Motivations for adolescent self-harm and the implications for mental health nurses.

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Abstract

Introduction: Although self-harm is a relatively common occurrence in adolescents, there is a lack of understanding about the motivations behind it. A poor understanding of self-harm contributes to negative perceptions about those who self-harm and a poor healthcare experience. **Aim & Methods:** This study identifies motivations behind self-harm in school-based adolescents using a cross-sectional survey. Motivations behind self-harm were elicited using a scale and open-ended responses. **Results:** Of the 856 adolescents who completed the survey across 11 post-primary schools, 103 reported a history of self-harm. The most commonly endorsed reason for self-harm was to 'get relief from a terrible state of mind' (79%). Open-ended responses were consistent with scale responses with most reporting that they self-harmed to relieve distressing emotions. **Discussion:** Findings provide support for the affect-regulation model of self-harm with support also demonstrated for the self-punishment and anti-dissociation models. There was little support for the interpersonal-influence model suggesting that the commonly held belief that self-harm is attention-seeking is one attributed by others to young people, and not widely reported by young people themselves. **Implications for practice:** Mental health services need to be responsive to the needs of young people who self-harm which requires eliciting and understanding the individual and multiple meanings behind self-harm to best inform treatment options.

Key words adolescents, attitudes, mental health nurses, motivations, self-harm, understanding.

Accessible summary

What is known on the subject?

- Self-harm is a relatively common occurrence in adolescents however there remains a lack of understanding about the motivations behind adolescent self-harm and this poor understanding can have a negative impact on how mental health professionals respond to young people who self-harm.

What this paper adds to existing knowledge?

- This paper identifies the reasons for self-harm in a community sample of young people and finds that the functions of self-harm differ for different people and that there may be multiple reasons for self-harm.
- Findings provide support for the affect-regulation model of self-harm which states that young people self-harm to regulate how they are feeling; but provides little support for the interpersonal-influence model which proposes that self-harm is an attempt to influence how other people respond to them.

What are the implications for practice?

- Self-harm for most young people serves at least one specific function and is an indication of distress.
- There is a requirement for a non-pathologising response towards young people who self-harm; self-harm should be understood as a meaningful behaviour rather than a symptom of an illness.
- Mental health nurses need to understand the multiple functions of self-harm. A better understanding of the individualised meaning behind self-harm can positively impact

on attitudes towards young people who self-harm and provide for improved mental health service provision.

Introduction

Self-harm is a serious public health problem and has been identified as one of the most significant social and healthcare problems for young people (Hawton & Rodham 2006), and one of the primary reasons for their presentation to hospital (Hawton *et al.* 2012a). In Ireland, community studies identify that 1 in 8 adolescents report a lifetime history of self-harm (Doyle *et al.* 2015) and this trend is also reflected in hospital treated self-harm which peaks in adolescence (Griffin *et al.* 2015). Although self-harm is recognised as a serious problem internationally, a major large-scale longitudinal study of self-harm found that most adolescent self-harm resolved spontaneously with no significant adverse outcomes (Moran *et al.* 2012). While these are promising findings, the same study also identified that young people who reported repeated episodes of self-harm were more likely to self-harm into adulthood (Moran *et al.* 2012). Furthermore, those who repeat self-harm are also known to be at a higher risk for completed suicide (Zahl & Hawton 2004), highlighting the need for appropriate assessment of and intervention for adolescent self-harm.

There remains much debate among researchers, clinicians and service users about the definition of self-harm with little consensus internationally about the use of a common term. As understanding about self-harm has increased over the past three decades, the terminology used to describe it has also evolved. The term ‘attempted suicide’ was abandoned many years ago in recognition that many acts of self-harm have no suicidal intent and was replaced by the term ‘parasuicide’ (Kreitman *et al.* 1969). However, this term caused confusion for many and so was subsequently dropped and replaced by ‘deliberate self-harm’ (De Leo *et al.* 2004); a term which was in favour for a number of years particularly throughout Europe and Australia. In recent years however, the word ‘deliberate’ was subsequently dropped in recognition that

it can have connotations of blame and lead to value judgements about those who self-harm (Prymachuk & Trainor 2010). Current terminology within self-harm research currently focuses on two main terms; that of self-harm and that of non-suicidal self-injury (NSSI). The term 'self-harm', still largely favoured throughout Europe and Australia, is a broader term and has been briefly defined as self-injury or self-poisoning regardless of suicidal intent (Kapur et al., 2013). Self-injury, a term favoured in the USA (Hawton *et al.* 2012b), refers to the direct, intentional destruction of one's own body tissue without intent to die (Nock 2009). The study reported on in this paper focuses on the broader concept of 'self-harm' which incorporates self-injury.

Attention has been drawn to the need to better understand the multiple meanings behind self-harm (Hawton, *et al.* 2012b) and the individualised nature of those meanings. Theoretically the functions of self-harm have been delineated into positive and negative intrapersonal and interpersonal functions in which self-harm decreases negative and distressing feelings and/or brings about more positive emotional or physical sensations (Klonsky 2007; Nock 2009). Included within these categories are various explanatory models of self-harm including the affect-regulation model, the self-punishment model, the anti-dissociation model, and the interpersonal-influence model (Klonsky 2007). The affect-regulation model proposes that self-harm is a means to alleviate negative feelings and intense emotions such as anger, stress and anxiety (Klonsky 2007; Klonsky & Muehlenkamp 2007). The self-punishment model characterises self-harm as an inwards expression of anger and hostility (Klonsky 2007). The anti-dissociation model positions self-harm as an act an individual carries out in order to bring about physical and/or emotional sensations to counteract feelings of numbness and emptiness (Klonsky & Muehlenkamp 2007). The interpersonal-influence model holds that self-harm is used as a way to influence others and

effect their behaviour in some way (Klonsky 2007). It is from this model that the much misunderstood yet commonly attributed label of 'attention-seeking' derives.

The importance of working towards a holistic understanding of self-harm so that mental health professionals may respond in an empathic manner has been identified (Long et al, 2013). However, it appears that there is some way to go before this holistic understanding has been achieved. Self-harm is generally not a well understood phenomenon by staff in healthcare provision (Saunders *et al*. 2012; McHale & Felton 2010). A systematic review of the experiences of clinical services among people who self-harm identified a lack of staff knowledge and understanding about self-harm which in turn negatively impacted on the care service users received (Taylor *et al.* 2009). In addition to this lack of knowledge, a number of studies have identified problematic attitudes towards those who self-harm among healthcare professionals including mental health nurses (Karman *et al.* 2015; Saunders *et al*. 2012). Studies find that healthcare professionals appear to evaluate the reason for a self-harm act and hold more favourable attitudes towards those they believe to have a 'genuine' reason compared to those whom they deem responsible for their self-harm (Doyle *et al*. 2007; Law *et al*. 2009; McHale & Felton 2010; Saunders *et al.* 2012). It is recognised that the portrayal of negative attitudes from healthcare professionals can compound an already poor self-esteem and sense of shame in those who self-harm (Long *et al.* 2013). That many of these negative attitudes are rooted in incorrect assumptions about the purpose and function of self-harm suggests that there is potential to decrease these negative attitudes by increasing knowledge and understanding about the functions of self-harm.

Aim of the Study

This study aims to increase understanding about adolescent self-harm by identifying motivations behind self-harm in a school-based community sample. The motivation behind a young person's decision to self-harm is an important factor to understand as it can provide

useful information about the intent of a self-harm act and can guide appropriate interventions (Klonsky & Muehlenkamp 2007). As most studies of the functions of self-harm include only clinical samples, there is a requirement to focus on community samples with a view to developing appropriate interventions for this cohort (Klonsky 2007).

Design

A cross-sectional self-report survey design was used to gather data for this study. One of the main drawbacks to survey research is that pre-set responses mean that participants are forced to choose a response that may not accurately reflect their view (Oppenheim 1992). However, in this study, further opportunity was given to participants in open-ended questions to describe their views and provide additional information. The use of an anonymous survey in this study was intended to increase the honesty with which adolescents replied to the questions asked allowing them to be more candid (Nardi 2006). Anonymous survey methods are particularly suited to collecting sensitive data as young people may be more likely to acknowledge their self-harming behaviours if they can do so anonymously (Evans *et al.* 2005).

Methods

Measures

The instrument used for data collection was the 96-item self-report Lifestyle and Coping survey, which was developed for use in the Child and Adolescent Self-harm in Europe (CASE) study, an international multi-site study of self-harm (Madge *et al*. 2008). Permission to use the survey was obtained by the co-ordinator of the CASE study. Self-harm was measured in a rigorous and consistent manner allowing comparison between all CASE studies. Participants were asked to identify if they self-harmed and to describe their last act of self-harm. Each description of self-harm was then compared to the standardised definition of self-harm utilised in this study which defined self-harm as an intentional act with a non-fatal

outcome regardless of intent. A case was coded as self-harm only where a description was given and where that description met the pre-determined criteria. In addition to self-harm, the survey covered a range of demographic variables, lifestyle factors, negative life events and psychological constructs including depression, anxiety, self-esteem and impulsivity. This paper focuses exclusively on participants' motivations for self-harm. To elicit these data, participants were asked to choose from a list of eight possible motives for self-harm adapted from work by Bancroft et al., (1976). These motives consisted of five externally directed reasons i.e. 'I wanted to show how desperate I was feeling', 'I wanted to frighten someone', I wanted to get my own back on someone', 'I wanted to find out if someone really loved me', and 'I wanted to get some attention'. Three inward directed reasons were also included and were 'I wanted to die', 'I wanted to punish myself' and 'I wanted to get relief from a terrible state of mind'. Participants could choose more than one reason if they felt this was applicable. It is recognised that relying solely on a questionnaire of clinician/researcher-derived motivations for self-harm could result in missing out on the personalised reasons for self-harm (Polk & Liss, 2009). Consequently, those participants who reported having self-harmed were also asked to describe in their own words why they did so.

Sample and Procedure

Target schools were divided into three groups based on a post-primary school's location in a low-, mid- or high-level of socio-economic deprivation in Dublin, Ireland to ensure a representative range of schools across the sample area. Schools were then randomly and proportionally selected from each group and 47 schools were invited to participate with 11 schools agreeing to participation. These schools comprised 6 co-educational schools, 1 all-boys school and 4 all-girls schools. Signed student assent and parental consent was required to participate in the survey. Participation rates varied in each school and ranged from 54% to 85% with an average of 73%. An actual sample size of 856 students across the 11 schools

was obtained, of which 51.2% were male and 48.8% female. The age range of participants was 15-17 years and the majority (50.2%) were 16 years. Ethical approval to undertake the study was granted by the Human Research Ethics Committee of the Faculty of Health Sciences, University College Dublin.

Analysis

SPSS for Windows Version 22.0 (SPSS, Inc., 2013) was used to analyse quantitative data. Descriptive statistics were run to identify the motivations behind self-harm. Pearson's chi-square test for independence was calculated to explore the proportion of males and females who reported each reason for self-harm. Responses to the open-ended question eliciting reasons for self-harm were analysed using conventional qualitative content analysis which is the subjective interpretation of text data by assigning codes and identifying themes (Hsieh & Shannon 2005). Individual responses were read and re-read to allow immersion in the data following which specific words and phrases were highlighted to capture key concepts (Hsieh & Shannon 2005). Labels for codes were generated from these specific words and phrases. Codes were then formulated into categories which were reflective of a number of related codes. Following a further level of analysis, categories were refined to comprise a final list of 5 thematic categories which reflect the reasons behind adolescents' self-harm with the addition of one final 'miscellaneous' category comprising disparate motivations with insufficient data to support an independent category. In addition to analysing the content of the text responses, participants' responses were also quantified to identify the extent of these responses. Responses ranged from one word to full paragraphs with most participants writing 2-3 sentences. A number of participants reported more than one reason for self-harm and in these instances, all responses were coded accordingly. Quotes from participants are provided in the findings section to illuminate the data.

Results

Findings relating to the prevalence of self-harm in this cohort and their basic demographics are presented elsewhere (Doyle *et al.* 2015) where it is reported that 12% (n = 103) of adolescents had engaged in self-harm, 46.6% of whom had done so more than once. The majority of those who self-harmed were female (n=75) with only just over one-quarter male (n=28). Most of those who self-harmed were 16 years of age and the most common method of self-harm was self-cutting (63%) (Doyle *et al.* 2015).

Reasons for adolescent self-harm

Participants were asked to choose from a list of eight possible motives to best explain why they self-harmed on the last occasion. Participants could choose more than one reason if they felt this was applicable. As is evident in Table 1, the most common motivating factor behind self-harm was 'I wanted to get relief from a terrible state of mind' (79%). Other common motives included 'I wanted to punish myself' (38%) and 'I wanted to die' (37%). The least frequently endorsed reason for self-harm was 'I wanted to get some attention' (11%). There was no significant difference between males and females for the majority of motives behind self-harm. However, there was a statistically significant difference in the frequency with which two motives were reported by females and males. Females reported 'I wanted to show how desperate I was feeling' more frequently than males (42.2% v 15.4%) X^2 (1, n=92) = 6.01, p = .014 *phi* = .256. Similarly, females identified the motive 'I wanted to punish myself' more frequently than males (44.3% v 22.2%) X^2 (1, n=97) = 4.02, p = .045 *phi* = .204.

Insert Table 1 here

Of the 103 adolescents who self-harmed, 95 described why they engaged in self-harm in their own words providing 114 separate responses. Following content analysis, 6 themes were developed from the data which were 1. Managing emotions, 2. Reacting to life events,

3. Feeling worthless, 4. Wanting to feel something, 5. Wanting to die, 6. Miscellaneous reasons.

Managing emotions

The most frequently identified reason for self-harm within the open-ended responses was to manage emotions which was reported by 43% of participants (n=49). Emotions requiring management were quite evenly split between feeling angry and frustrated (n=22) and feeling down and depressed (n=19). In addition to this, a further 8 participants simply identified that they self-harmed to 'feel better' but did not give further information on how self-harm made them feel better. Those who reported self-harming to relieve anger, tension and frustration provided some detail on how self-harm helped with these emotions:

> *"I was mad at myself for not being able to solve my problems. Sometimes I just have a really bad temper and become impetuous. That's when I self-harm but I do feel better for a while after."*

> *"I get extremely frustrated. Physical pain provides brief distraction from thoughts."*

The often repetitious nature of self-harm was also alluded to in participants' responses:

> *"I like the feeling I get from it. It's like a release but its sore when its healing and you wonder what you were thinking but I always end up doing it again."*

For most of those who self-harmed because they felt down, this was reported very simply:

> *"I was just really depressed."*

It was evident that self-harm was utilised as a way to manage feelings of being down and for some this helped:

> *"I was feeling down and it helped."*

Others provided a little more information describing what they believed to be the root cause of their low mood:

"I was depressed due to problems with family and friends. I felt I was pushing everyone away."

Reacting to life events

Just over one quarter of participants (27%) framed their self-harm as a direct reaction to stressful or significant life events. Most responses here focused on problems with friends and problems in the family home:

"There was too much pressure from friends. There was a lot of tension between us."

"It was just a bad time. Everyone in the house was fighting and then my dad left."

A number of participants reported having someone close to them die which had a significant impact on them:

"My uncle died. He was like a big brother to me. We were really close, like best friends. I found that too hard to cope with."

Feeling worthless

Feelings of worthlessness and low self-esteem were reported by 10% of participants. Responses here were worded very strongly and demonstrated the depth of feeling:

"I was just a bad person and I felt like I was a waste of life."

"I don't like me."

Included also were responses which suggested that in addition to having low self-esteem, some participants were also ashamed of their self-harm:

"I hate myself and that's why I do it but people doing this survey should know it's something cutters are ashamed of."

Wanting to feel something

While a number of participants reported self-harming as a means to manage the emotions they were feeling, there were a proportion of participants (8%) who used self-harm as a

means to feel *something.* These participants reported feeling numb and needing the pain of self-harm to remind them that they were still a living person:

> *"I felt I had to do something to make sure that I was still human."*
>
> *"I wanted to feel pain to show I exist."*
>
> *"I felt numb and I just wanted to feel something."*

No reason to live/Wanted to die.

A small number of participants (n=6) identified that their self-harm was intended to end their life. In these cases, very little information was given apart from very brief responses indicating 'I wanted to die'.

Miscellaneous reasons

A number of participants (n=16) reported varied reasons for self-harm that did not fit into distinct categories and so were grouped together as 'miscellaneous reasons'. Reasons for self-harm coded in this category included being drunk, being immature, being bored and because they 'just wanted to'. Somewhat surprisingly, a repeated rationale (n=4) identified in this category was the belief that antidepressant medication had influenced a person's decision to self-harm:

> *"I was sent to a psychiatrist who put me on anti-depressants at the age of 14. The tablets depressed me and drove me to self-harm."*
>
> *"I suffer with depression and mild OCD. At the time my doctor was lowering my anti-depressant and it was making me feel bad."*

Discussion

It is evident from the findings of this study that self-harm is a complex phenomenon and has a variety of functions which differ substantially between young people and is therefore not a homogenous behaviour. It was apparent from the multitude of responses that for some

individuals, self-harm serves more than one function at the same time. It is noteworthy that the top three responses to the scale identifying motivations for self-harm were the three inward directed reasons for self-harm. This finding replicates pooled findings from the cross-country Child and Adolescent Self-Harm in Europe (CASE) study which, using identical measures, also identified the three inward directed reasons as the most commonly identified motives across the seven countries studied (Scoliers *et al.* 2009) suggesting a consistency in the motivation behind adolescent self-harm.

Findings from this study elicited support for a number of the explanatory models of self-harm set out in the introduction. The over-whelming majority of participants (79%) reported that they self-harmed to get 'relief from a terrible state of mind' which supports the affect-regulation model of self-harm (Klonsky 2007) and has been identified in other studies (Laye-Gindhu & Schonert-Reichl 2005; Klonsky 2009; Scoilers *et al.* 2009; Polk & Liss, 2009; Straiton *et al.* 2013). Further support for this explanatory model of self-harm was demonstrated in the open-ended responses where participants reported self-harming to relieve emotions including feeling down, angry and frustrated. While self-harm in these instances provided immediate relief from feelings of distress, it is a problematic pattern as studies suggest that those who experience the greatest reductions in negative affect have a greater frequency of self-harm (Klonsky 2009), which is in turn linked with poorer mental health outcomes in adulthood (Moran *et al.* 2012). Support for the anti-dissociation model was also evident in this study's findings where young people reported self-harming in order to feel alive and to counteract feelings of numbness. There also appeared to be support for the self-punishment model as self-punishment was the second most common reason for self-harm selected from the scale (38%) and was also identified in the qualitative responses.

Findings from this study suggest little support for the interpersonal-influence model of self-harm which proposes that self-harm is used to influence or manipulate people in the

person's environment (Klonsky 2007). Only a small minority of young people reported self-harming as a means to elicit attention (11%), to frighten someone (14%) or to find out if they were loved (12%). Furthermore, in the open-ended survey responses very few participants reported any of these reasons as the motivation behind their self-harm. The finding that only a small minority of young people who self-harm do so to seek attention is illuminating and supports others studies which also demonstrate that adolescent self-harm is largely a private expression of emotional distress with a marked reluctance to seek help (Klineberg *et al.* 2013) Those who self-harm recognise that many consider their behaviour to be 'deviant' and so most go some lengths to hide it by hiding their cuts and scars or devising alternative explanations for their injuries (Hodgson 2004). Furthermore, many young people who self-harm do not tell anyone about it and most acts of self-harm do not come to the attention of health professionals (Madge *et al.* 2008; *reference withheld*). Self-harm as an attention seeking behaviour is therefore not borne out by research findings suggesting that this motive is more frequently attributed to adolescents by others (Scoliers *et al.* 2009; Saunders *et al.* 2012). These findings suggest that mental health nurses need to be cognisant of the fact that mental distress of some kind is central to most cases of adolescent self-harm.

It is noteworthy that in describing their motivations for self-harm, few young people contextualised their self-harm as a feature of a diagnosed mental health problem. Instead, the vast majority discussed their self-harm as a response to distress and as a means of coping with difficult emotions. A non-pathologised framing of self-harm has also been advanced by participants in other studies who also did not describe their self-harm as a component of a mental illness (Hodgson 2004; Straiton *et al*. 2013). This finding is interesting in the light of the recent inclusion of NSSI as a 'condition for further study' in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, with the potential that it will be considered as a 'disorder' in its own right (American Psychiatric Association 2013;

Crowe 2014). This is a highly contentious inclusion which sparked a great deal of debate amongst service users, clinicians and researchers. Those who advocate for the inclusion of self-harm as a syndrome in its own right argue that it will lead to greater communication between mental health professionals, reduced likelihood of an inappropriate diagnosis and a greater opportunity for the young person to avail of appropriate assessment and treatment (Wilkinson 2013). Others however point out that this inclusion inappropriately pathologises peoples' reactions to distress and their way of manging this distress as an 'illness' and therefore labels young people during a particularly turbulent period of their life (De Leo 2011; Crowe 2014). Others still express concern about the attempt to classify behaviours as disorders (De Leo 2011; Kapur *et al*. 2013) and the creation of an apparent false dichotomy between suicidal and non-suicidal self-harm (Kapur *et al*. 2013). It is suggested that mental health nurses and other professionals look beyond the confines of rigid diagnostic labels to a more holistic consideration of the person who is self-harming which will be better informed by understanding their reasons for self-harm.

For the small number of those who did make reference to a diagnosed mental health problem, they appeared to link their self-harm to their treatment with antidepressant medication which is an interesting and currently very contentious issue. Historically, pharmaceutical companies have denied that antidepressants cause an increase in the incidence of self-harm and were accused of selectively publishing positive trial data while minimising adverse effects (Healy 2016). However, a recent large scale systematic review and meta-analyses of clinical study reports established that the incidence of suicidality (including self-harm) doubled in adolescents prescribed antidepressant medication with the authors subsequently recommending only minimal use of antidepressants in adolescents (Sharma *et al.* 2016). This area requires further research and elucidation from the perspective of the

young person who self-harms while on antidepressant medication and requires mental health nurses to be mindful of potential adverse effects of antidepressant medication on adolescents.

These findings about the motivations behind adolescent self-harm have significant implications for mental health professionals. Findings demonstrate that for the vast majority of participants, self-harm served at least one distinct purpose and was a meaningful action in response to real distress. This highlights the problematic haste of mental health nurses and other professionals making snap judgement calls about whether self-harm is 'genuine' or not, and basing the tone of their therapeutic actions on this judgement. Young people who access healthcare for their self-harm report experiencing stigmatising attitudes including labelling and minimising of their distress in addition to a lack of understanding of self-harm from a range of healthcare professionals (Mitten *et al.* 2016). These negative interactions are problematic as there is a relationship between negative staff attitudes towards self-harm and reduced intention to seek help; highlighting the need for an increased understanding of self-harm among mental health professionals (McHale & Felton 2010). A lack of understanding about the function of repeated self-harm in particular can cause mental health professionals to become frustrated leading potentially to punitive and non-therapeutic interactions with distressed young people (Thompson *et al.* 2008; McHale & Felton 2010; Gibb *et al.* 2010; Saunders *et al.* 2012).

There are however examples of good practice in caring for adolescents who self-harm. Young people who self-harm have identified what they found to be important characteristics of service providers and have reported that being non-judgemental, employing active listening, being sympathetic and understanding and involving the person in treatment decisions contributes to a positive service experience (Taylor *et al*. 2009; McAndrew & Warne 2014).There is, therefore, clearly a requirement for appropriate training and education about self-harm for mental health nurses in order to promote these attributes and increase

understanding about self-harm and reduce negative attitudes (Gibb *et al*. 2010; Saunders *et al.* 2012; Karman *et al*. 2015; O'Reilly *et al.* 2016). Training needs to also consider the important issue of assessment of self-harm in adolescents which has been identified as a complex and challenging endeavour (LeCloux 2013; O'Reilly *et al.* 2016). However, it is imperative that mental health professionals assess the function of the individual's self-harm in order to better understand their motivation and personal meaning of the behaviour with a view to better informing appropriate, sensitive and individualised care planning (Klonsky 2009; LeCloux 2013).

Limitations

A limitation of this study concerned the challenges involved in exploring retrospective accounts of self-harm. There was variation in the amount of time that had elapsed since the last reported episode of self-harm and for those whose self-harm was longer ago, their interpretation of it may have been impacted by a number of factors including time for reflection and difficulties in remembering their motivation for self-harm at that time. A further limitation is that the scale used to determine motivation for self-harm was based on findings from a study of participants who self-harmed by taking overdoses only (Bancroft *et al.* 1976). This may limit the utility of this scale for those who self-harmed using other methods. As permission to use the Lifestyle and Coping questionnaire was granted on condition that no change be made to it, it was not possible to amend this scale. Finally, while participants were facilitated to choose a number of reasons for their self-harm from the scale, there were not asked to rank their motivations in order of importance. This is a limitation in light of research which suggests that there are primary and secondary reasons for self-harm (Klonsky 2009).

Conclusion

Understanding the reasons behind adolescent self-harm is important to provide the most appropriate treatment and to prevent repeated episodes of self-harm with the possibility of poorer outcomes in the longer term. Mental health nurses are often best placed to help young people who self-harm so there is therefore a requirement for them and other health professionals to examine their role and increase their understanding of self-harming behaviour. The negative stereotype that exists about people who self-harm hampers the ability to fully understand the complex reasons for self-harm on an individual level and contributes to perpetrating the cycle of stigmatisation against those who self-harm. Increasing understanding about the motivations and functions of self-harm can result in a more positive healthcare experience for young people and an increased intention to seek help in the future.

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Table 1: Motivation for Self-Harm

Motivation for self-harm	Total	Female	Male	Pearson X^2 & effect size
I wanted to get relief from a terrible state of mind	79%	80.3%	76.9%	X^2 (1, n=97) = .131, p = .717 *phi* = .037
I wanted to punish myself	38%	44.3%	22.6%	**X^2 (1, n=97) = 4.02, p = .045 *phi* = .204**
I wanted to die	37%	34.8%	42.3%	X^2 (1, n=92) = .445, p = .505 *phi* = -.070
I wanted to show how desperate I was feeling	35%	42.4%	15.4%	**X^2 (1, n=92) = 6.01, p = .014 *phi* = .256**
I wanted to frighten someone	14%	13.8%	15.4%	X^2 (1, n=91) = 0.36, p = .850 *phi* = -0.20
I wanted to get my own back on someone	13%	16.4%	3.8%	X^2 (1, n=93) = 2.63, p = .105 *phi* = .168
I wanted to find out whether someone really loved me	12%	10.6%	15.4%	X^2 (1, n=92) = .405, p = .525 *phi* = .066
I wanted to get some attention	11%	12.3%	7.7%	X^2 (1, n=91) = .404, p = .525 *phi* = .067