with moderate exposure and considerable exposure, but not for workers with only minor exposure to consumers who used NSSI. This could be attributed to an overly cautious approach from workers with only minimal experience, reflecting a propensity to overrefer.

4.1 | Limitations

Although the present study builds on the existing literature regarding antipathy and NSSI, providing further nuance and understanding, there are some limitations. Firstly, there was potential for response bias during the recruitment as the purpose of the study was openly advertised. It is likely this attracted participants with an interest and experience working with people who use NSSI. Secondly, there was a gender bias in the present study, with males underrepresented. Gender-based comparisons and generalisations must be interpreted with caution. Likewise, the sample represented a variety of mental health workers but notably did not include, for example, mental health nurses or occupational therapists, so discussions are restricted to psychologists, social workers and counsellors. The mixed results about the impacts of NSSI training on confidence and antipathy must be interpreted with caution as the study did not obtain details about the length, quality or modality of the training reported by participants. The impacts of training require further rigorous investigation to better understand components that can lead to improving confidence and attitudes towards consumers who use NSSI.

4.2 | Clinical Implications

The results of this study have implications for workers treating consumers who use NSSI. We found intrapersonal functions of NSSI were more regularly endorsed, while workers rated the interpersonal influence function quite high. This highlights the perception that NSSI is an attention-seeking and manipulative behaviour persists, even in empathic workers, a finding that supports previous research (Law et al. 2009; Warm et al. 2002). Importantly, the functions or the reasons why an individual engages in NSSI are generally not stable. They are often contextually driven (Lloyd-Richardson 2008), and as an overdetermined behaviour, may serve multiple functions simultaneously for the individual. Helping workers develop a more comprehensive, compassionate understanding of the varied and interconnected functions of NSSI is a key training target, particularly as beliefs about the functions impact levels of antipathy.

With approximately the same prevalence rates in Australia as many anxiety disorders (Lim et al. 2019), NSSI treatment and management requires evidence-based supports and treatments. Moreover, as the current study highlighted, with no significant difference found between the level of exposure to NSSI across differing professional orientations, this should be implemented across disciplines (Turp 1999). Notably, previous research has indicated this training should extend to the nursing and medical professions (Karman et al. 2015; Moriarty et al. 2021; Rayner et al. 2019). A recent systematic review of 19 papers (Akinola and Rayner 2022) indicated that worker responses to NSSI can be improved by targeting education, training and supervision. These in turn improve outcomes for those with NSSI as it improves staff attitudes and reduces burnout and hopelessness. Given the relationship between confidence and antipathy identified in the current study, a targeted educative approach would not only clinically equip workers but also imbue them with greater confidence in their ability to work with consumers engaging in these challenging behaviours.

4.3 | Future Research

Future research should aim to address several gaps. First, longitudinal studies are needed to clarify causal relationships between exposure, confidence, training and attitudes. Second, research should explore the mechanisms of change in training—what components are most effective in reducing antipathy? In line with this recommendation, research exploring antipathy towards NSSI when understood through the lens of distress tolerance is needed. Third, there is scope for qualitative research to understand how clinicians internalise and apply training content, and how their emotional responses to NSSI evolve over time. Given the continued prevalence of NSSI and its association with elevated suicide risk (Whitlock et al. 2013), building a more detailed, evidence-based training framework for all mental health workers remains a priority.

5 | Conclusion

Mental health workers in the current study endorsed more positive attitudes and less antipathy towards consumers who used NSSI in comparison to previous studies, indicating a more understanding and empathic attitude in these workers. While these positive attitudes are associated with less antipathy, our research highlights that common misconceptions about the functions of NSSI persist, namely, that it is used for manipulation and interpersonal influence, suggesting that programmes aimed at modifying beliefs about the function of NSSI may have greater utility in reducing antipathy. Our research highlighted that training improves the confidence of workers in working with people who use NSSI. Although training alone is not sufficient to reduce antipathy, when workers feel confident in addressing NSSI, antipathy drops, likely improving therapeutic alliance and outcomes for people who use NSSI.

Data Availability Statement

The data and codebook used for this study have been deposited in an open access repository PsychArchives. The link for this file has been removed to allow for anonymous peer review. This will be reappended when requested by the editors or editorial assistant.

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