

# Types of Self-harm Behaviour among Chinese Adolescents in Malaysia

**Guan Teik Ee<sup>1</sup> & Lau Poh Li<sup>2</sup>**

<sup>1</sup>Faculty of Psychology and Education, Universiti Malaysia Sabah

<sup>2</sup>Department of Educational Psychology and Counselling,  
Faculty of Education, University of Malaya

Corresponding author's email: [guanteikee@ums.edu.my](mailto:guanteikee@ums.edu.my), [janicepolly@um.edu.my](mailto:janicepolly@um.edu.my)

**Abstract.** Suicide statistics obtained from the World Health Organization in 2014 revealed that approximately one million people worldwide die from suicide every year which is equivalent to one death every 40 seconds. Since suicide rates throughout Asia are higher than in Western countries, it was hypothesized that rates of self-hurt might also be higher. In recent years, adolescent self-harm behaviour has become an issue of major concern in the international arena. There is virtually no empirical data about self-harm in Malaysia, as the subject remains a taboo. Records showing the prevalence of such behaviour among Malaysian Chinese adolescents are only available from non-government organizations and newspaper reports. Hence, any pioneer research carried out in this area should take cognizance of self-harm behaviour among the ethnic Chinese. The data obtained would then be compared with results from other countries.

**Keywords:** self-harm behaviour, Malaysian Chinese adolescents, mental health, Self-Harm Assessment

## INTRODUCTION

Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his/her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/her community (World Health Organization [WHO], 2014). However, in recent years, self-harm has become a common mental health problem encountered by adolescents (Matsumoto et al., 2008). The World Health Organization WHO, 2001) reported (that self-harm has escalated so much that it had emerged as one of the contributory factors

to the increase in morbidity and mortality rates. It is because people who self-harm were more likely to repeat the behaviour, and this tendency, in turn, increased their risk of completed suicide (Hawton, Fagg, Simkin, Bale, & Bond, 2000; Cleaver, 2007). In this study, self-harm behaviour is defined as an intentional performance of a harmful behaviour either by self or by a permitted associate to alter or harm body tissue without suicidal intent.

## STATEMENT OF PROBLEM

About one per cent of the American population engage in self-harm as a means to escape from overwhelming situations or feelings encountered (van Sell et al., 2005) while the rates of self-harm among UK teenagers were among the highest in Europe (Anderson, Woodward, & Armstrong, 2004). In Asia the prevalence of self-harm among Mainland Chinese high school students was 22.3% out of a total of 10,894 (Sun et al., 2008), 15% out of a total of 6,374 Hong Kong adolescents (You, Leung, Fu, & Lai, 2011) and 11.3% out of 742 Taiwanese high school students (Tsai, Chen, Chen, Hsiao, & Chien, 2011).

Although there has been anecdotal reports claiming that self-harm is on the increase in Malaysia, a developing nation with a relatively young population of 31.2 million as of September 2017 (Department of Statistics Malaysia, 2017), Thompson and Hasking (2009) claimed that there has not been a single study which has explicitly examined self-harm among Malaysians, not to mention adolescent self-harm behaviour. There is little understanding of this phenomenon of adolescent self-harm in Malaysia. This is an unexplored “terrain” as the subject is considered taboo. Studies need to be conducted in this area to gather empirical evidence to determine the extent of adolescent self-harm in Malaysia. A good starting point would be to study self-harm behaviour in terms of gender and age since literature related to these two factors already exists.

## THE OBJECTIVES OF THE STUDY

This study seeks to bring together all available evidence on Chinese adolescent self-harm behaviour in Malaysia. The aims of this study may be itemized as follows:

- (1) To identify the percentage of Chinese adolescents who engage in self-harm behaviour
- (2) To identify the types of self-harm behaviour among Chinese adolescents
- (3) To ascertain the association among gender, age group, and self-harm behaviour among Chinese adolescents

## HYPOTHESES OF THE STUDY

- H<sub>o</sub>1: There is no significant association among gender, age group, and self-harm behaviour among Chinese adolescents.
- H<sub>o</sub>2: There is no significant association between gender and self-harm behaviour among Chinese adolescents.
- H<sub>o</sub>3: There is no significant association between age group and self-harm behaviour among Chinese adolescents.

## METHODOLOGY

The study basically employed a two-stage random sampling method. Out of 112 schools in Penang, Malaysia, 12 schools were selected (Gay & Airasian, 2003). Penang was selected as it has the biggest number of ethnic Chinese in Malaysia. Based on a blind draw, a total of 602 adolescents (300 male, 302 female) were recruited for this study. Self-Harm Assessment (SHA) was used to determine the prevalence rate (frequency and percentage) and types of self-harm behaviour (Table 1). It is counted on the types of self-harm behaviour endorsed in total in the sample. SHA was adapted from Functional Assessment of Self-Mutilation (Lloyd-Richadson, Kelly, & Hope, 1997) and its reliability and validity have been verified, whereby 16 types of self-harm behaviour have been itemised.

For the purpose of this study, any adolescent performing at least one of the behaviours mentioned in SHA are considered to have engaged in self-harm behaviour. Log-linear analysis was used to determine the association among gender, age group, and types of self-harm behaviour. This study used hierarchical log-linear analysis. Log-linear analysis is used to examine all the main effects and their interactions. However, this study focused on examining the association of A\*B\*C (gender\*age group\*self-harm behaviour), A\*C (gender\*self-harm behaviour) and B\*C (age group\*self-harm behaviour), so that only these effects are reported in this study.

Participants of this study comprised males and females in the age groups of 13 to 14 (Age Group 1) and 15 to 16 (Age Group 2).

**Table 1** Self-harm Assessment (types of self-harm behaviour)

Item	Statement	Yes	No	If yes, please state the level:			
				1	2	3	4
1.	Used any sharp object to cut my skin						
2.	Used ruler to cut my hand or any part of my body						
3.	Used any sharp object to carve on my skin						
4.	Gave myself a tattoo						
5.	Scraped my skin						
6.	Used eraser to erase my skin						
7.	Hit myself on purpose						
8.	Pulled my hair out						
9.	Bit myself, for example mouth or lip						
10.	Picked at a wound						
11.	Burned my skin, for example with cigarette, match or other hot object						
12.	Used wire or string to tie my neck or hand or any part of my body						
13.	Picked areas of my body						
14.	Inserted objects under my nails or skin						
15.	Bit my nails						
16.	Scratched myself						

**Notes:**

Level 1: No bleeding. Only first layer of the skin affected; no medical treatment required.

Level 2: Minor bleeding, bandage required but no medical treatment.

Level 3: Significant bleeding; medical treatment required.

Level 4: Life-threatening self-harm behaviour.

## RESULTS OF THE STUDY

Results of the study are reported in the following sequence:

### (i) The percentage of Chinese adolescents who engaged in self-harm behaviour

The Self-harm Assessment distributed to 602 participants aged 13 to 16 years, consists of 300 males and 302 females. Participants who acknowledged engaging in at least one type of self-harm behaviour mentioned in SHA made up the self-harm group. Table 2 shows the sample size and the number and percentage with self-harm behaviour for each gender and age group. From the total of 602 participants, 342 (56.81%) committed self-harm behaviour, of which 139 (23.09%) were males, and 203 (33.72%) were females.

A total of 176 (29.24%) participants, comprising 69 (11.46%) males and 107 (17.78%) females were found to have committed self-harm behaviour in Age Group 1 compared to 166 (27.57%), comprising 70 (11.63%) males and 96 (15.94%) females in Age Group 2.

**Table 2** Sample size and number and percentage with self-harm behaviour

Sample size (N = 602)				Number and percentage with self-harm behaviour (n = 342)			
Gender	Age Group 1 (13 – 14 years old)	Age Group 2 (15 – 16 years old)	Total	Gender	Age Group 1 (13 – 14 years old)	Age Group 2 (15 – 16 years old)	Total
Male	152 (25.25%)	148 (24.58%)	300 (49.83%)	Male	69 (11.46%)	70 (11.63%)	139 (23.09%)
Female	152 (25.25%)	150 (24.92%)	302 (50.17%)	Female	107 (17.78%)	96 (15.94%)	203 (33.72%)
<b>Total</b>	<b>304 (50.50%)</b>	<b>298 (49.50%)</b>	<b>602 (100%)</b>	<b>Total</b>	<b>176 (29.24%)</b>	<b>166 (27.57%)</b>	<b>342 (56.81%)</b>

From the total number of male and female adolescents who self-harm, the male-to-female ratio was approximately 1:1.46 (139: 203). The ratio of Age Group 1 participants to Age Group 2 participants was approximately 1.06:1 (176: 166).

### (ii) Types of self-harm behaviour among Chinese adolescents

As for the types of self-harm behaviour, all the types of self-harm behaviour were committed by the participants to some degree. The difference was only the frequency of the types of self-harm behaviour engaged in by participants.

Most of the participants endorsed engaging in a single type of self-harm behaviour out of the 16 items in Table 3 while the rest engaged in multiple types of self-harm behaviour from items 2 to 16.

**Table 3** Endorsement of self-harm behaviour based on types of self-harm behaviour

Frequency of endorsement for type of self-harm behaviour	Number of participants	Percentage of participants who engaged in self-harm behaviour
1	77	22.51
2	6	1.75
3	17	4.97
4	19	5.56
5	9	2.63
6	10	2.93
7	9	2.63
8	7	2.05
9	10	2.93
10	4	1.17
11	4	1.17
12	1	0.29
13	4	1.17
14	13	3.80
15	76	22.22
16	76	22.22
Total	342	100.00%

Table 4 shows the ranking of the total endorsement for each type of self-harm behaviour in the sample. The highest-endorsed item was “used any sharp object to cut my skin” (69.01%).

**Table 4** Endorsement of self-harm behaviour based on frequencies and percentages

Ranking	Participants who check “yes”	Percentage of endorsing participants	Item/Types of self-harm behaviour	Less serious	Serious
1	236	69.01	1/ Used any sharp object to cut my skin	231 (97.9%)	5 (2.1%)
2	234	68.42	2/ Used ruler to cut my hand or any part of my body	234 (100%)	0 (0%)
2	234	68.42	6/ Used eraser to erase my skin	234 (100%)	0 (0%)
3	227	66.37	5/ Scraped my skin	227 (100%)	0 (0%)
3	227	66.37	15/ Bit my nails	224 (98.7%)	3 (1.3%)
4	222	64.91	16/ Scratched myself	222 (100%)	0 (0%)
5	216	63.16	8/ Pulled my hair out	21 (100%)	0 (0%)
6	211	61.70	10/ Picked at a wound	211 (100%)	0 (0%)
7	207	60.53	12/ Used wire or string to tie my neck or hand or any part of my body	207 (100%)	0 (0%)
8	189	55.26	7/ Hit myself on purpose	189 (100%)	0 (0%)
9	175	51.17	13/ Picked areas of my body	175 (100%)	0 (0%)
10	173	50.58	11/ Burned my skin, for example with cigarette, match or other hot object	173 (100%)	0 (0%)
11	171	50.00	9/ Bit myself, for example mouth or lip	171 (100%)	0 (0%)
12	169	49.42	4/ Gave myself a tattoo	169 (100%)	0 (0%)
13	168	49.12	3/ Used any sharp object to carve on my skin	166 (98.8%)	2 (1.2%)
14	157	45.91	14/ Inserted objects under my nails or skin	157 (100%)	0 (0%)

Self-harm behaviour was categorized into 2 categories, less serious and serious. Less serious self-harm behaviour is when there was no bleeding or minor bleeding (levels 1 and 2; Table 1), and did not involve medical treatment. In contrast, serious self-harm behaviour involved significant bleeding or was life-threatening (levels 3 and 4; Table 1) and required medical treatment.

As seen from Table 4, all the types of self-harm behaviour were of a less serious nature except for three items, which needed medical treatment; namely Item 1 (“used any sharp object to cut my skin”), Item 15 (“bit my nails”), and Item 3 (“used any sharp object to carve on my skin”).

### (iii) Association among gender, age group, and self-harm behaviour among Chinese adolescents

A log-linear analysis was used to test the frequencies of self-harm behaviours endorsed by gender (either male or female) and age group (either Age Group 1 or Age Group 2). The frequencies of all the types of self-harm behaviour are synonymous of the type of self-harm behaviour under study. In this study, 342 participants engaged in self-harm behaviour; therefore the maximum frequencies of self-harm behaviour should be 5472 (342 participants  $\times$  16 types of self-harm behaviour). In presenting the results, the descriptive statistics for the frequency would be performed first, and then a log-linear analysis was performed after getting the frequency for each type of self-harm behaviour. Table 5 shows the total number of self-harm behaviours. 640 male participants aged 13 – 14 (Age Group 1) checked “No” compared to 464 who checked “Yes” whereas 666 male participants aged 15 – 16 (Age Group 2) checked “No” compared to 454 who checked “Yes.”

The figures were higher for females in the same age groups, 964 female participants (Age Group 1) checked “No” compared to 748 who checked “Yes” whereas 946 female participants (Age Group 2) checked “No” compared to 590 who checked “Yes”.

**Table 5** Sample size for gender in proportion to age group for Self-harm Behaviour

Gender	Age group	Self-harm behaviour	Frequency	
Male	1 (13 – 14 years old)	No	640	
		Yes	464	
	2 (15 – 16 years old)	No	666	
		Yes	454	
Female	1 (13 – 14 years old)	No	964	
		Yes	748	
	2 (15 – 16 years old)	No	946	
		Yes	590	
			Total	5472

The lower part of Table 6 which shows the K-way log-linear analysis revealed that main effects (either A, B, or C) ( $\chi^2(3) = 370.51, p = .00$ ) and two-way interaction effects (either A\*B, A\*C, or B\*C,  $\chi^2(3) = 12.81, p = .01$ ) were the significant terms in the [ABC] model.

**Table 6** K-way and higher-order effects for Gender (A), Age Group (B), and Self-harm Behaviour (C)

	K	Pearson		
		Degrees of freedom, df	Chi-square, $\chi^2$	Significance value
K-way and higher-order effects <sup>a</sup>	1	7	385.29	.00
	2	4	14.78	.01
	3	1	1.96	.16
K-way effects <sup>b</sup>	1	3	370.51	.00
	2	3	12.82	.01
	3	1	1.96	.16

**Notes:**

a. Tests that k-way and higher-order effects are zero.

b. Tests that k-way effects are zero.

**Table 7** Step summary showing the final model for Gender (A), Age Group (B), and Self-harm Behaviour (C)

Step <sup>b</sup>	Effects	Chi-square <sup>a</sup> $\chi^2$	Degrees of freedom, df	Significance value
0	Generating class <sup>c</sup>	[ABC]	.00	0
	Deleted effect	1 A*B*C	1.96	1 .16
1	Generating class <sup>c</sup>	[AB], [AC], [BC]	1.96	1 .16
	Deleted effect	1 A*B	5.00	1 .03
		2 A*C	.02	1 .88
		3 B*C	7.88	1 .01
2	Generating class <sup>c</sup>	[AB], [BC]	1.98	2 .37
	Deleted effect	1 A*B	4.98	1 .03
		2 B*C	7.86	1 .01
3	Generating class <sup>c</sup>	[AB], [BC]	1.98	2 .37

**Notes:** Generating Class<sup>c</sup>: in the hierarchical model, the presence of any interaction includes all lower order interactions and main effect (Knoke & Burke, 1980).

a. For “Deleted Effect,” this is the change in the Chi-square after the effect is deleted from the model.

b. At each step, the effect with the largest significance level for the Likelihood Ratio Change is deleted, provided the significance level is larger than .05.

c. Statistics are displayed for the best model at each step after step 0.

\* = interactions



Table 7 further shows the step summary using backward elimination to find out the best-fitting model. The result showed that at Step 2 deleting A\*B had a significant effect on the models [AB] and [BC] ( $\chi^2(1) = 4.98, p = .03$ ), so that A\*B needs to be retained. It also shows that deleting B\*C had a significant effect on the models [AB] and [BC] ( $\chi^2(1) = 7.86, p = .01$ ), so that B\*C also needs to be retained. Hence, Step 3 shows the final models were [AB] and [BC]. The final models had non-significant results ( $\chi^2(2) = 1.98, p = .37$ ), indicating that they were the best-fitting models for variables gender, age group, and self-harm behaviour.

Table 8 further confirms that the  $p$ -value of Likelihood Ratio statistic of Goodness-of-Fit test after Step 3 for the final models were non-significant ( $\chi^2(2) = 1.98, p = .37$ ), meaning that [AB] and [BC] were the best-fitting models. However, [AB] was not the focus of this study as it focused only on gender and age group without self-harm behaviour, so that only the [BC] was reported. This best-fitting model [B\*C] shows that age group (B) had association with self-harm behaviour (C).

**Table 8** The Goodness-of-Fit test after Step 3 for the Model of Gender(A)\*Age Group(B)  
\*Self-harm Behaviour(C)

	Chi-square, $\chi^2$	Degrees of freedom, df	Significance value
Likelihood ratio	1.98	2	.37

Next, the odds ratio was calculated in order to find out the strength of association between “age group” and “self-harm behaviour.” Table 9 shows that the odds for Age Group 1 was higher than the odds for Age Group 2 (0.76 compared with 0.65). Hence, the odds ratio between them was 1.17. Given that an odds ratio equal to 1 implies no association between two variables (Knoke & Burke, 1980), we can interpret this by saying that the odds of self-harm behaviour was 1.17 times higher for Age Group 1 participants than for Age Group 2 participants. In other words, the Age Group 1 participants were more likely to engage in self-harm behaviour compared to Age Group 2 participants.

**Table 9** Odds ratio for age group in relation to self-harm behaviour

Self-hurt behaviours	Age Group 1 (13 – 14 years old)	Age Group 2 (15 – 16 years old)	Odds ratio for Age Group 1 to Age Group 2
No	1604	1612	1.17
Yes	1212	1044	

**Notes:**

Odds of “yes” for Age Group 1 =  $1212/1604 = 0.76$

Odds of “yes” for Age Group 2 =  $1044/1612 = 0.65$

Odds ratio for Age Group 1 to Age Group 2 =  $0.76/0.65 = 1.17$

Based on the above findings, we could conclude that there is no association among gender, age group, and self-harm behaviour ( $A*B*C$ ), and between gender and self-harm behaviour ( $A*C$ ), but there exists an association between age group and self-harm behavior ( $B*C$ ), in that, Age Group 1 participants (13 – 14 years old) had a greater tendency (1.17 times) to harm themselves than Age Group 2 participants (15 – 16 years old).

Therefore, the null hypothesis ( $H_01$ ) stating that there is no significant association among gender, age group, and self-harm behaviour is accepted. The null hypothesis ( $H_02$ ), stating that there is no significant association between gender and self-harm behaviour, is also accepted. However, the null hypothesis ( $H_03$ ), stating that there is no significant association between age group and self-harm behaviour is rejected.

## DISCUSSION AND CONCLUSION

Evidence gathered from this study showed that 56.81% of the participants engaged in self-harm behaviour. This indicated that self-harm behaviour not only exists among adolescents, but was also a common phenomenon nowadays, as more than half of the participants had engaged in self-harm behaviour.

The rate of self-harm behaviour was comparatively higher in this study probably due to the differences in measurement. This study included most of the superficial self-harm behaviours (Favazza, 1996) such as hair-pulling, and nail-biting. This study also revealed that multiple types of self-harm behaviour were practised, with cutting oneself with sharp objects topping the list.

This finding was consistent with other findings that cutting is the most common type of self-harm behaviour (Lloyd-Richardson, 2010; Villar, 2011). Self-harm through cutting oneself has become the most popular because it is relatively easy compared to other methods. Heinsz (1999) stated that everyday household objects such as pins, glass shards, matches, pens, razors, scissors, and erasers were commonly used to damage the flesh, as these were easily found in the subjects' daily lives.

Fortunately, current study shows that most self-harm behaviours performed nowadays were of a less serious nature. However, early identification is crucial not only in treating such behaviours but also to develop healthy coping strategies and also prevent escalation of the problem.

The log-linear analysis revealed that unlike gender, age group was associated with self-harm behaviour. Age Group 1 participants (13 – 14 years old) showed a higher tendency of engaging in self-harm behaviour than Age group 2 participants (15 – 16 years old). However, the odds ratio for Age groups was only 1.17 (Table 9), indicating

that the effect size between them was small. Table 1 also shows that the ratio of Age Group 1 participants who engaged in self-harm behaviour was 1.06: 1 (176: 166). One highly possible explanation is that the age gap between the two groups is small, there being only one or two years' difference between them. Hence, it is reasonable that adolescents aged 13 to 14 years are slightly more likely to engage in self-harm behaviour than adolescents aged 15 to 16 years.

The age range from 13 to 14 represents an important transition stage for Malaysian students as they move from primary to secondary school. The new environment which requires adjustment to new friends, new teachers, and a more difficult syllabus will affect the emotions of students who have not adjusted well.

Moyer (2005) stated that self-harm behaviour is an integral part of adolescents' lives, helping adolescents to achieve what they want and to ease their pain. Hence, self-harm though destructive in nature also has a positive side of enabling the achievement of certain desired goals. Youth counselling should include prevention and intervention programmes that help adolescents to be more aware of constructive ways of attaining the desired goals, especially for adolescents in their first twenty years.

There were a few contributions to this study. First, previous study concentrated on two variables (either gender or age group) in relation to self-harm behaviour, this study covered three other variables (gender, age group, and self-harm behaviour) to ascertain the interactive effects among these three variables. Second, this study not only adds to the literature on self-harm behaviour of adolescents in Asian countries, but has also made a great contribution in unveiling this phenomenon among adolescents in Malaysia, where mention of self-harm is taboo. The results of the study have definitely helped in eliminating much of the taboo surrounding this topic assisting future researchers intending to study self-harm behaviour.

## REFERENCES

- Anderson, M., Woodward, L., & Armstrong, M. (2004). Self-harm in young people: A perspective for mental health nursing care. *International Nursing Review*, 51 (4), 222 – 228.
- Cleaver, K. (2007). Adolescent nursing: Characteristics and trends of self-harming behavior in young people. *British Journal of Nursing*, 16 (3), 148 – 152.
- Department of Statistics Malaysia. (2017). *Statistics yearbook Malaysia 2017*. Putrajaya: Author.
- Favazza, A. R. (1996). *Bodies under siege: Self-mutilation and body modification in culture and psychiatry* (2nd ed.). Baltimore, MD: The Johns Hopkins University Press.
- Hawton, K., Fagg, J., Simkin, S., Bale, E., & Bond, A. (2000). Deliberate self-harm in adolescents in Oxford, 1985 – 1995. *Journal of Adolescence*, 23, 47 – 55.
- Heinsz, S. V. (1999). *Self-mutilation in child and adolescent group home population*. (Unpublished doctoral dissertation).Walden University.
- Knoke, D., & Burke, P. J. (1980). Loglinear models. *Series: Quantitative applications in the social sciences* (20). Beverly Hills, CA: Sage.

- Lloyd-Richardson, E. E. (2010). Nonsuicidal self-injury in adolescents. *The Prevention Researcher*, 17 (1), 3 – 7.
- Lloyd-Richardson, E. E., Kelly, M. L., & Hope, T. (1997). *Self-mutilation in a community sample of adolescents: Descriptive characteristics, provisional prevalence rate*. Poster session at the annual meeting of the Society of Behavioral Medicine, New Orleans, LA.
- Matsumoto, T., Imamura, F., Chiba, Y., Katsumata, Y., Kitani, M., & Takeshima, T. (2008). Prevalences of lifetime histories of self-cutting and suicidal ideation in Japanese adolescents: Differences by age. *Psychiatry and Clinical Neurosciences*, 62, 362 – 364.
- Moyer, M. S. (2005). *Investigating and understanding self-harming behaviors in adolescents: A phenomenological study* (Unpublished doctoral dissertation). Texas A & M University.
- Sun, Y., Tao, F., Xu, S., Zhu, P., Huang, K., & Zhu, P. (2008). Self-injurious behaviors and psychosocial factors among rural middle school students in Anhui province. *Chinese Journal of School Health*, 29, 424 – 427.
- Thompson, H. K., & Hasking, P. A. (2009). Reviewing self-injury: Implication for the study of self-injury and suicidal behaviour in Malaysia. *Jurnal Sains Kesihatan Malaysia*, 7 (2), 1 – 27.
- Tsai, M. H., Chen, Y. H., Chen, C. D., Hsiao, C. Y., & Chien, C. H. (2011). Deliberate self-harm by Taiwanese adolescents. *Acta Paediatrica*, 100 (11), e223 – e226.
- van Sell, S., O'Quin, L., Oliphant, E., Shull, P., Austin, K., Johnston, E., & Nguyen, C. (2005). Help stop self-injury. *Modern Medicine*, 68 (11), 55 – 59.
- Villar, I. V. G. (2011). Non suicidal self-injurious behavior. *Journal of Counseling*, 4 (1), 16 – 24.
- World Health Organization (WHO). (2001). *Giving adolescents a voice: Conducting a rapid assessment of adolescent health needs: A manual for health planners and researchers*. Manila: World Health Organization Regional Office for the Western Pacific.
- World Health Organization (WHO). (2014). *What is mental health?* Retrieved from <http://www.who.int/topics/mental-health/en/>
- You, J., Leung, F., Fu, K., & Lai, C. M. (2011). The prevalence of nonsuicidal self-injury and different subgroups of self-injurers in Chinese adolescents. *Archives of Suicide Research*, 15, 75 – 86.