PREVALENCE AND FACTORS ASSOCIATED WITH SELF-MUTILATION AMONG ADOLESCENTS OF MALE' SCHOOLS

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PREVALENCE AND FACTORS ASSOCIATED WITH SELF-MUTILATION AMONG ADOLESCENTS OF MALE' SCHOOLS

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DECLARATION

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I hereby declare that this project is the result of my own work, except for the Quotations and summaries, which have been duly, acknowledge.

Signature 17th May 2015

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ABSTRACT

The aim of this study was to investigate the prevalence and associated factors of Self-mutilation. A descriptive, cross-sectional Study, by using structured questionnaire, was carried out from 7th - 19Th April at Iskandar School, Thaajuddeen School, Rehendhi School and Ghaazy School. 147 respondents was participated in this study. The result shows prevalence of self-mutilation is 41 students (28%). Other deliberate self-harm includes (10.2%) banging head intentionally and 2.7%) Burn self intentionally. The most frequent reason for self-mutilation shows (37.3%) responded as angry with someone. (22.2%), responded, as I hate myself. (20.3%) upset and tried it. (20.3%) said to cope with uncomfortable feeling. Other reasons they have mentioned was, "My past" and "got low marks". The study found the frequency and percentages of Self-mutilation among four schools. Iskandar School 17 students (12%) Thaajuddeen School 15 Students (10.3%). Rehendhi School 12 students (8.3%) Ghaazy School 11 students (8%). This study shows significant association between self-mutilation and parental marital status. The result shows Odd ration2.25. Which indicated students whose parents are separated has 2.25 higher chances of self-mutilation than those whose parents are married and living together. The other association found in the study was bullying in Schools. There was significant association between bullying and self-mutilation. Bullying victims have 2.23 times higher chances of self-mutilation than those who were not bullied. The result of this study show very high association between self-mutilation and wanting to kill oneself or suicidal ideation. Crude odd ratio for self-mutilation and wanting to kill oneself is 3.08, which indicated those who self-mutilate have 3 times higher chances of wanting to die or suicide. If Schools and families neglect the findings, there could be serious consequences such as involving high-risk behaviours and violence and increase incidents of attempting suicide among adolescents.

Keyword: Self-mutilation, Adolescents, negative coping mechanism

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Prevalence and factors associated with Self-mutilation among Adolescence

CHAPTER: 1 INTRODUCTION

1.1 Background of the study

Adolescence defines the developmental phase between childhood and adulthood.

The World Health Organization (WHO) defines ‘adolescence ‘as 10 to 19 years, while ‘youth’ is defined as the years between 15 and 24.Th concerning fact in this age group is Many causes of health problems are more usually psychosocial than biological and they are more prone to unhealthy forms of risk behaviours and mental conditions. Patton(2011) wrote, many adolescents call the period of adolescence as pleasant and exciting, and as a phase of satisfaction in achieving many exciting events, such as first relationships, completing school, getting a job and learning to drive. In contrast, A Haghdoost(2014) wrote, adolescent period is mostly difficult period for teen-agers. They are undergoing all kinds of new changes in their bodies and in their feelings. In addition, they often feel confused as they are struggling to get over their childhood and become adults. Besides, Issues such as stubborn behaviour, lying, cheating, school performance problems, negative attitudes, rebellion and lack of respect, self-harm, sibling conflict, drug and alcohol abuse, peer pressure, depression, and issues of sexuality have commonly characterized adolescence(Haghdoost, 2014).

Among obove mentioned risky behaviours, this study will forcus on Self- mutilation, which also called Self-injury, self-harm, defined as any deliberate injury to one's own body. Usually, self-injury leaves marks or causes tissue damage. Self-injury can include any of the following behaviours:

- Cutting
- Burning (or "branding" with hot objects)
- Picking at skin or re-opening wounds
- Hair-pulling
- Head-banging
- Hitting (with hammer or other object)
- Bone-breaking

The International Society for the Study of Self-injury defines non-suicidal self-injury as the deliberate, direct, and self-inflicted destruction of body tissue resulting in immediate tissue damage, for purposes not socially allowed and without suicidal intent (International Society for the Study of Self-injury, 2007).

Buchanan(2014)wrot that, research has shown that self-harm has increased recently, that in particular self-cutting has increased and there is some contagion effect. According to Rodham& Hawton(2009), those who engage in NSSI are at higher risk of suicidal behaviours and normally, self-injury has occur during adolescence and the likelihood of onset falls during adulthood (Rodham & Hawton, 2009). Nevertheless, many of these young people engage in self-injury once or twice, and then stop. Others become chronic self-injurers. Studies of self-injury in college populations suggest that about 6% of the college population are actively and chronically self-injuring, while many more have some history of self-injury (Whitlock, 2009).

The literature on self-injury prevalence and gender is varied. While some studies indicates it to be more common among females, other studies advocate that it is as prevalent in males as in females. The common understanding is that self-injury is much more visible among females than among males (Whitlock, J, & Knox,K. 2007).

(Walsh, 2006) wrote, mostly, for those unfamiliar with self-injury could assume that it is a suicide attempt or gesture. In fact, lack of suicidal intent is one of the defining characteristics of NSSI. Generally, Individuals, who self-injure generally, want to feel better, not end life However, Whitlock, J, & Knox,K,(2007) mentioned, it is important to note that individuals with a history of self-injury are at higher risk for suicide thoughts, gestures. Moreover, Study found that individuals reporting NSSI were nine times more likely to report having made a suicide attempt at some point in their life attempt at a later point in life.

(Yates, 2004) wrote, that self-injury shares many of the risk factors of other negative coping mechanisms, Such as history of child trauma and/or abuse (particularly sexual or emotional abuse), poor family communication, low family warmth, and/or perceived isolation

Melinda & Jeaanne (2014) Wrote, Certainly, Self-harm is a way of expressing and dealing with deep distress and emotional pain. As it may comprehends to those on the outside, hurting oneself makes feel better. “It is like slapping on a Band-Aid when what you really need are stitches. It may temporarily stop the bleeding, but it does not fix the underlying injury” (Melinda & Jeaanne, 2014 p.1).

1.2 Problem statement

When focus on the situation of Maldives, almost half of the population is adolescent age group.

Ibrahim, Sermsri, & Thepthien (2012), Study higlighted that, Every One in four Maldivians belongs to the 15-24 age groups. In number, they have increased from 45,000 in 1995 to more than 75,000 in 2006.6 the number of adolescents and youth in the Maldives has increased substantially in recent years, and is rapidly approaching 40% of the country's total population. The percentage of adolescents and young people between the ages of 15 and 24 have peaked in 2004, and now constitute to approximately 25% of the country's total population, while the 10 to14 years age group is increasing and has peaked in 2011 (Ibrahim, Sermsri, & Thepthien, 2012).

There is limited information available on self-mutilation or other mental health issues among adolescents. In this regard, Adolescent health issues including mental health was included in Health Research priority list by Ministry of Health and Gender. Since, No research on the subject has done, the only piece of official information that exists comes from the Global School Health Survey (2009). The survey found that Overall, in Maldives, 37.7% of students suffer from bullying. Likewise, 17% of students had forced sexual intercourse when they did not want to. Additionally, 15.8% of students most of the time suffer from loneliness. In addition, 14.8% of students felt so worried about something that they have sleeping difficulties (GSHS Report, Maldives , 2009).

Self mutilation is visible signs of hidden mental health problems. The reality is self mutilation became very common among adolescents of Maldives and it is often taken as dicipline issue in Schools. Unfortunately there is limited statistics availabel regarding this problem. Therefore it is important to investigate the factors associated with Self-mutilation among adolescent age group students in order to understand major mental

health issues they go through and to carryout proper intervention to prevent from further health risks of individuals. This study aimed to determine the prevalence of self-harm in NI adolescents and the factors associated with it

1.3 Research Question

What is the prevalence of Self-mutilation among adolescents of Male' Schools and the factors associated with self-mutilation.

1.4 Objectives

1- To determine the prevalence of non-suicidal self-harm in adolescents age 12-14 years

2- To determine how parental separation associates with self-mutilation

3- To determine disputes with sibling has any relation with self-Mutilation

4- To identify the how parents attachment associate with Self-mutilation

5- To understand the prevalence of bullying among students self-mutilation

6- To understand the relationship between demographic characteristic and self-mutilation

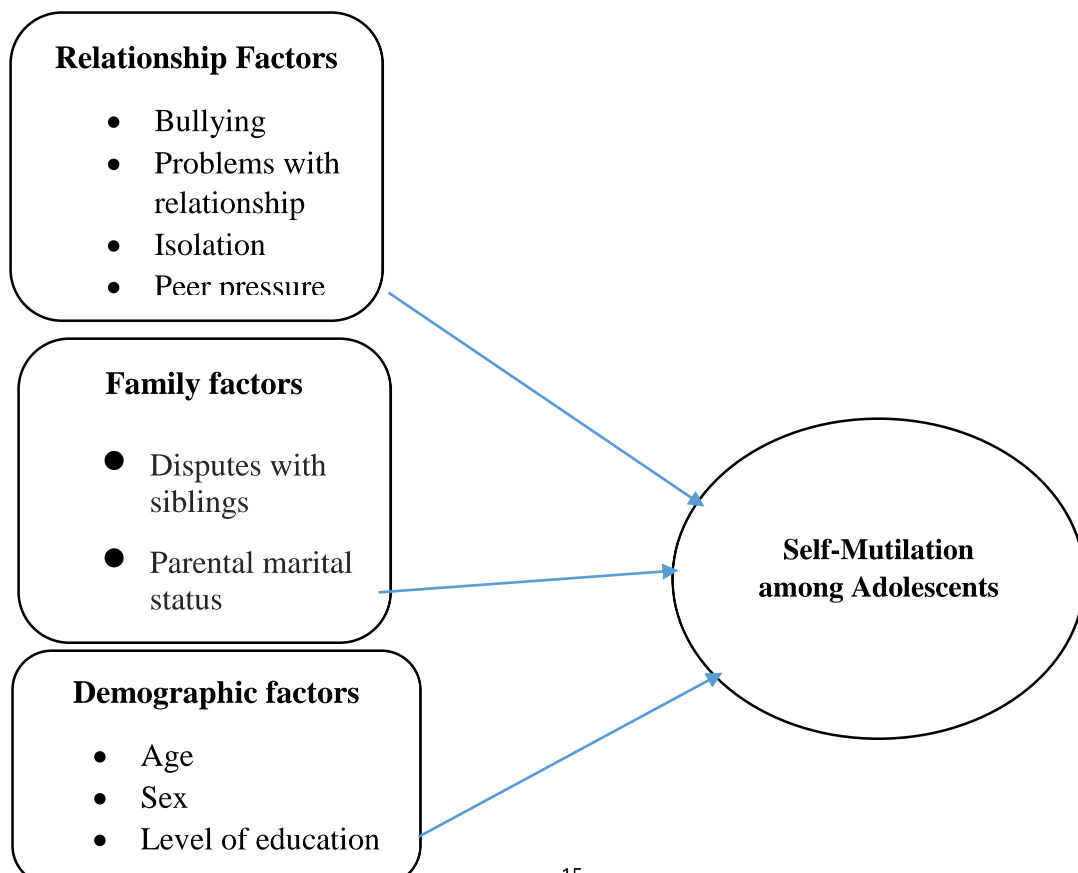
1.5 Significance of the study

Self-injurious behaviours among adolescents are eliciting increased attention and concern around the world. Research shows that self-injury is associated with a range of psychiatric difficulties, significantly associated with increased suicidality. This study could be an important tool to understand the current mental health status of the Adolescent age group of Male school as Male is the most densely populated city in Maldives as well as the issues regarding violence and many crimes occur in Male. It is vital to understand what actually the youth and adolescents experience at schools because School play important role in setting individual student's personality. Schools can be a reason of a student's life to end. Sadly, there is no solid evidence to address the issues of self-mutilation in schools. However, the truth is this behaviour happens at

schools, schools are not very aware of the magnitude of the problems, and they are not aware of how to react on such situation. Instead of looking in to the reasons of the behaviour, often students who self-harm become as discipline case. Therefor this study can be evidence to sensitize the Schools, parents and the society regarding the underline mental health issues of the behaviour and to find proper interventions to prevent it. Therefor it will be useful to implement further policies regarding adolescent's mental health issues. Besides that with the recommendation of the study, Schools can develop guideline, protocol, and policies regarding Self-Mutilation, as a result School could be a protective factor for students who suffer from mental health issues.

1.6 Theoretical Framework

The development of NSSI and its relationship with other variables could assume through an examination of risk factors. Risk factors allow for the prediction of the probability of an outcome. Therefore this study aim to investigate the current literature related with the below listed risk factors.



1.7 Scope of the study

The study aim to find out the prevalence of self-mutilation among 12-14 years age group adolescents of Male schools and explore the risk factors associated with the self-harming behaviour and factors associated reason for the behaviour. The reason why the study focuses Male School is that Almost all the Atolls of the Maldives, represent at Male School so that the study can show result of broader picture of the problem area. With the limitation of time, this study is not testing any hypothesis regarding the study area. The study also did not cover the qualitative data, only focuses on quantitative data due to time and resources

1.8 Abbreviations

NSSI: non-suicidal self-injury

SM: Self-Mutilation

SI: Self- Injury

DSH: Deliberate Self-harm

BPD: borderline personality disorder

CSA: child sexual abuse

1.9 Definition of terms

Adolescent: The transitional period between puberty and adulthood in human development

Self- mutilation: Self-mutilation, also called self-harm, is the act of deliberately harming your own body, such as cutting or burning own self without suicidal intend.

Peer pressure: The strong influence of a group, especially of children, on members of that group to behave as everyone else does

Bullying: Is unwanted, aggressive behaviour among school-aged children that involves a real or perceived power imbalance. The behaviour is repeated, or has the potential to be repeated, over time.

Parental separation: a situation in which a mother and father agree to live apart even though they are still married or divorced

Neglect: type of maltreatment related to the failure to provide needed, age-appropriate care

Siblings: One of two or more individuals having one or both parents in common; a brother or sister

Parental Attachment: Attachment is one specific aspect of the relationship between a child and Parent that is involved with making the child safe, secure and protected

Coping strategies: Coping strategies refer to the specific efforts, both behavioural and psychological, that people employ to master, tolerate, reduce, or minimize stressful events

Dysfunctional families: is a family in which conflict, misbehaviour, and often child neglect or abuse on the part of individual parents occur continually and regularly

CHAPTER 2: REVIEW OF LITRATURE

Although in current research, on non-suicidal self-injuries (NSSI) and suicidal behaviour been differentiated by intention, frequency, and fatality of behaviour, researchers have also revealed that these two types of self-injurious correlated behaviour. Other than the reasons of NSSI and suicidal behaviour, however, little attention has given as to find why these self-injurious behaviours linked. To address wide-range of area of the research on self-mutilation and its risk factors associated with the behaviour, theory of risk factors will be explored by current research, which addresses potential risk factors in NSSI. The main areas to be address is demographic factors, Family factors, parent's marital status, Attachment; Parent-child relationships characterized by a secure attachment allow the developing child to feel worthy of trust and care, relationship of siblings and issues regarding peer relationship, which includes peer pressure, bullying and how these factors are associated. Lastly, the chapter will conclude by presenting the major aims and objectives of the current program of research

Non-Suicidal Self-Injury (NSS): Definition and Brief History

Simpson (2001) cited that numerous definitions of this problem area occurrence exist. However, the term, self-harm, self-injury and self-mutilation are frequently used collectively. Some researchers have characterised self-mutilation as a form of self-injury. Self-injury is considered as any form of self-harm that involves inflicting injury or pain on one's own body.

In addition to self-mutilation, examples of self-injury include, hair pulling, picking the skin, etc. Moreover, Favazza, A.R & Rosenthal, R. J, (1993) wrote, as uncontrolled self-mutilation as the deliberate destruction of body tissue without suicidal intent. A common example of self-mutilating behaviour is cutting the skin with a knife, razor until pain sensed or blood has been drawn. Burning the skin with an iron, or more commonly with the ignited end of a cigarette, is also a form of self-mutilation (Favazza, A.R & Rosenthal, R. J, 1993).

As deviations in understandings of NSSI varied over the time, the terms used to define the behaviour changed. Terminology has included for example, wrist-cutter syndrome, self-mutilation, self-injurious behaviour, para suicide, deliberate self-harm, self-carving, and self-cutting (MacPhee, 2011).

According to Richardson (2006), by deliberately hurting their bodies, young people often say they can change their state of mind so that they can cope better with 'other' pain they are feeling. They may be using physical pain as a way of diverting themselves from emotional pain. Others are conscious of a sense of release. For some, especially those who feel emotionally effected, they are often numb and cannot feel anything They will often try hard to keep what they are doing secret, and to hide their scars and bruises. However, the burden of guilt and privacy is difficult to carry, it can affect everything from what they wear to the kinds of sports and physical activities they take part in, as well as close physical relationships with others (Richardson, 2006). Likewise, Jonathan Clark (2011) wrote, some might do self-harm with the feelings of anger or hopelessness, and hit something or cut themselves to express their pain. Unexpectedly, when they cause injury they realise that they unusually feel better inside. Some may do self-harming by seen or hear from others and copy it. Others may try to cut their wrists as part of a suicide attempt, but by cutting themselves, they realise that they can get relief.

Some are drawn to self-harm through stress (school work is a major trigger for some teenagers). Yet others may find that self-harm gives them a sense of control over something in their lives. Self-harm can make “real” the emotional pain an individual cannot express, giving it an outlet. Moreover, Stanley, B, Gameroff, M. J, Michalsen, V, & Mann, J. J (2001) wrote, Individuals who self-injure often have suffered sexual, emotional, or physical abuse from someone within families such as a parent or sibling. This often results loss or disruption of the relationship. Often this behaviour is difficult to express or revealed because of the trust towards that particular person established in the family. In fact, superficial self-mutilation has been described as an effort to escape from intolerable or painful feelings relating to the trauma of abuse, which the child fails to express in other form. Consequently, cutting or disfiguring the skin serves as a coping mechanism. The review of literature focus some of the factors associated with Self-harm behaviour.

Coping strategies

Adults and adolescents with Non-suicidal Self injury frequently have, trouble managing emotions, unbalanced social relations, lack of coping strategies. They frequently experience anger, and their self-harm can result from turning this anger inward because they are unable to express it toward others.

Campbell (2008) mentioned, embarrassment is one of the factor, which can be a major barrier to diagnosing NSSI. Adolescents who are feeling guilty of the behaviour will hide it from others, including clinicians. In spite of the shame, many adolescents feel unable to stop engaging in NSSI because it fulfils a powerful need (Campbell, 2008). Similarly, Salters-Pedneault(2014) wrote, several consider that people engage in self-mutilation or self-injury is to get attention. In fact, most people who self-harm do it in

isolated and make sure that the area of the injury is not visible. They are also often ashamed of the behaviour and keep it a secret. This kind of privacy and shame about the behaviour indicates that it could certainly not meant to manipulate others or to gather attention. Yet, there might be people who report that they seek attention (Salters-Pedneault, 2014). Since Self-mutilation is not usually intended to die, one might consider the purpose of this behaviour, as way of expressing distress emotion, calling for help to avoid harming others. Researches indicate that self-harm mainly an emotion regulation strategy. Furthermore, Moı¨ra Mikolajczak, K. V. Petrides, & Jane Hurry, (2009) done a study to understand the relationship between adolescents choosing self-harm and emotion regulation strategy. The result showed that the relationship between trait Emotional intelligence and emotional coping was a particularly powerful mediator, signifying that self-harm maybe a way to decrease the negative emotions that are worsened by maladaptive coping style, such as ,self-blame, and helplessness. Emotional intelligence was correlated positively with adaptive coping styles and negatively with maladaptive coping styles, and depression. , (Moı¨ra Mikolajczak, K. V. Petrides, & Jane Hurry, 2009).

Gender

Often women are to be more vulnerable, specially psychological and emotional issues. AL, Barrocas; B, Hankin; JF, Young; JR, Abela(2012) study found that children engage in rates of NSSI surged affectedly from childhood into adolescence, especially for girls. Specifically, 3 times as many girls reported engaging in NSSI compared with boys. In addition, there were grade and gender differences in behavioural methods of NSSI engagement; older youth and girls report higher rates of cutting or carving their skin. In contrast, Ingrid Van Camp, Mattias Desmet, & Paul Verhaeghe (2011) found,

Gender ratio in the study, of young adults, found no gender differences in the lifetime rate of NSSI. This stands in contrast to the notable gender differences that found in the past. This could explained in two ways. The witnessed differences from the earlier could be research biases. In the past, data were mainly collected in psychiatric populations, where female patients tend to form a majority. Studies also focused almost absolutely on cutting as a method of NSSI. Since women used this method more often, this explains why NSSI assumed a womanly phenomenon. On the other hand, the study suggest that NSSI is indeed happening more often in men because of a traditional manly role pattern to more equality between the sexes. However, Navneet Kapur, et al.(2005) done a prospective cohort study for four years to analyse the risk of suicide after deliberate Self-Harm and the prevalence of gender. The study found that sixty suicides happened in the cohort during the follow-up period. Roughly, 30-times increase in risk of suicide, compared with the over-all population, observed for the entire cohort. Suicidal incidents found remarkably, higher for female patients than for male patients (Navneet Kapur, et al 2005).

Age

It is a time of speedy change. In a period of just a few years, teens changeover dramatically. Physically, they grow and start to look like mature adults. Tina In-Albon, Martina Bürli, Claudia Ruf, & Marc Schmid (2013) wrote, adolescence is a transition period from childhood to adulthood that often characterized by variability in body image, personality, and emotion. Key developmental matters in adolescence include independence and - separation from parents, and emotion regulation in physiological and relational development.

Consequently, adolescence can be measured a period of sensitive stress and increased occurrence of psychological problems. Klonsky*(2011) done a study for adult population (n=439) Among Self-injurers of United States. The study found Lifetime prevalence of NSSI was 5.9%, including 2.7% who had self-injured five or more times. The average age of onset was 16 years (median 14 years).This indicates that adolescent age is more prone to indent NSS. Likewise, MacPhee (2011) published thesis "The First Episode of Non-Suicidal Self-Injury and Risk Factors for Age of Onset". The study results indicated a mean age at first episode of NSS was at the age of 14-15 years, and a majority response for participants" home as the location of the first episode. In utmost cases, NSS has start during adolescence and the probability of onset decreases during adulthood. The study also highlighted, younger age of onset of Self Harm has greater risk of reoccurrence of Self-harm behaviour (MacPhee 2011).

Parental Separation and dysfunctional families

Acoording to Prinstein MJ, Prinstein, Julie Boergers, Anthony Spirito, Todd D. Little, & W. L. Grapentine (2010) Study, carried out for 96 psychiatric inpatients (32 boys, 64 girls) examined models of suicidal ideation severity that include two psychosocial risk factors (ages 12 to 17,) who were hospitalized because of concerns of suicidality. Adolescents completed a structured diagnostic interview, measures of suicidal ideation, and several dimensions of family and peer functioning. Results supported a model in which greater levels of perceived peer rejection and lower levels of close peer support could directly related with more severe suicidal ideation. In addition, indirect trails included different peer relationship and family dysfunction related to suicidal ideation via substance use and depression symptoms.

Parental relation plays huge role in developing resilience in a child, as it is an essential protective factor for children. Furthermore, according to Jean-Franccois Bureau, Jodi Matin, Alexane Alie Poirier, Nathalic Freynet, Marie France Lafontaine, & Paula Clountier (2009) findings, family experiences are influential in the development of non-suicidal self-injury (NSSI). The study found, significant differences for the relationship dimensions between the two groups. The result of the study emphasize the need to acknowledge the role of parent–child relationships in prevention programs and intervention models for NSSI. Furthermore, Gunilla Ringbäck Weitoft, Anders Hjern, Bengt Haglund, & Måns Rosén (2003) population based survey found, Children with single parents indicated greater risks of psychiatric disease, suicide or suicide attempt, injury, and addiction. Children in single-parent households had increased risks compared with those in two-parent households for psychiatric disease in childhood. Boys in single-parent families were more likely to develop psychiatric disease and narcotics-related disease than were girls, and they had a raised risk of all-cause mortality. Family separation and dysfunctional families could be a major risk factor for self-mutilation among adolescents in Maldives.

Lisa H, Glassman,Mariann R, Weierich, Jill M, Hooley,Tara L, Deliberto,Matthew K, & Nock (2007) wrote, NSSI, in which we predicted that critical parenting, would contribute to NSSI via its negative impact on parental representations, as reflected by increased feelings of distancing toward parents. Furthermore, Kaat Ponnet, Robert Vermeiren, Ine Jespers, Belo Mussche, Vladislav Ruchkin , Mary Schwab-Stone, & Dirk Deboutte (2005) also found, Boys living in a single parent family reported more suicidal ideations and self-harming behaviour than boys living in an intact family or in a remarried family.

However, the interesting fact found in this study was, Girls living in a remarried family reported more suicidal ideations and self-harming behaviour than girls living in an intact or in a single parent family.

Parental Attachment

Parent child relationship is important protective factor for a child's mental health wellbeing. Secure attachment with parents prevents adolescents to expose to risky behaviour. Likewise, Hilt, et al (2008) found a significant effect of affection on NSSI among a sample of 508 participants from grades 6, 7, and 8. The researchers found that those participants who reportedly engaged in NSSI described poorer parental bonding when compare to those who did not reportedly engage in NSSI. According to Bureau, J.-F, Martin, J, Freynet, N, Poirier, A. A, Lafontaine, M.-F, & Cloutier, P (2010) findings, the major differences between Self-mutilation and comparison group on parental attachment measures. Those who engaged in Self-harm reported poor protection, fear, overprotection from parents and isolation, as well as lack of trust, and communication, in comparison to those that reported no history of Self- harm. Moreover, Tuppett M. Yates, Allison J. Tracy, & Suniya S. Luthar(2008) study results indicated that lack of attachment towards children leads and NSSI initiation. In this study, parental distancing found significant for the Self-mutilation for both genders as well as the frequency of the behaviour. Conflicting to the previous findings, Heath, N. L, Toste, J. R., Nedecheva, T, & Charlebois, A(2008), could not to discover significant change in attachment between those who informed engaging in NSSI and those who did not. The authors suggested that this finding might reflect the low educational performance associated with their results, as well as the low severity of NSSI behaviour among the sample.

Bullying

L. Arseneault*, & L. Bowes and S. Shakoor(2009) cited, bullying includes repetitive hurtful activities between peers where disproportion of power exists. Bullying is separate from other forms of violent behaviours by covering three elements. First, bullying occurs between individuals of the same age group. Bullying can take place between youths or between adults. When aggressive behaviour by adults towards children or adolescents, generally consider as maltreatment but not bullying. Second, the hurtful actions repeat over time so a pattern of dealings recognizes between the bullies and a victim. Third, the relationship between the bullies and a victim is considered by a power imbalance where it is tough for the victim to protect him- or herself. Physical strength, popularity and age are factors that characterize power imbalance between the bullies and their victim (L. Arseneault*, & L. Bowes and S. Shakoor 2009). According to, Helen L Fisher, Terrie E Moffitt, Renate M Houts, Daniel W Belsky, Louise Arseneault, & Avshalom Caspi (2012) bullying by peers is a major problem during the early school years. This study found that before 12 years of age a small proportion of children frequently exposed to this form of victimisation already deliberately harmed themselves and in some cases attempted to suicide. Frequent harassment by peers increased the risk of self-harm independently of a range of potential confounders. In addition, Nauert (2013) results of the study shows clear links between bullied at a young age and self-harm in teenage years. Often bullying occurs in schools, adolescents face unexpected level of situations, which make them low. Likewise, Kidger J, et al, Self-reported school experience as a predictor of self-harm during adolescence: A prospective cohort study in the South West of England, (2015) found, Students who feel isolated to school, hopeless at school, or feel that teachers are

discriminating are more likely to self-harm in the future. Poor school experiences were related to both suicidal and non-suicidal self-harm.

Besides, Hay C, (2010) found in a School based survey that, both types of bullying (cyber bullying and physical and verbal harassment) are positively related to self-harm and suicidal ideation. As a general conclusion, the authors of this study claim that stressed social relations are associated with negative emotions; these emotions are finally associated with intended self-harm. The impact of these relationships depends on other features of the adolescent's social environment and individual level factors such as self-control. Moreover, Studies show that bullying victimization affects not only adolescents at school but also young children before school entry. Therefor it is necessary for research and intervention programmes to focus on young children before or at school entry. Early studies on rebellious behaviour mostly piloted on groups of adolescents during the age period when it seemed to be most prevalent, until evidence suggested that these behaviours found their roots in childhood. In contrast with above-mentioned studies, Anu-Helmi Luukkonen, Pirkko Räsänen, Helinä Hakko, & Kaisa Riala,(2009) found No association of bullying behavior with suicide attempts or self-mutilation among boys in study. The Author highlighted the fact that there are several causes why in relationship of bullying behavior with suicidal behavior can be seen among girls, but not among boys.

Initially, in boys who are bullied do not certainly report being bullied as simply as girls, because boys might be more ashamed of being victims than girls. (Anu-Helmi Luukkonen, Pirkko Räsänen, Helinä Hakko, & Kaisa Riala, 2009)

Peer pressure

Adolescents often build dependency on their peers. They change their values, habits and beliefs according to the belonged peer group. Peer influence in generally very critical factor for adolescents mental health and wellbeing. Peer rejection, isolation, bullying leads numerous problems in school life for an adolescent. Researches has revealed that peer influence also has significant relationship with self-harm and peer pressure. In addition, Keren Michael & Hasida Ben-Zur (2007) found that risky deeds among male adolescents was mostly associated towards peer group, while for female adolescents relationships with parents was the noticeable factor in risk behaviour. The parental factor also contributed to the depressive mood of both genders in the sample. Nevertheless, depressive mood indicated only a weak relationship with risk taking. These results emphasise the differential associations of relationships with parents vs. peers among adolescent boys and girls, respectively, concerning risk-taking (Keren Michael & Hasida Ben-Zur 2007). Additionally, John M. Goldenring & Rosen (2004) wrote, the peer group is mostly vital in early and middle adolescence, when young people wants independence from their parents. This stage of life, they develop much of their identity and self-esteem from peer activities. The adolescence may have involve in a higher-risk peer group or begun to isolate from peers, signifying potential isolation and the accompanying risks of depression, anxiety, or some other acute stressor.

Especially concerned fact about adolescents who express being bored all the time is a warning sign for depression, which happens often in the adolescent years (John M. Goldenring & Rosen, 2004).

CHAPTER: 3 METHODOLOGY

This chapter includes the research methodology. It contains study design chosen; the study gives brief description about population and sampling; data collection techniques and tools; validity and reliability; data analysis and the ethical considerations regarding the study

A cross sectional descriptive study design utilizing a quantitative method to describe the prevalence and factors associated with self-mutilation among adolescents age 12-14 years of Male and Hulhumale' Schools. This design was chosen, as it would provide information on Self-harm behaviour among Schoolchildren.

3.1 Population and Sampling

Selected Sample for the study was Two School of Male, (Thaajuddeen School and Iskandar School) and Two Schools from Hulhumale' (Ghaazy School and Rehendhi School). This was School Based survey, carried on student age of 12- 14 years studying in Grade 6, 7, 8.The reasons for selecting Two schools in Male' and Two schools in Hulhumale was mainly for the sake of comparison among Male, and Hulhumale schools. The number of Secondary students in selected Schools are total Schools (n=1767). The recommended sample size by Rao soft sample calculator recommend (n=316). However, due to time and resource constrain, this study have drawn the sample of 150 students in Total. Students were taken from randomly selected class from each grade (Grade 6, 7, and 8). The selected classes were 6A, 7D, 8B2 of all of the four Schools. Sample size was distributed according to the number of the student in a particular School. Total number of students in age group 12-14 were, Iskandar School

712 students, sample number is 50 students. (6A Class, 17 students, 7D class, 17 and 8B2 class, 16 students). Thaajuddeen 466 students, sample number is 40 students(6A Class, 14 students,7D class, 13 and 8B2 class,13 students), Rehendhi School 296, sample number is 30 students(6A Class, 10 students, 7D class, 10 and 8B2 class, 10 students), and Ghaazy School 293 students. Sample number is 30 students (6A Class, 10 students, 7D class, 10 and 8B2 class, 10 students) class, 17students. To minimise bias, sample were taken randomly according to register order. (E.g., register first five girls and five boys). The selected four Schools represent almost all the islands students of Maldives.

3.2 Instrumentation

Self-administered questionnaire on Self Harm behaviour, which was adopted from previous published studies Self-administered questionnaire, was adopted from previous published studies inventory of statements about self-injury (Klonsky, 2009). Bullying questions were adopted from Prospective bullying questionnaire (Frieden, 2011)used as a survey instrument. The questionnaire includes questions on socio-demography, Types of Self-harm behaviour, the reason for self-harm, How they felt after self-harm. The questionnaire used for survey instrument was pretested prior to the data collection with a school counsellor and three general office staff, and pilot study done with 10 volunteered students of grade 6 and 7 of Rehendhi School on 2nd April 2015. The changes made according to the Identified issues like, one question not having an option for those who do not mutilate.

3.3 Data collecting procedures

The participants were aware of anonymity, information obtained would be confidential, and the survey would not affect their studies. The sample size of (N=150) students were taken from randomly selected class from each grade (Grade 6, 7, and 8) of the four government Schools where almost all the island of Maldives students represent. Prior to commencing the study, negotiated with the School management in order to get the convenient time for the School. A written consent form, given to parents with detail information, one-day prior to the data collection. Those refuse to participate their students, should give the consent form back mentioning that they do not want to participate. Assurance given to the students that information obtained would be confidential and their participation would not affect their studies. Although the targeted population size was 150, total three parents refused to participate their children in the study; therefor Response rate was 98%. The collected sample size was 147 students from four Schools.

3.4 Framework of data Analysis

The data will be analysis by using Microsoft Excel and Statistical Package for Social Sciences (SPSS) version 17. Descriptive statistics to analyse the frequency, mean, mode of variable. To analysis the association Chi square, correlation, and regression would be analyse.

CHEPTER 4: DATA ANALYSIS AND RESULTS

4.1 Percentage of Respondents of School

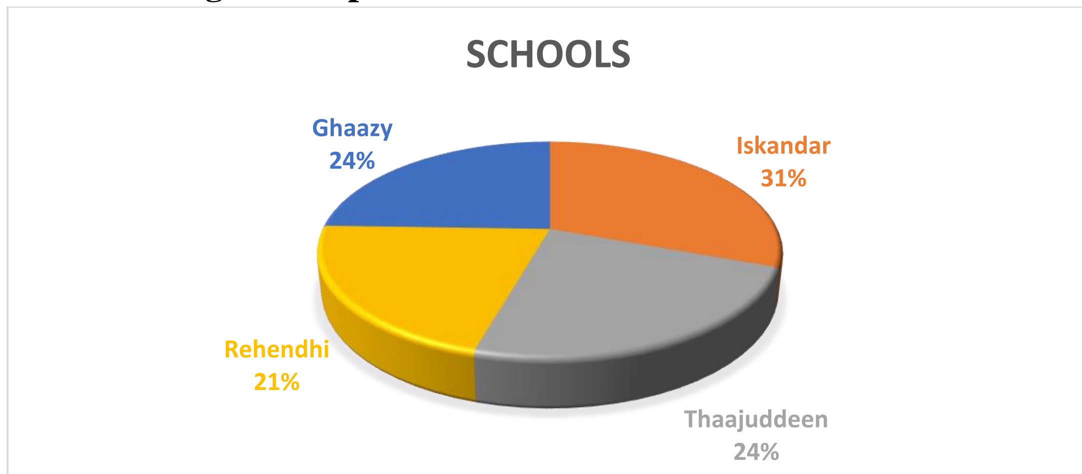


Figure: 4.1 percentages respondents in Four School

Figure 4.1 shows the percentages of respondents in Four School. Number and percentages of respondents in Iskandar School are 45(29%). Thaajuddeen School 35 respondents (23%). Rehendhi School 31 respondents (20%). Ghaazy School, 36 respondents (23.2%) Total number of respondents in this study was 147. The difference in percentages of respondent depended on the population size of the Schools.

4.2 Percentage of Age of respondents

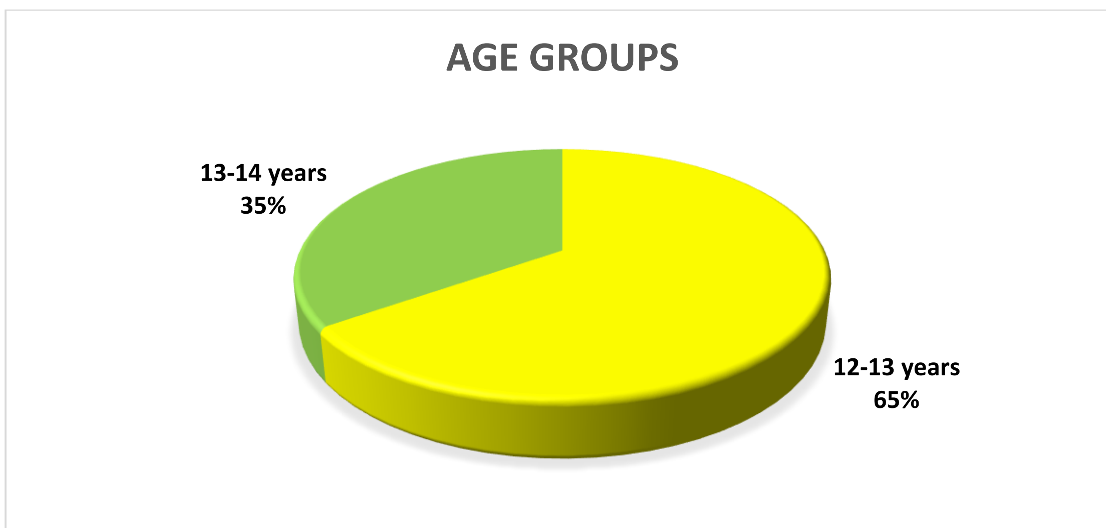


Figure: 4.2 percentages respondents' age group

Figure: 4.2 shows the frequency and percentages age group reprents the study. respondents(65.3%) were in the age group of 12-13 years. (35%) were in the age group of 13-14 years.

4.3 Frequency and percentage of Grade of respondents

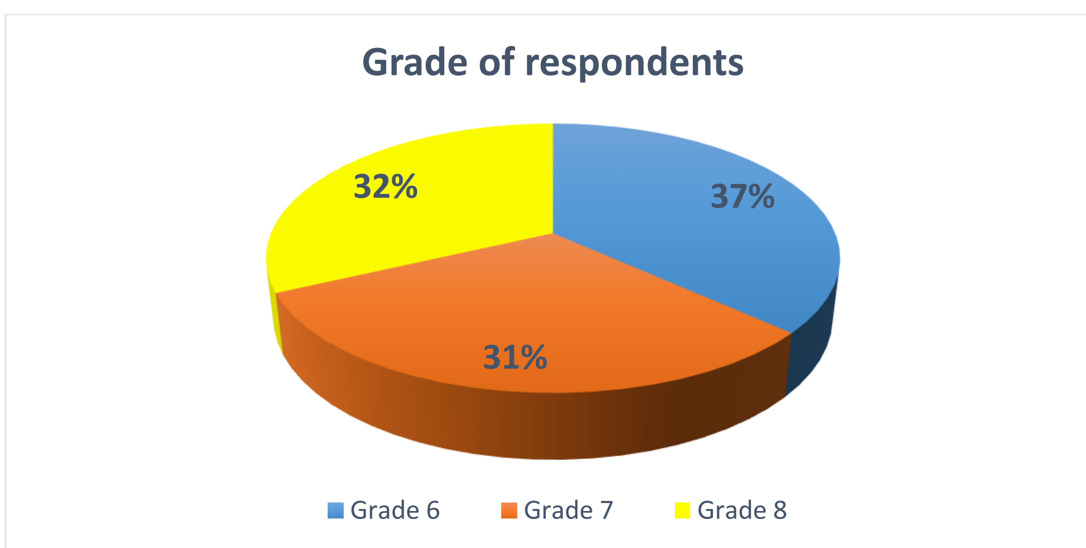


Figure 4.3: Frequency and percentage of Grade of respondents

F 4.3 shows the frequency and the percentage of respondents in different grades. Out of 147 (36.7%) are in grade 6. (36.3%) are in Grade 7 and (32%) are in grade 8.

4.4 Frequency and percentage of marital status of respondents

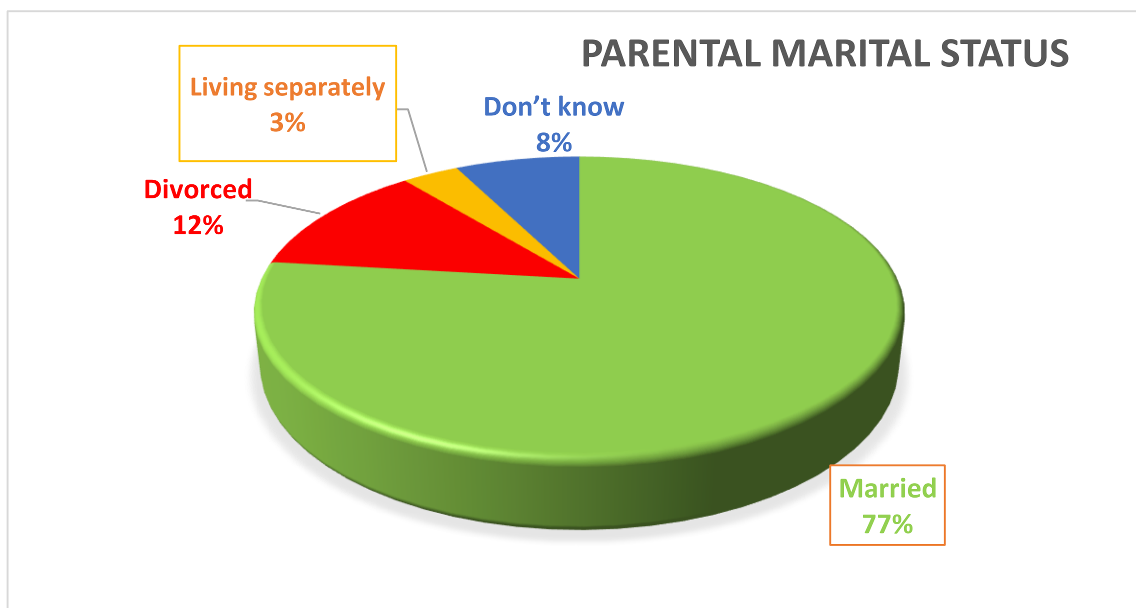


Figure: 4.4 frequency and percentages respondent's parental marital status

Figure 4.4 shows parental marital status of the respondents. Out of 147 students (77%) said their parents are married. (12.2%) said parents are divorced. (3.4 %) said parents are living separately and (7.5%) said they do not know their parent's marital status.

4.5 Frequency and percentage of whom the respondents liv with

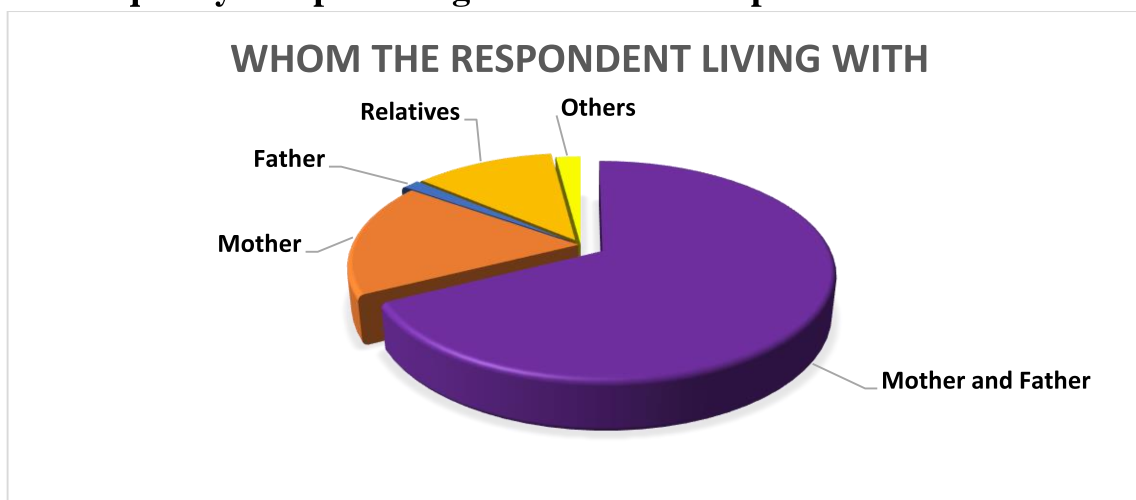


Figure: 4.5 frequency and percentages of whom the respondent living

Figure:4.5 shows(67%) said they are living with Mother and father. (17.2%) said they are living with mother only. (1.4%) said they live with father only. (12%) are living with relatives. (2.1%) said they living with other than above mentions reasons. The others column students has mentioned they live adopted guardian and cousins.

4.6 Frequency and percentages of respondents who has problems with siblings

Characteristics Problems with siblings	Frequency N=147	Percent
Not at all	68	46.3
Sometimes	62	42.2
Most of the time	17	11.6

Table 4.1: frequency and percentage of respondents with problems of sibling.

Table 4.shows, 68 students (46.3%) responded, as they do not at all have problems with siblings. 62 students (42.2%) said sometimes they have problems and 17 students (12%) said Most of the time they have problems with their siblings

4.7 Frequency and percentages of respondents with friends at School

Characteristics Friends at School	Frequency N=147	Percent
Yes	145	98.6
No	2	1.4

Table 4.2: frequency and percentage of respondents with friends at School.

Table 4.2 shows frequency and percentages of respondents with friends at school.145 students (99%) said they have friends. Only 2 students (1.4 %) said they do not have friends at all.

4.8 Frequency and percentages of person in the family to share when feel upset

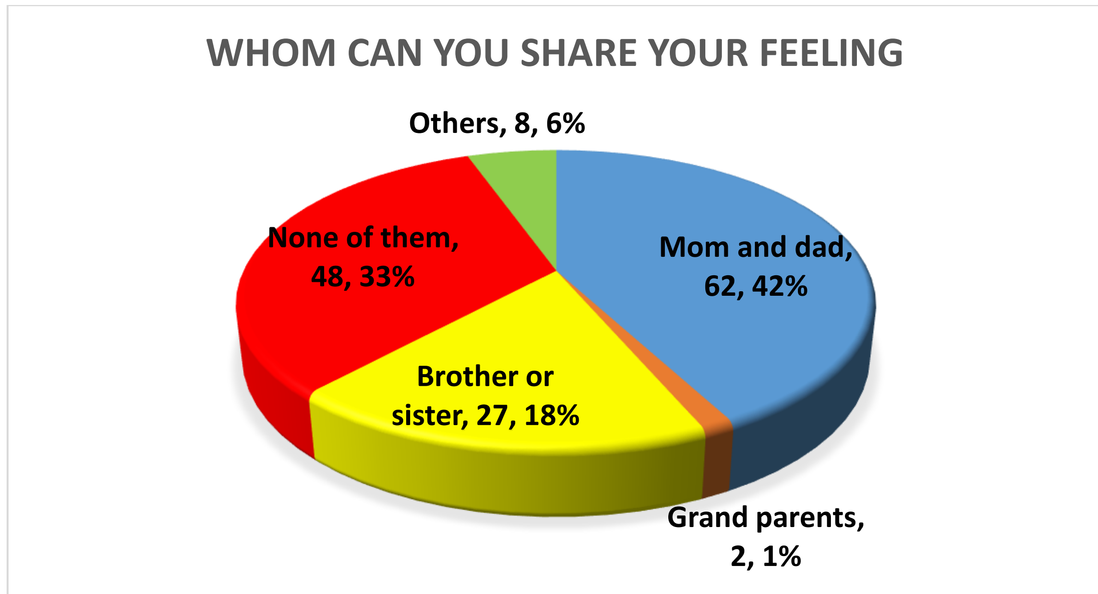


Figure 4.6: frequency and percentage of person who could be shared feelings

Table 4.8 shows the family relationship with the respondents. It shows the protective factors for the students in the family when they feel upset or emotionally down. 62 students (42%) said they could share their feelings with their mom and dad when they feel upset. Only 2 students (1.4%) said they share with their grandparents. 27 students (18.4%) said with brother or sister. However, 48 students 33% said they do not share anyone in the family.8students (5.4%) said they share their feelings with others. Students have specified others as cousins in the family.

4.9 Percentages types of bullying

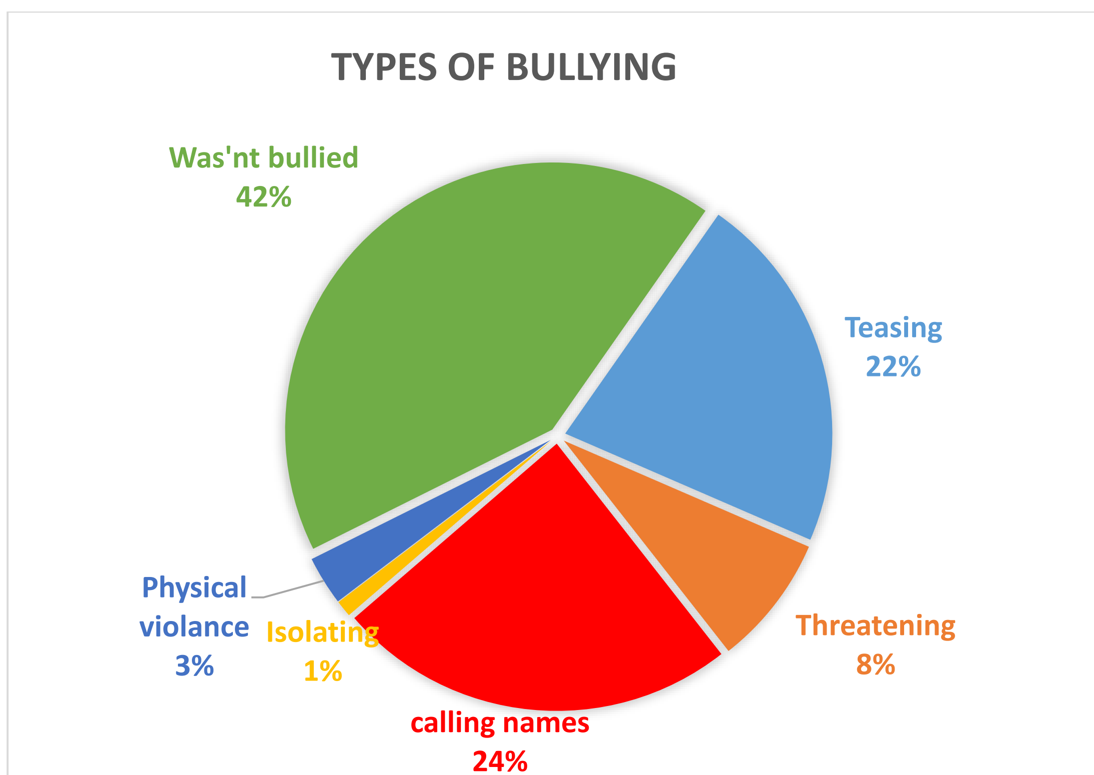


Figure 4.7: frequency and percentage of types bullying

Figure 4.7 shows the types of bullying incidents occur in the School.(22%) said they are bullied by teasing.(24%)said by calling names.(8%)said by threatening.(3%) said by threatening.(1)% said by isolating and (42%) said wasn’t bullied.

4.10 percentages respondents by who bullied

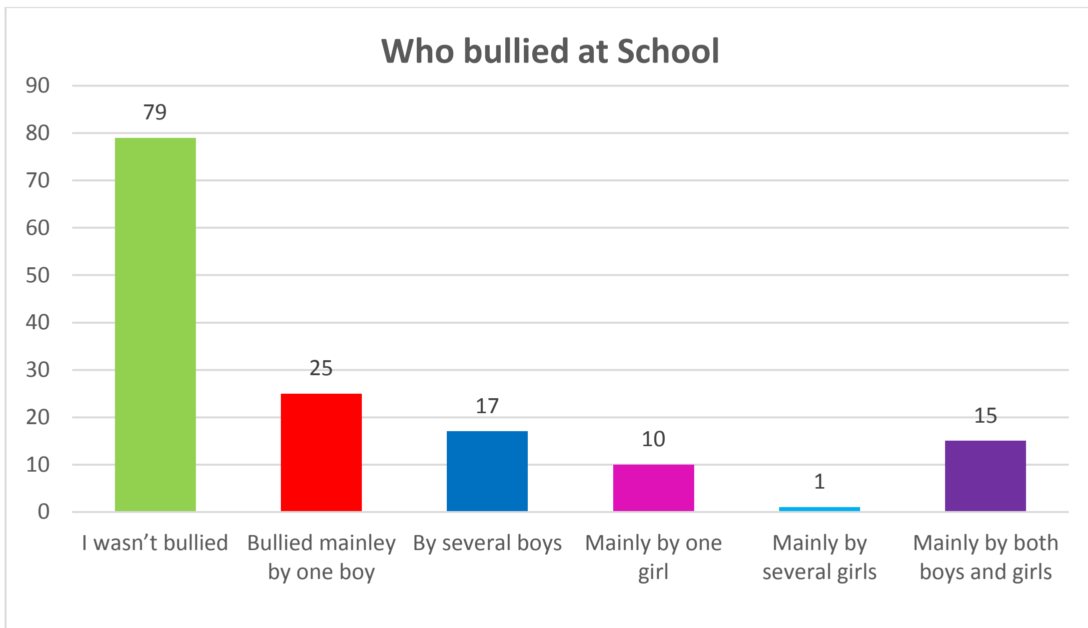


Figure: 4.8 percentages respondents by who bullied

figure 4.8 shows 79 students(54%) responded as they wasn't bullied. 25students(17%) said they were mainly bullied by one boy. 17 students(12%) said they were bullied by several boys. 10 students(7%) said they were bullied by mainly several girls.only 1 student said by several girls and 15 students(10.2%) students said they were bullied by boys and girls.

4.11 Frequency and percentages seriousness of bullying

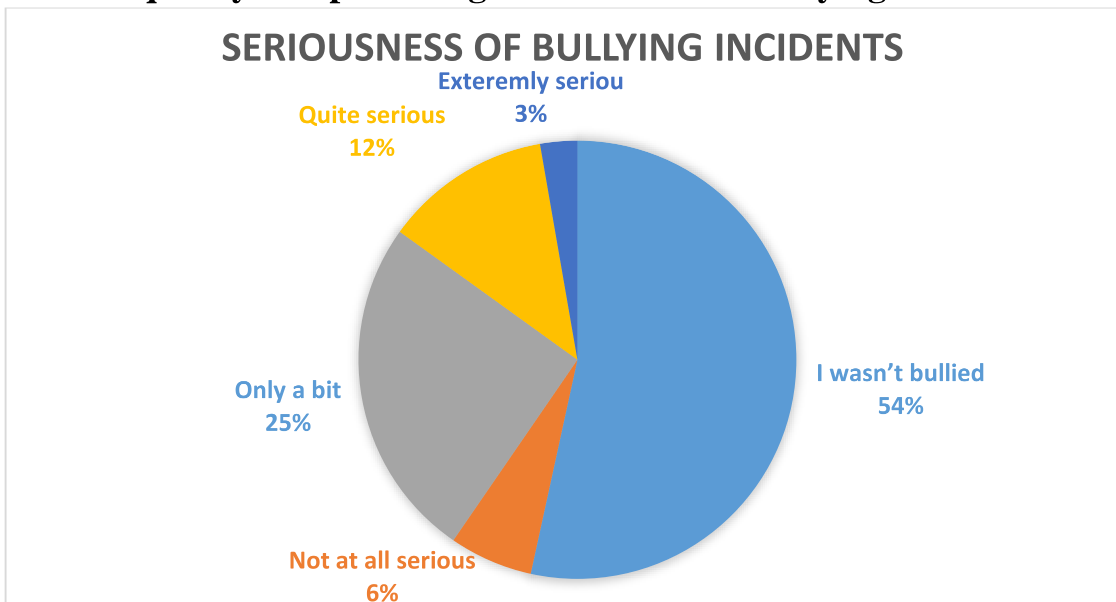
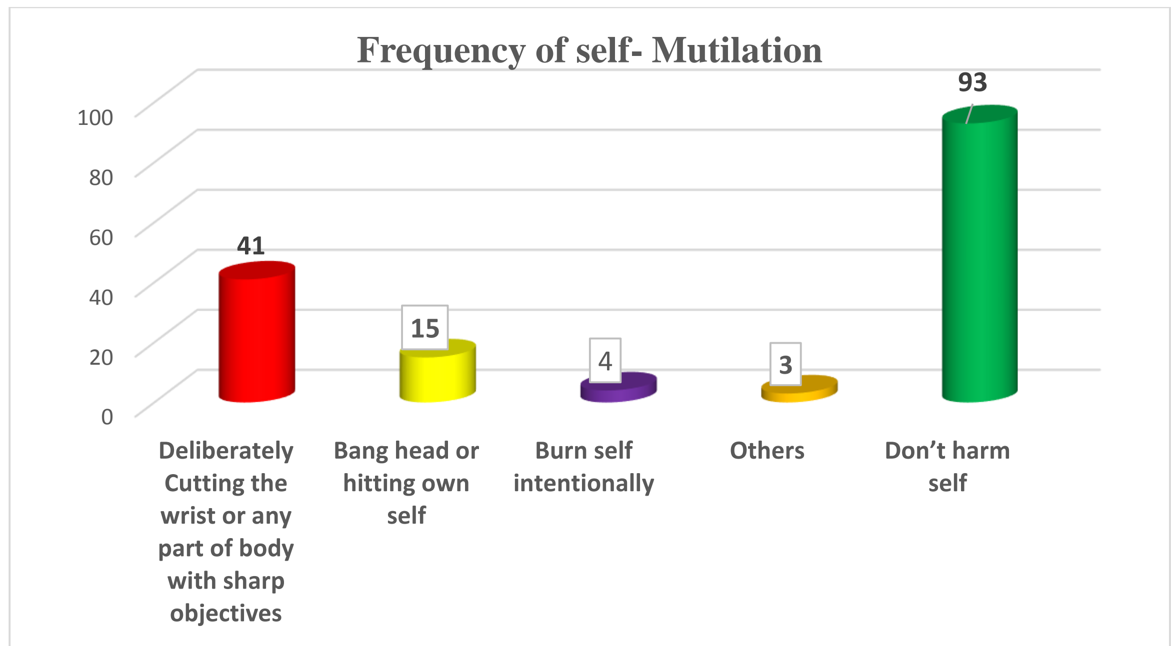


Figure: 4.9 frequency and percentages seriousness of bullying incidents

Figure 4.9 shows (54 %) said they wasn't bullied. (6 %) said they did not consider bullying incidents were not serious at all. (25%) said it is bit serious. (12.2%) said it is quite serious and (2.7%) said bullying they consider the incidents as extremely serious problems.

4.12 Frequency and percentages of Self-mutilation and other deliberate self-harm



***Multi response Question**

Figure 4.10: frequency and percentage Self-mutilation and other deliberate self-harm

Out of 147 respondents 41 (28%) said they cut their wrist with cutter or other sharp objectives. 15 students (10.2%) said they deliberately hit or bang their head. 4 students(2.9%) said they intentionally burn themselves.

4.13 Frequency and percentages of Respondents who felt pain during self-mutilation

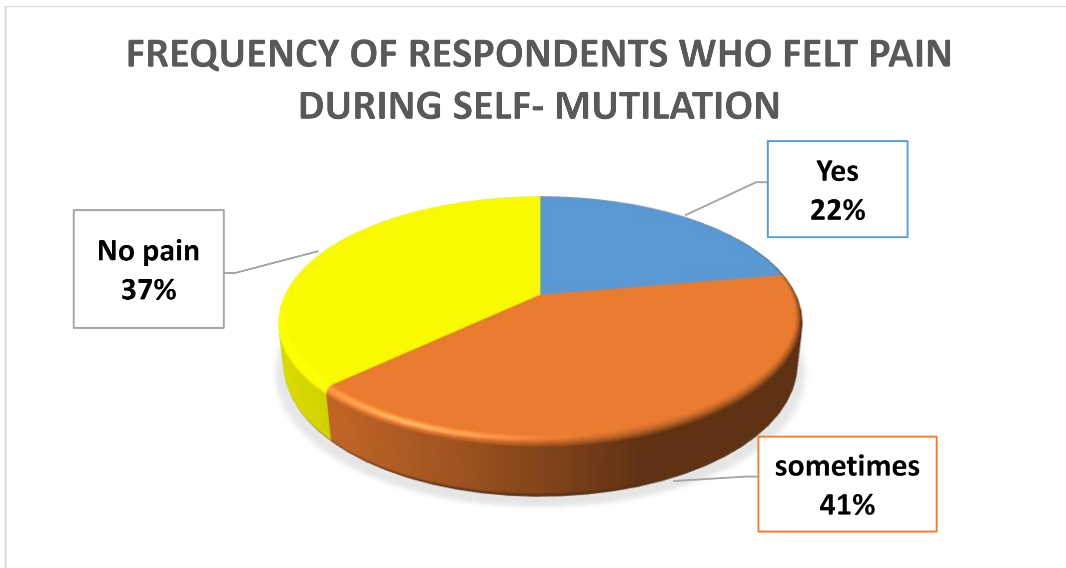


Figure 4.11: frequency and percentage respondents who felt pain during self-mutilation

Figure 4.11 shows the frequency and percentages of respondents who felt pain during self- mutilation. Out of 54 respondents who do self-mutilation, (22 %) said they felt pain while cutting the write or any part of the body. (41%) said they sometimes feel the pain and (37%) said they do not feel pain while they cut their wrists.

4.14 Frequency and percentages of Respondents who were alone when self-mutilate

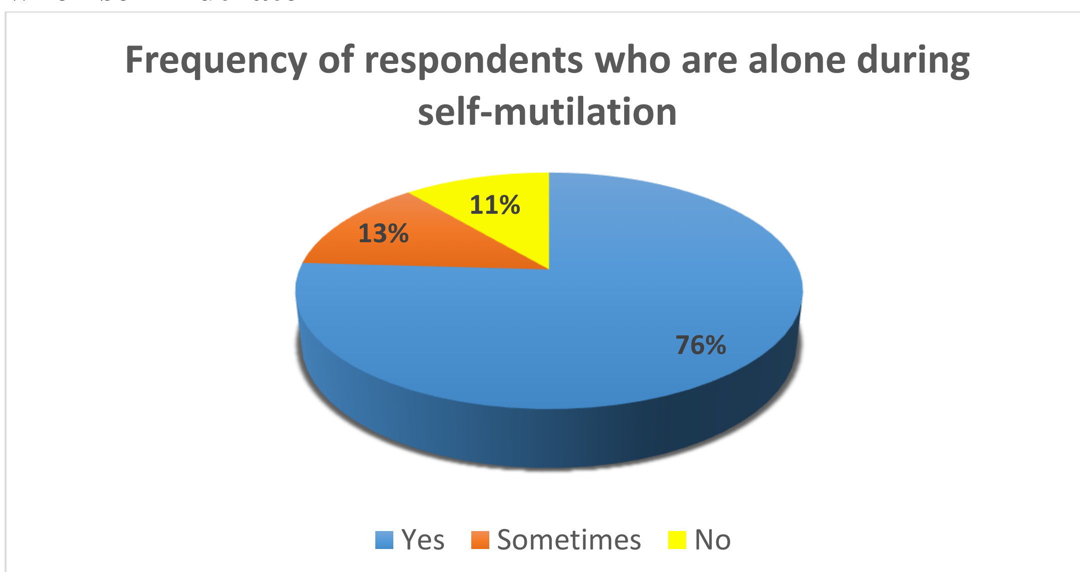
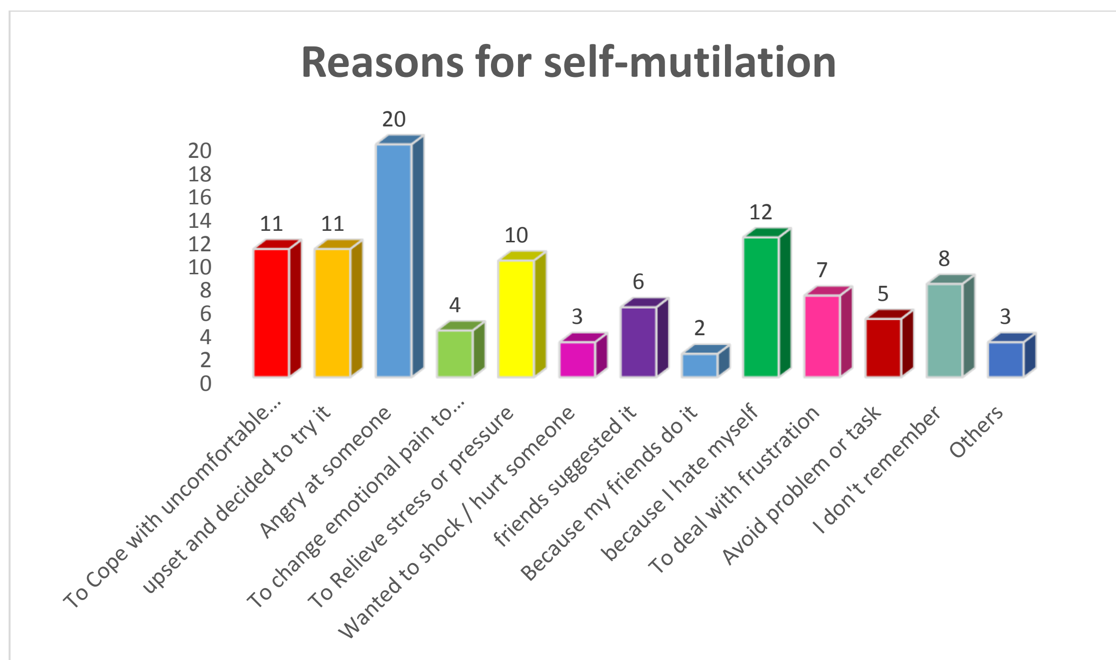


Figure 4.12: frequency and percentage respondents who were alone during mutilation

Out of 54 respondents who self-mutilate, 41(76%) said they were alone when they mutilate. 7 students (13% said sometimes they were alone and 6 students (11%) said they were not alone when they cut or mutilate.

4.15 Frequency and percentages of respondent's reason for self-mutilation



***Multi response Question**

Figure 4.13: frequency and percentage of reasons for self-mutilation

Table 4.14: shows out of 54 respondents who mutilate, most frequently responded reason was, 20 students (37.3%) as they were angry with someone. 12 students (22.2%), responded, as I hate myself. (20.3%) upset and tried it (20.3%) to cope with uncomfortable feeling. 10 students (19 %) said to relieve stress or pressure. Other reasons they have mentioned, "My past" and "got low marks".

4.16 Frequency and percentages of how respondent feel after self-mutilation

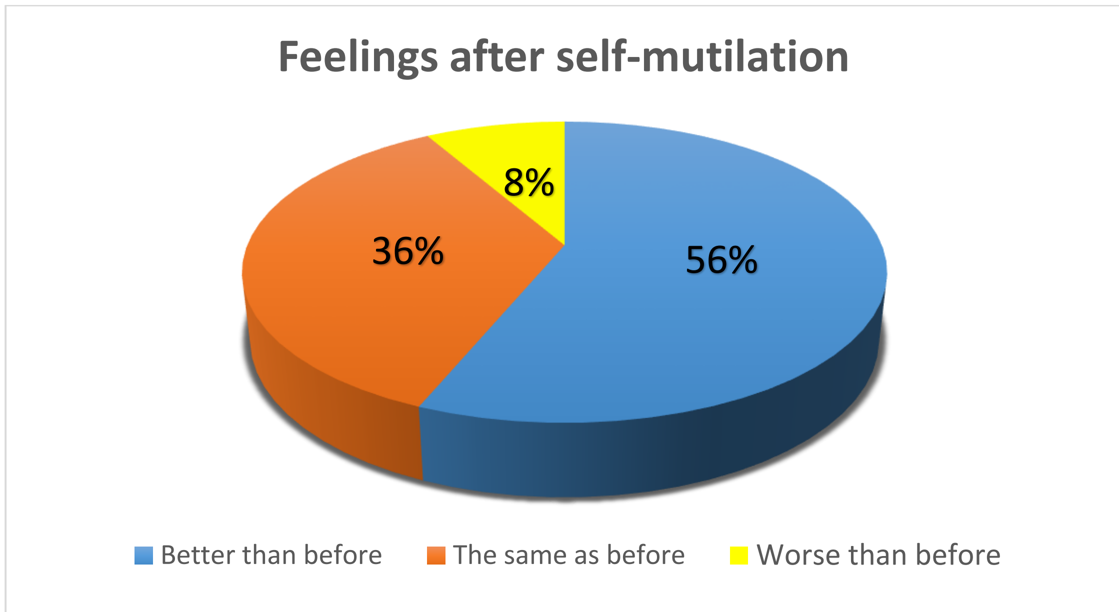


Figure 4.14: frequency and percentage of how respondents felt after self-mutilation

Figure 4.14 shows how the respondents feel after self-mutilation. Out of 48 respondents, who mutilate or deliberately harm (56 %) said they felt better, (35.4%) said they felt the same as before. Only (8.3%) said they felt worse than before.

4.17 Frequency and percentages of how respondent who feels life is not worth living

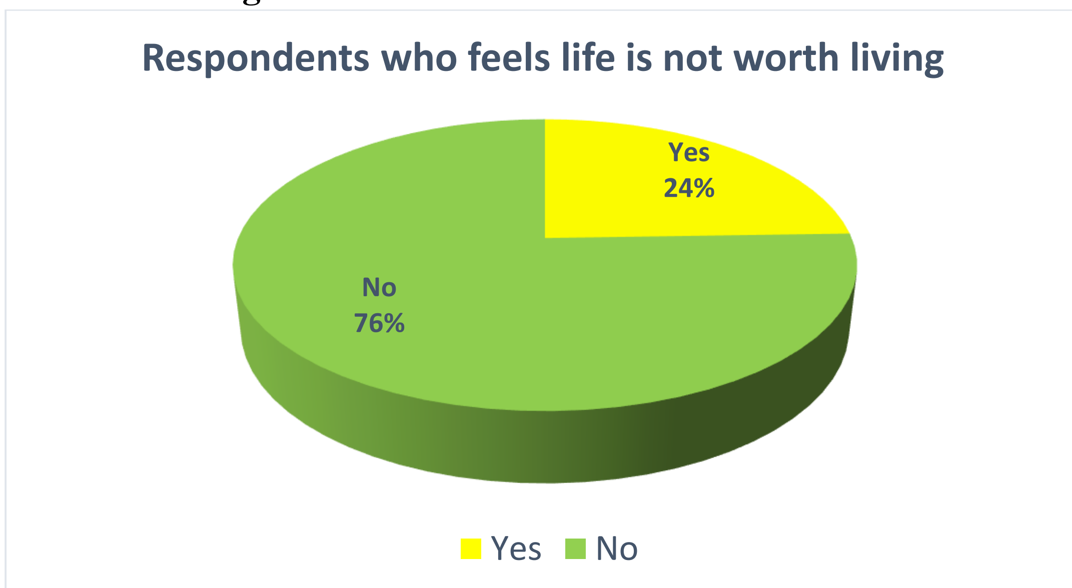


Figure 4.15: frequency and percentage of respondents who feels life is not worth living

Figure 4.15 shows the percentages of respondents who felt life is not worth living. (24%) said "yes" life is not worth living. (76%) said" no" life is worth living.

4.18 Frequency and percentages of respondents who have seen self-mutilation by known person

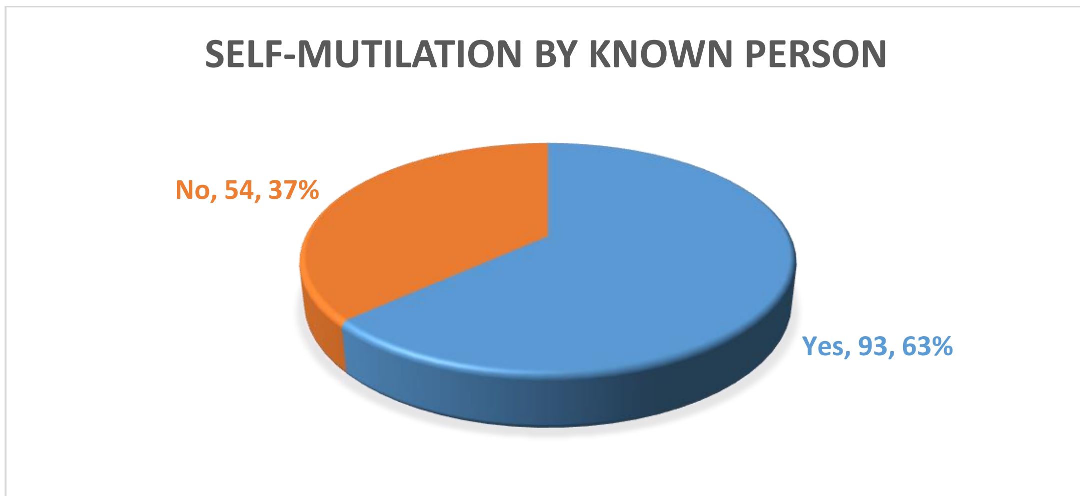


Figure 4.16: frequency and percentage of respondents who have seen self-mutilation by known person

Figure 4.16 shows the frequency and the percentages of respondents who have seen self-mutilation by known person. 93respondents (63%) said they have seen self-mutilation by someone they know. 54 respondents (37%) said they have not seen by anyone they know.

4.19 Percentages of respondents who wants to stop self-mutilation

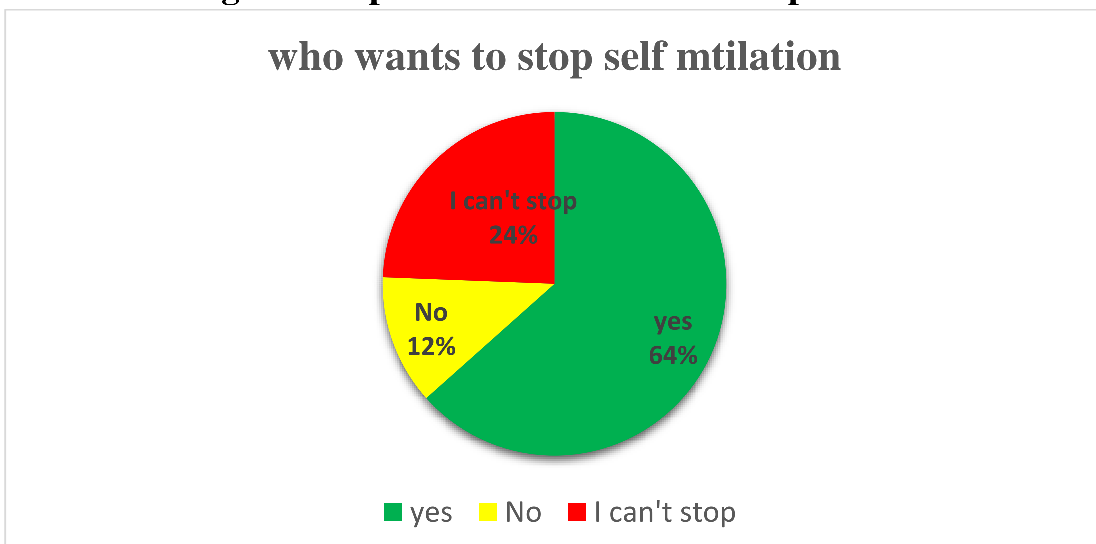


Figure 4.17: frequency and percentage of respondents who wants to stop self-mutilation

Figure 4.17 shows 0ut of 41 respondents who mutilate, (64%) said they want to stop. (12 %) said they do not want to stop and (24%) said they could not stop mutilation

4.20 Frequency and percentages of respondents who ever seriously wants kill oneself or suicidal ideation

Characteristics **Have you ever seriously wants to kill yourself**	**Frequency** **N=147**	**Percent**
Yes	17	52.4
No	130	46.3

Table 4.3: Frequency and percentages of respondent's who ever seriously kill onself or sucidal ideation

Table 4.3 shows the frequency and percentage of students who ever seriously wants kill oneself. 17students (52.4%) Said they have seriously wanted to kill themselves. 130 students (46.3%) said they have never wanted to kill themselves.

4.21 Association between parental marital status and Self-mutilation

Variable	**Self-mutilation**			**Crude OR**	**95% CI**	X^2	**p-value**
		Yes (%)	**No**				
Marital status					1.030 8 to 4.911	4.25	<0.039*
Married Yes		18 (12.4%)	74 (51%)	1			
Married No		37 (25.5%)	16 (11%)	2.25			

*P-value = <0.05

Table 4.4 Association between parental marital status and Self-mutilation

Table 4.4 shows the association with parental marital status and self-mutilation. It shows Chi square value 7.41 Odds ratio2.25 and P value< 0.039. Which indicated there is significant association between Self-mutilation and parental marital status. There is 2.25 times higher chances for those whose parents are separated than those whose parents are married and living together.

4.22 Association between Bullying and self-mutilation

Variable	Self-mutilation			Crude OR	95% CI	X^2	p-value
	n	Yes (%)	No				
Bullying					1.12- 4.44	5.293	0.021*
Yes		34 (23.8 %)	37 (25.9 %)	2.23			
No		21 (14.7 %)	51 (35.7 %)	1			

*P-value = <0.05

Table 4.5 Association between bullying and Self-mutilation

Table 4.5 shows significant association with bullying and self-mutilation. P value is 0.021 with confidence interval of 1.12 to 4.44. Those who are bullied 34(23.8%) mutilate themselves. And those who are not bullied but mutilate is (14.7%) Those who have being bullied, have 2.32 times higher chances for self-mutilation.

4.23 association between self-mutilation and wanted to die or suicidal ideation

Variable	Self-mutilation			Crude OR	95% CI	X^2	p-value
		Yes (%)	**No**				
Wanted to kill self					0.04- 0.21	25.82	0.00*
Yes		16 (11%)	1 (0.7%)	3.08			
No		39 (26.9%)	89 (61.4%)	1			

*P-value = <0.05

4.6 association between self-mutilation and wanted to die or suicidal ideation

Table 4.6 shows very high association between self-mutilation and suicidal thoughts and ideation. The question was “have you ever seriously wanted to kill yourself”. Of those who do not mutilate and wanted to kill, oneself is only one (0.7%) said” yes “they want to kill. However, those who mutilate and wanted to kill self is 11(16%). The analysis shows, P value 0.00 and chi square value is 25.8 with confidence interval of 0.04-0.21. Crude odd ration is 3.08, which indicated those who self-mutilate have 3 times higher chances of wanting to die or suicide.

4.24 Frequency and percentages of Self-mutilation among four Schools

Schools			Mutilation		Total
			No	yes	
School	Iskandar	Count	28	17	45
		% of Total	19.30%	11.70%	31.00%
	Thaajuddeen	Count	19	15	34
		% of Total	13.10%	10.30%	23.40%
	Rehendhi	Count	19	12	31
		% of Total	13.10%	8.30%	21.40%
	Ghaazy	Count	24	11	35
		% of Total	16.60%	7.60%	24.10%
Total		Count	90	55	145
		% of Total	62.10%	37.90%	100.00%

Table 4.7 Frequency and percentages of Self-mutilation among four Schools

Table 4.7 shows the frequency and percentages of Self-mutilation among Four schools. Iskandar School 17 students (12%) Thaajuddeen School 15 Students (10.3%). Rehendhi School 12 students (8.3%) Ghaazy School 11 students (8%).

CHAPTER 5: DISCUSSION AND CONCLUSION

5.1: Discussion &Summary of findings

The purpose of the study was to investigate the prevalence and factors associated with deliberate self-harm or self-mutilation among adolescents of (Grade6, 7, 8) students of Male' and Hulhumale' Schools. Total sample (n= 147) was drawn from Iskandar school (N=45) Thaajuddeen School (N-=35) Ghaazy School (N=36) Rehendhi School (N=31). The objectives of the study was to determine the prevalence of non-suicidal self-harm among adolescents age 12-14 years and to investigate the relationship between gender, parental marital status, problems with siblings, and bullying with self-mutilation.

The result shows prevalence of self-mutilation is (28%). Other deliberate self-harm includes, (10.2%) banging head intentionally and 2.7%) Burn self intentionally. The reason for self-mutilation shows Angry at someone (13%), I hate myself (8%), and upset and tried it (7%) and to cope with uncomfortable feeling (7%). Other reasons include "My past" and "got low marks". The study found the frequency and percentages of Self-mutilation among Four schools. Iskandar School 17 students (12%) Thaajuddeen School 15 Students (10.3%). Rehendhi School 12 students (8.3%) Ghaazy School 11 students (8%).Compare to Hulhumale Schools, Male Schools have 6% high prevalence of Self-mutilation. However, it would be difficult and might be bias to justify students who live in Male Schools are more prevalent than those who live in Hulhumale without investigating the in-depth study social condition and without controlling other confounders. There is need for further study to investigate this aspects.

One of the associated factor found in this study was parental marital status. Gunilla Ringbäck Weitoft, Anders Hjern ,et al(2003) population based survey found,

Children with single parents indicated greater risks of psychiatric disease, suicide or suicide attempt, injury. Another study by Hilt, et al (2008) found, those who reportedly engaged in Self-mutilation described poorer parental bonding when compare to those who did not reportedly engage in Self-injuries.

Similarly, this study shows significant association between self-mutilation and parental marital status. The result shows Odd ration2.25. Which indicated students whose parents were separated has 2.25 higher chances of self-mutilation than those whose parents are married and living together.

The other association found in the study was bullying in Schools. There was significant association between bullying and self-mutilation. Study result shows significant association with bullying and self-mutilation. P value of 0.021 with confidence interval of 1.12 to 4.44. Those who are bullied 34(23.8%) mutilate themselves. In addition, those who are not bullied but mutilate is (14.7%). Those who have being bullied, have 2.32 times higher chances for self-mutilation Likewise, Nauert (2013) result found Clear links between bullied at a young age and self-harm in teenage years.

The study result found, significant association between self-mutilation and suicidal ideation. The question was "have you ever seriously wanted to kill yourself". Of those who do not mutilate, and wanted to die is only one 0.7%. Nevertheless, those who mutilate, and wanted to die is 11(16%). The analysis shows, P value 0.00 and chi square value is 25.8 with confidence interval of 0.04-0.21. Crude odd ration is 3.08, which indicated those who self-mutilate have 3 times higher chances of wanting to die or suicide. The result of this study show very highly associated between self-mutilation and wanting to die or suicidal ideation. In the same way Buchanan (2014) wrote, those who engage in Non-suicidal self-injuries are at higher risk of suicidal behaviours.

Additionally, Walsh (2006) found, individuals with a history of self-injury are at higher risk for suicide thoughts, gestures and are nine times more likely to report having made a suicide attempt at some point in their life.

AL, Barrocas; B, Hankin; JF, Young; JR, Abela(2012) found, children engage deliberate self-harm affects especially for girls. Girls are 3 times as many reported engaging in self-mutilation compared with boys. In contrast, this study, result found no significant association with gender and self-mutilation. Ingrid Van Camp, Mattias Desmet, found similar result & Paul Verhaeghe (2011)study result found no significant gender ratio differences.

This Study found most of the mutilators do it privately, however few does in front of others. (76%) of students who deliberately harm said they alone at the time of self-mutilation. (13 %) said they were sometimes alone. Only 11 % said they were not alone.

Relatively MacPhee (2011) wrote self-mutilators often try hard to keep what they are doing secret, and to hide their scars and bruises. Additionally, Salters-Pedneault(2014) wrote, most people who self-harm do it in isolated and make sure that the area of the injury is not visible, yet, there might be people who report that they seek attention. (Salters-Pedneault,2014).

Problems with siblings result shows (46.3%) responded, as they do not at all have problems with siblings. (42.2%) said sometimes they have problems and (12%) said Most of the time they have problems with their siblings. The study could not find significant association with problems with siblings and self-mutilation. In contrast with the findings, Stanley, B, Gameroff, M. J, Michalsen, V, & Mann, J. J (2001) Individuals who self-injure often have suffered sexual, emotional, or physical abuse from someone within families such as a parent or sibling. Even though 12% of students responded as they

have problems with siblings, the chi square test shows no association with siblings disputes and self-mutilation.

Another important finding was about the respondents having friends at school. Although they have bullying problem at School, (98.6%) respondents said they have friends at school. Only 1.4 % said they do not have friends at all. Relationship with friends found not a problem for the respondents. Nevertheless, the result shows frequency and the percentages of respondents who have seen self-mutilation by known person. 93respondents (63%) said they have seen self-mutilation by someone they know. 54 respondents (37%) said they have not seen by anyone they know. Similarly, Buchanan(2014)wrot that, research has shown that self-harm has increased recently, that in particular self-cutting has increased and there is some contagion effect. Therefore, the findings of 63% respondents seen mutilation by known person indicates it could have contagion effect to mutilate by seen the behaviour from known person.

The result also shows the family relationship with the respondents. It shows the protective factors for the students in the family when they feel upset or emotionally down. 62 students (42%) said they could share their feelings with their mom and dad when they feel upset. Only 2 students (1.4%) said they share with their grandparents. 27 students (18.4%) said with brother or sister. However, 33% said they do not share anyone in the family.8students (5.4%) said they share their feelings with others. Students have specified others as cousins in the family. This result indicates 33% students do not share their feelings with anyone in the family when they are upset. The literature on factors associated with self-ham reveals family factor as important factor for child to prevent from self-injuries. According to Bureau, J.-F, et al., (2010) study result,, those who engaged in Self-harm reported poor protection, fear, overprotection

from parents and isolation, as well as lack of trust, and communication, in comparison to those that reported no history of Self- harm. It is very important to build secure attachment with a child.

The study result shows, among those who mutilate (37%) said they do not feel pain. (41%) said that sometimes they feel pain. (22%) said they feel pain when they cut or mutilate. Moreover the fact that how they feel after self-mutilating, has influence to seek negative coping strategies and continue the behaviour.

The study also shows (24%) respondents feel life is not worth living. (76%) feels life is worth living. This finding indicates that (24%) of respondents could have been suffering from emotional distress. The feelings of hopelessness shows the emotional status of their mind. Yates (2004) wrote, that self-injury shares many of the risk factors of other negative coping mechanisms, Such as history of child trauma and/or abuse (particularly sexual or emotional abuse), poor family communication, low family warmth, and/or perceived isolation.

The reasons for self-mutilation found, out of 54 respondents who mutilate, most frequently responded reason was, (37.3%) as they were angry with someone. (22.2%), responded, as I hate myself. (20.3%) upset and tried it. (20.3%) said to cope with uncomfortable feeling. Other reasons they have mentioned was, “My past” and “got low marks”. The reasons for mutilation and feeling life is not worth and suicidal ideation are interrelated. The anger they feel might be because of bullying incidents or other trauma due to someone. It could be sexual abuse as well. Therefore, it is essential to investigate the prevalence of sexual abuse and other traumas. To support the findings, Yates (2004) wrote, that self-injury shares many of the risk factors of other negative coping mechanisms, due to history of child trauma and/or abuse (particularly sexual or emotional abuse).

Other findings of the study shows among those who mutilate, (56%) said they feel better after self-mutilation. (35.4%) said they felt just the same. Only (8%) said they felt worse than before. in the same way, Jennifer Lukomski,(2004) Wrote, the pain from the self-mutilation causes an increase in the production of endorphins, which inhibits the feelings of pain and tension. Many mutilators reported feeling an emotional release during an episode of Cutting. Similarly, Jonathan Clark (2011)also Wrote, Those who mutilate, they realise that they unusually feel better. Therefore, these students could have more probability to get addicted to mutilation and adopt negative coping mechanism (Jonathan Clark (2011). With regard to this issue, Figure 4.17 shows 0ut of 41 respondents who mutilate, (64%) said they want to stop. (12 %) said they do not want to stop and (24%) said they could not stop mutilation. Those who could not stop mutilation could be addicted to self-mutilation.

5.2 Implication of the finding

The study found very high association with Self-mutilation and wanting to attempt suicide. If the issues are neglected, there could be serious consequences such as involving high-risk behaviours and violence and attempting suicide. The study result found high necessity to have anti bullying campaign in schools. Because bullying impact children very deeply. The result of this study also shows significant relation with bullying and self-mutilation. The fact is mental health issues are often ignored, because those who suffer emotional problems and anxiety often do not have any visible signs. However, students who deliberately self-harm often are calling for help. Schools should not overlook the problem in order to prevent further consequences.

5.3 Direction for future research

In order to investigate the individual experience and the common risk factors for self-mutilation there is essential need to carryout qualitative analysis for self- mutilators. Moreover, there is significant need to do broader research to identify the prevalence of deliberate self-harm among school Children. It could be done through global School health survey or other population based survey. Furthermore it is very essential to investigate, socio economics status of School children and how sexual abuse and drug abuse and more in-depth associate with self-mutilation or other deliberate self-harm behaviour.

5.4 Recommendations

Schools should strengthen anti bullying policies and raise awareness on bullying prevention. Training student leaders, peer helpers to identify and help bullying students could be an effective way because peers could understand the bullying incidents than teachers or other staff of School community.

There is crucial need to carryout mass campaign to teach the students positive coping strategies. Moreover, schools should develop guideline and protocols to prevent Self-mutilation and help students suffer other emotional problems.

According to Jennifer Lukomski (2004) ,the most effective interventions for self-harm involves incorporating cognitive Behaviour Therapy approaches including skill training in the areas of mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance(Jennifer Lukomski,2004).

Parental awareness programs are also very important to build good attachment with parents and to promote protective factors within the family. Additionally, it is very essential to conduct population based survey to identify how sexual abuse and drug abuse associate with self-mutilation or other deliberate self-harm behaviour.

5.5: Limitation

The cross-sectional design may not be most relevant type of design to investigate self-harm behaviour. Due to time constrain, the study could not take most appropriate sample size, which might affect the study result. There could be chances of recall bias, as students might not remember their feelings at the time of self-mutilation as well as they might not express their true feelings as self-harm is a sensitive issue. History of child trauma, other emotional issues, and the number of occurrence of self-mutilation, could evaluated as the study used structured self-reported questionnaire. Moreover, the study could not find detailed information of the given reason for self-mutilation. Furthermore, Due to socio cultural and religious sensitivity issues, the relationship with child abuse and drug abuse excluded in the questionnaire, which may affect the result of the study. The study did not deeply investigate the socio economics status of the students, which might affect the result.

Qualitative research could be more relevant to analyse the reasons of self-mutilation, like the reasons given for mutilation as their past. Cross sectional study could be more appropriate to analyse prevalence.

5.6: Conclusion

The result shows prevalence of self-mutilation is 28%. Other deliberate self-harm includes 10.2% banging head intentionally and 2.7% Burn self intentionally. The study found significant association between parental marital status, bullying with self-mutilation. The study also found highly significant association with self-mutilation and suicidal ideation. There is important need strengthen anti bullying policies and parental awareness found to be crucial to prevent the children from emotional problems. There is a need for further qualitative research to conduct for self-mutilators to understand the in-depth causes of the issues.

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APENDIX - A

ސާރވޭގައި ދަރިވަރު ބައިވެރި ކުރުމަށްޓަކައި ބެލެނިވެރިޔާގެ ހުއްދައަށް އެދޭ ފޯމު

އަޅުގަނޑުގެ ނަމަކީ އަންޖިލާ ނަސީމް އެވެ. އަޅުގަނޑަކީ ބެޗެލަރސް އެޑް ޕްރައިމަރީ ކޯސް ހަދާ ކިޔަވަމުންދާ ދަރިވަރަކަށް ވުމާއި އެކު، ނިންމަން ޖެހޭ ދިރާސާއެއްގެ މަސައްކަތަށް ދަރިވަރުންގެ ޚިޔާލު މައުލޫމާތު ހޯދަން ޖެހެއެވެ. އަޅުގަނޑު ދިރާސާ ކުރުމަށް ހަމަޖެހިފައިވަނީ މާލެ އާއި ހުޅުމާލޭގެ 4 ސްކޫލެއްގެ ދަރިވަރުންނަށް ޚާއްސަކޮށްގެ ފުރާވަރުގެ އުމުރުފުރާގައި (ގްރޭޑް 8،7،6) ދަރިވަރުންނަށް ސްކޫލް ތެރެއިންނާއި އަދި ރައްޓެހިން ފަރާތުން ދިމާވާކަންތައްތަކުގެ ސަބަބުން އަމިއްލަ ނަފްސަށް ގެއްލުންވާ ކަންތައްތަކާއި އަނިޔާތައް ދަރިވަރުންގެ ތެރޭގައި ދެކޭ މިންވަރު ދަނެގަތުމެވެ.

މި ސާރވޭ ފޯމުގައި ދަރިވަރަކު ކޮން ކުއްޖެއްކަން އެގޭނެ ގޮތެއް ނުހުންނާނެއެވެ. އަދި މި ދިރާސާގެ ނަތީޖާ އަދި އަޅުގަނޑުގެ ކިޔެވުމަށް ބޭނުންކުރާނީ މައުލޫމާތަކަށް ވުމާއި އެކު މި މައުލޫމާތަކީ ސިއްރު ހިފެހެއްޓިފައިވާނެ މައުލޫމާތެއް ކަމަށް ޔަގީންކަން ދަންނަވަމެވެ. އަދި މި ދިރާސާގައި ބައިވެރި ވުމަކީ ނުވުމަކީ ދަރިވަރުގެ ކިޔެވުމަށް އާދޭ އަސަރެއް ނުކުރާނެ ކަމުގައި ދަންނަވަމެވެ.

މިދިރާސާގެ ނަތީޖާގެ އަލީގައި ދަރިވަރުންނަށް ސްކޫލް ތެރޭގައި ދިމާވާ ޖިސްމާނީ ކަންތައްތަކާއި އެކަންކަމުގެ ސަބަބުން ކުރިމަތިވާ ނުރައްކާ އަސަރުތައް ދަނެގަނެ ސްކޫލްތަކުގެ ތެރޭގައި ރައްކާތެރިކަމުގެ ޕްރޮގްރާމް ތަކެއް ރާވަން މި ދިރާސާގެ ސަބަބުން އެހީތެރިކަން ލިބިދާނެކަމަށް ދެކެމެވެ.

މި ދިރާސާގެ ސުވާލު ކަރުދާސް ފުރިހަމަ ކުރުމަށް ހޭދަވާނީ ގާތްގަނޑަކަށް 10-15 މިނެޓް ދެމުދަތުގެ ވަގުތު ނަގާނެއެވެ. ސުވާލު ކަރުދާސް ފުރިހަމަ ކުރާއިރު ދަރިވަރުންގެ ކިޔެވުމަށް ބުރަ ނުވާނެ ގޮތަށް ސްކޫލާއި ގުޅިގެން ކުރިއަށް ގެންދިޔުމަށް ރާވާފައިވާ ވާހަކަ ދަންނަވަމެވެ.

ވީމާ މި ސާރވޭ ގައި ދަރިވަރު ބައިވެރި ކުރުމަށް ބެލެނިވެރިޔާ **ބޭނުން ނުވާނަމަ** ތިރީގައިވާ މައުލޫމާތު ފުރިހަމަ ކޮށްދެއްވުމަށް ފަހު ކްލާސް ޓީޗަރާއި ހަވާލުކުރައްވުން އެދެމެވެ. އަދި މިފޯމު ނުގެނެސް ކުދިންނަކީ ބެލެނިވެރިޔާގެ އިއުތިރާޒެއް ނެތް ކުދިން ކަމަށް ބަލާ ސާރވޭ ގައި ބައިވެރި ކުރުވޭނެ ވާހަކަ ދަންނަވަމެވެ.

ޝުކުރިއްޔާ

1 އޭޕްރިލް 2015

އަންޖިލާ ނަސީމް (7755411)

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މިސާރވޭގައި އަޅުގަނޑުގެ ދަރިފުޅު ބައިވެރިކުރުމަށް ބޭނުމެއް ނުވެއެވެ.

ދަރިވަރުގެ ނަން.............................. ސްކޫލުގެ ނަން................ ކްލާސް .... ބެލެނިވެރިޔާގެ ސޮއި.................

APENDIX: B

Survey Questionnaire on Prevalence and factors associated with Self-mutilation among Adolescence

School …………………. Date …...

Part 1(Demographic factors)
1-**Your Age group (please underline your answer)** a) 12 - 13 years b) 14- 15 Years
2- **Your Sex**: **(please underline your answer)** a) Male b)Female
3- **Your Grade**: **(please underline your answer)** a) Grade 6 b) Grade 7 c) Grade 8
Part 2 (family factors)
4-Are your parents: (please underline your answer) a) Married b) Divorce c) Living separately d) Don't know
5-How many siblings do you have? (Please write the number) ……………
6-Whom are you living with? (please underline your answer) a) Mom and dad b)Mother c) With father d) With family relative e) Others (please specify)……………………
7-Do you have problems with your siblings? (your brothers and sisters) a) Not at all b) Sometimes c) Most of the time

8-When you feel upset, whom you can share in your family? (please underline your answer)

a) Mom and dad b) Grandparent c) Brother or sister

d) None of them e) Others (please specify)……………………..

Part 3 (Peer Relationship factors)

9-Do you have friends at School? (please circle the answer)

a) Yes b) No

10- Have any of your school friend or classmate tried to bully you by :(Please mark **all** that apply)

a) Teasing ☐

b) threatening ☐

c) Physical violence ☐

d) calling names ☐

e) Isolating ☐

d) I wasn't bullied ☐

11- How many students bullied you in the School? (please mark your answer)

a) I wasn't bullied ☐

b) Mainly by one boy ☐

c)By several boys ☐

d) mainly by one girl ☐

e) several girls ☐

f) mainly by both boys and girls ☐

12- How serious did you consider these bullying attacks to be? (please mark your answer)

a) I wasn't bullied ☐

b) not at all ☐

C) only a bit ☐

d) quite serious ☐

e) extremely serious ☐

Part 4(prevalence and reason for self-harm)

13- Have you ever intentionally or purposely done any of the following: (Please mark all that apply)

(a) Cutting the wrist or any part of the body?(with cutter or any sharp objectives) ☐

(b) Burn yourself purposely ☐

(c) Bang your head or Hitting Self ☐

d) Others…………….. ☐

e) I don't harm myself ☐

(please skip this question if you don't involve in self-harm or cutting

14- At what age did you First harm yourself/ cutting? ☐

15- Do you experience physical pain during self-harm/ cutting? (please mark your answer)

a) yes ☐

b) sometimes ☐

c) no ☐

d) I don't harm myself ☐

e) I don't harm myself ☐

17- Do you want to stop Self-harming/ cutting? (please mark your answer)

a) yes ☐
b) No ☐
c) I can't stop ☐
d) I don't harm my self ☐

18- What were the reason for you to self-harm?(Please mark or underline all that apply)

a) Cope with uncomfortable feelings ☐
b) Upset and decided to try it ☐
c) Angry at someone else ☐
d) Relieve stress or pressure ☐
e) Change emotional to physical pain ☐
f) Deal with frustration ☐
g) Wanted someone to notice me or my injuries ☐
h) Wanted to shock/hurt someone ☐
i) Friend suggested it ☐
j) Hope others notice something is wrong ☐
k) Because my friends do it ☐
l) Because I hate myself ☐
m) Avoid from problems or task ☐
n) Any other reason (please specify)…………………………..
o) I don't remember ☐
p) I don't harm myself ☐

19- Have anyone you know ever hurt themselves on purpose?(please tick one)

a) Yes ☐
b) No ☐

20- After you had hurt yourself on that occasion, how did you feel…? (Please mark **one** box only.) a) Better than before ☐ b) The same as before ☐ c) worse than before ☐ d) don't know ☐
21- On any of the occasions when you have hurt yourself on purpose, have you ever seriously wanted to kill yourself. a) Yes ☐ b) No ☐
22- Have you ever felt that life was not worth living? a) Yes ☐ b) No ☐
23- Have you **ever found yourself wishing you were dead and away from it all**? a) Yes ☐ b) No ☐