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Research Article

Self-harm and PTSD among a sample of women in Turkey: the role of self-compassion[1]

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Abstract

The present study analyzes the association between self-harm and post-traumatic stress disorder (PTSD) and a moderating role of self-compassion in a sample of women residing in Turkey. This study has examined prevalence of s PTSD and CPTSD among women who did harm themselves. A cohort of women in Turkey underwent an internet survey utilizing established measures to assess self-compassion, self-harm inclinations, PTSD and Complex PTSD. The questionnaires used were Self-Compassion Scale (SCS), Inventory of Statements About Self-Injury, PDS-5 and International Trauma Questionnaire (ITQ). The data shows that higher levels of self-compassion are connected with a reduction in self-harm behaviors. The rate of PTSD prevalence (PDS-5) was 32%. Complex PTSD (ITQ) prevalence was 36%. The most common self-injury behavior was cutting. Self-compassion correlated negatively with PTSD. Common Humanity correlated negatively with all PTSD and CPTSD symptoms intensity. Self-Kindness correlated negatively with PTSD symptoms criterion B, D and E, avoidance, affective dysregulation, negative self-concept, DSO score and total intensity of PTSD symptoms. Self-Judgement correlated positively with PTSD symptoms criterion B, C and D, negative self-concept, DSO score and total intensity of PTSD symptoms. Isolation correlated positively with PTSD symptoms criterion B and D and negative self- concept. Over-identification correlated positively with affective dysregulation, negative self-concept and DSO score. The total level of self-compassion correlated negatively with the sense of current threat.

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Introduction

In accordance with DSM-5 (American Psychiatric Association, 2013, p. 273), the subsequent criteria are applicable to individuals who are adults, adolescents, and children aged 6 years and above: A. Being exposed to real or potential death, severe injury, or sexual violence in one or more of the following manners: 1. Directly undergoing the experience of the traumatic event(s). 2. Observing, firsthand, the occurrence(s) as they were perceived by others. 3. Discovering that the distressing incident(s) befell a loved one or intimate acquaintance. Where a family member or friend is already or potentially dead, the event(s) must have been either violent or unintentional. 4. Experiencing recurrent or severe exposure to unpleasant aspects of the traumatic event(s) (e.g., first responders gathering human remains; police officers chronically exposed to specifics of child abuse). B. Manifestation of one or more of the following intrusive symptoms linked to the traumatic event(s), commencing subsequent to the occurrence of the such event(s): 1. Recurrent,

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involuntary, and intrusive painful recollections of the original traumatic incident(s). 2. Repetitive unpleasant dreams characterized by the connection between the content and/or impact of the dream and the traumatic event(s). 3. Dissociative reactions, such as flashbacks, are characterized by the individual's perception or behavior as if the traumatic event(s) were happening repeatedly. These reactions can manifest on a spectrum, with the most severe manifestation being a total withdrawal from consciousness of the current environment. 4. Severe or extended psychological anguish experienced when confronted with internal or external stimuli that represent or correspond to a part of the traumatic event(s). 5. Explicit physiological responses to internal or external stimuli that represent or bear resemblance to a component of the traumatic event(s). C. Chronic avoidance of stimuli linked to the traumatic event(s), commencing subsequent to the occurrence of the traumatic event(s), as indicated by one or both of the following: 1. Avoidance or deliberate attempts to avoid painful recollections, thoughts, or emotions related to or strongly linked to the traumatic event(s). 2. The deliberate avoidance or attempts to avoid external stimuli (such as individuals, locations, conversations, activities, items, or circumstances) that trigger painful memories, thoughts, or emotions related to the traumatic event(s). D. Adverse changes in cognitive and mood states linked to the traumatic event(s), commencing or exacerbating after the traumatic event(s), as indicated by two (or more) of the following: 1. Deprivation of memory of a significant element of the traumatic incident(s) (usually caused by dissociative amnesia and not by other causes such as head trauma, alcohol, or narcotics). 2. Chronic and unduly inflated pessimistic thoughts or anticipations regarding oneself, others, or the universe (e.g., "I am morally flawed," "No one can be relied upon," "The world is entirely perilous," "My entire nervous system is irreparably damaged"). 3. Enduring, false beliefs regarding the origin or outcomes of the traumatic event(s) that cause the person to attribute blame to herself or others. 4. Chronic negative affective condition (e.g., dread, terror, rage, remorse, or humiliation). 5. Significantly reduced interest or involvement in important activities. 6. Sense of remoteness or alienation from others. 7. Chronic incapacity to undergo good emotions (e.g., incapacity to manifest feelings of happiness, contentment, or affection). E. Significant changes in arousal and reactivity linked to the traumatic event(s), commencing or exacerbating after the traumatic event(s), as indicated by two (or more) of the following: 1. Irritable behaviour and enraged outbursts, usually manifested as verbal or physical hostility towards individuals or objects, generally without any apparent cause. 2. Irrational or self-destructive conduct. 3. Extreme alertness. 4. Heightened startle reaction. 5. Concentration difficulties. 6. Sleep disruption (e.g., insomnia or nocturnal agitation). The duration of the disturbance, as defined by Criteria B, C, D, and E, exceeds one month. G. The disruption results in clinically substantial anguish or impairment in social, vocational, or other crucial domains of functioning.

Indicate whether: Using delayed expression: If all the diagnostic criteria are not fulfilled by a minimum of 6 months following the incident (although the emergence and manifestation of certain symptoms may occur immediately). In cases when a traumatic incident includes the violent death of a person with whom the person had a strong relationship, symptoms of both extended grief disorder and post-traumatic stress disorder (PTSD) may manifest.

Prevalence of PTSD in different populations

According to the American Psychiatric Association (2013), the national lifetime prevalence estimates for PTSD among U.S. adults, based on DSM-IV criteria, are 6.8%. According to Kilpatrick et al. (2013), within two U.S. national epidemiological investigations, the lifetime prevalence estimates for DSM-5 PTSD varied between 6.1% and 8.3%. In both studies, the national 12-month DSM-5 prevalence estimate was 4.7%. The same source also indicates nationwide lifetime DSM-IV PTSD estimates from World Mental Health Surveys in 24 nations shown significant variation between countries, income country groups, and WHO regions, but averaged 3.9%. Following adjustments for age differences among studies, the point prevalence of PTSD with functional impairment in conflict-affected populations worldwide is 11%. Obuobi-Donkor et al. (2022) indicates that post-traumatic stress disorder (PTSD) rates are elevated among veterans and individuals whose profession heightens the likelihood of painful exposure, such as police officers, firefighters, and emergency medical workers. According to Obuobi-Donkor et al. (2022), the highest prevalence rates,

ranging from one-third to over one-half of those exposed, are observed among survivors of rape, military warfare and captivity, as well as ethnically or politically driven incarceration and genocide.

According to DSM-5 (2013), the occurrence of PTSD may differ throughout different stages of development. Specifically, children and adolescents, including preschool children, tend to have lower rates of PTSD after experiencing severe traumatic events. However, this lower prevalence may be due to the fact that the previous criteria used were not adequately based on developmental considerations. Demographic disparities, as indicated by DSM-IV data, reveal elevated prevalence of PTSD among Latin Americans, African Americans, and Native Americans in the United States in comparison to Whites. Possible explanations for these variations in prevalence include disparities in predisposing or enabling factors, such as previous experiences of hardship and racism, as well as differences in the accessibility or standard of treatment, social support, socioeconomic status, and other social resources that aid in recovery and are influenced by ethnic and racial background.

According to DSM-5 (2013), PTSD can manifest at any stage of life, typically emerging after the first year of survival. In most cases, symptoms manifest within the initial three months following the injury, although there can be a significant delay of many months or even years before all the necessary criteria for the diagnosis are fulfilled. There is ample evidence supporting the concept of "delayed onset" as defined in DSM-IV (1994), which is now referred to as "delayed expression." This term acknowledges that some symptoms usually manifest promptly and that the delay is in not fully completing the qualifying requirements.

Risk Factors for PTSD

PTSD risk factors can manifest in several ways, such as a predisposition of persons to trauma or to intense emotional reactions upon exposure to traumatic experiences. According to the American Psychiatric Association (2013), typically, risk (and protective) variables are categorized as pre-traumatic, peritraumatic, and posttraumatic factors. Same source indicates that post-traumatic stress disorder (PTSD) is more common in women than in males during their total lifespan. Baselined on two extensive U.S. population-based studies employing DSM-5 criteria, the lifetime prevalence of PTSD varies from 8.0% to 11.0% for women and 4.1% to 5.4% for men. One possible explanation for the higher risk of PTSD in women stated by American Psychological Association (2013) is their increased probability of being exposed to childhood sexual abuse, sexual assault, and other types of interpersonal violence, which are the most significant factors contributing to the development of PTSD. Longer rates of PTSD are observed in women in the general population compared to men. Further reasons that probably contribute to the greater occurrence in women include gender disparities in the emotional and cognitive processing of trauma, together with the influence of reproductive hormones. Comparisons of men and women's responses to particular stresses reveal ongoing gender disparities in the risk for PTSD. Nevertheless, the symptom profiles and component structures of PTSD are comparable between males and females. According to the American Psychiatric Association (2013), persons with PTSD are more prone to experiencing symptoms that satisfy the diagnostic criteria for at least one other mental disorder, such as substance use disorders, depression or anxiety disorder, compared to those without PTSD. Post-traumatic stress disorder (PTSD) is also linked to a higher likelihood of developing significant neurocognitive disorder, typically dementia. In a study conducted in the United States, women had a higher likelihood of developing PTSD after a mild traumatic brain injury. While the majority of young children with PTSD furthermore have at least one other diagnoses, the comorbidity patterns differ from those observed in adults, with oppositional defiant disorder and separation anxiety disorder being the most common.

Definition of Self-Harm

Within the DSM-5, self-harm is categorized as "Non-Suicidal Self-Injury Disorder" (NSSID). Non-suicidal self-inflicted injury (NSSID) is the intentional, self-inflicted harm to one's body without any intention to commit suicide. As per the DSM-5 criteria for Non-Suicidal Self-Injury (NSSI), the following conditions must be fulfilled: The individual

deliberately causes harm to their body via self-inflicted means, such as self-inflicted cutting, burning, or hitting, among other mechanisms.

Self-injury refers to actions that are not socially acceptable, such as tattooing or piercing, and are not caused by any concurrent medical condition or substance usage. The conduct is accompanied by the individual's anticipation of alleviation from bad emotions, detachment, or a perception of control, and/or as a method of expressing distress. The conduct is not primarily motivated by the desire to elicit a favorable reaction from others, such as seeking attention or influencing others. The behavioral patterns cannot be more effectively explained by any other psychiatric condition or as a mechanism to fulfill cultural, religious, or social objectives.

Self-Compassion Definition

The notion of self-compassion was formulated by psychologist Dr. Kristin Neff in 2007. It pertains to the capacity to show benevolence, empathy, and assistance towards oneself during periods of hardship or distress, akin to how one would treat a dear friend. Self-compassion comprises three primary elements:

- Self-kindness: Being kind, gentle, and understanding toward oneself, especially in moments of pain, failure, or inadequacy.
- Common humanity: Recognizing that everyone experiences pain, suffering, and imperfection, and understanding that these experiences are a part of the shared human experience.
- Mindfulness: Being present and aware of one's thoughts, emotions, and experiences without judgment or overidentification.

Psychological Trauma and Self-Harm in Women

Research conducted in Turkey has indicated a significant association between trauma and self-harm in women. For example, a study by Aydin, Doğan, Özpolat, & Ulaş, (2017) found that Turkish women who experienced childhood abuse had higher rates of self-harm compared to those without a history of trauma. This highlights the need to explore factors that may moderate the relationship between trauma and self-harm, such as self-compassion.

Green (1978) conducted the first controlled study which revealed that 41% of his sample of children who were physically abused displayed far higher levels of self-destructive behaviors (such as head banging, self-biting, self-burning, and self-cutting) compared to children who were not subjected to such abuse. Ferguson et al. (1996), propose that from 16.5% to 19.5% of suicide attempts among young adults could be attributed to their experience of childhood sexual abuse. Several authors have hypothesized that traumatization leads to the disturbance of fundamental psychobiological structures that make up personality (Hulette et al., 2011, Mauritz et al., 2013). These formulations propose that sufferers of trauma may display behavioral issues, such as impulsivity, violence, substance misuse, and self-harming behaviors, as well as internalization issues including symptoms of sadness and anxiety (Stein et al., 2013). Furthermore, very often observed was major depression, which appears to play a pivotal role in a propensity for suicide actions. The study conducted by Leiner et al. (2008) provided data supporting the argument that comorbid depressive disorder has a mediating role in explaining the significant associations between suicidal thoughts and PSTD. A thorough meta-analysis established that suicidal ideation and suicidal behaviors were more significant predictors of PTSD than completed suicides. These associations were found to be consistent regardless of the specific types of traumatic events and the samples taken from either psychiatric or community populations (Panagioti et al., 2012).

Self-Compassion as a Protective Factor in Self-Harm and Other Mental Health Outcomes

According to Suh & Jeong (2021), self-compassion has emerged as a potential protective factor against self-destructive behaviors, including self-harm. Neff (2023), claims that the self-compassion framework proposes that being self-compassionate involves treating oneself with kindness and understanding, acknowledging that suffering and difficulties are part of the shared human experience. Individuals who possess higher levels of self-compassion are more likely to engage in healthier coping strategies, seek social support, and have greater emotional regulation skills.

Studies conducted in various cultural contexts have demonstrated the beneficial effects of self-compassion on reducing self-harm behaviors. For example, a study by Neff and colleagues (2007) found that higher levels of self-compassion were associated with lower rates of self-harm among trauma-affected women in a Western cultural context. This study contributed to the establishment of a correlation between self-compassion and adaptive psychological functioning. Self-compassion played a crucial role in safeguarding against self-evaluative anxiety when contemplating personal shortcomings, and enhancements in self-compassion were linked to improvements in other indicators of mental well-being. This suggests that self-compassion may serve as a protective factor against self-harm across different populations, including women in Turkey.

Neff and colleagues (2007) also aimed to investigate whether changes in self-compassion can significantly predict changes in aspects of well-being, as well as the effectiveness of a self-compassion training program on self-compassion, positive and negative affect, depression, anxiety, stress, life satisfaction, and subjective happiness. Social science students from a sample of 74 are randomly split into an intervention group (N = 33) and a control group (N = 41). While the control group received no instruction, the intervention group underwent a psycho-educational training program designed to teach people how to be more self-compassionate under trying circumstances. In comparison to the control group, which reported no changes, the results showed that the intervention group had higher ratings for self-compassion, positive affect, life satisfaction, and subjective happiness and lower levels for negative affect, depression, anxiety, and stress. The importance of self-compassion for psychological health and the efficiency of targeted intervention programs are suggested by these findings(Neff, Kirkpatrick, & Rude, (2007), 139-154).

Theoretical frameworks suggest that self-compassion may moderate the relationship between psychological trauma and self-harm. It is hypothesized that higher levels of self-compassion can buffer the negative effects of trauma, providing individuals with an internal resource to cope effectively with distressing emotions and reducing the likelihood of engaging in self-harming behaviors as a means of escape or self-punishment.

Although limited research has specifically examined the moderator role of self-compassion in women in Turkey, studies from other contexts provide preliminary support for its potential moderating effect. For instance, a study by Satici, Kayis, & Uysal (2019) found that self-compassion significantly weakened the relationship between trauma and self-harm in a sample of adolescent girls in Turkey. This suggests that interventions promoting self-compassion may be effective in reducing self-harm tendencies among trauma-affected women in Turkey as well.

Psychological trauma refers to an overwhelming event or series of events that exceeds an individual's ability to cope. Noll, Horowitz, Bonanno, Trickett, and Putnam (2003) conducted a study that examined revictimization and self-harm in females who experienced childhood sexual abuse. Their findings revealed a significant association between childhood sexual abuse and self-harm behaviors, highlighting the potential long-term effects of trauma. Abused participants reported twice as many subsequent rapes or sexual assaults ($p = .07$), 1.6 times as many physical affronts including domestic violence ($p = .01$), almost four times as many incidences of self-inflicted harm ($p = .002$), and more than 20% more subsequent, significant lifetime traumas ($p = .04$) than did comparison participants. Sexual revictimization was positively correlated with posttraumatic stress disorder symptoms (PTSD), peritraumatic dissociation, and sexual preoccupation. Physical revictimization was positively correlated with PTSD symptoms, pathological dissociation, and sexually permissive attitudes. Dyer at al. (2009) explored the role of anger, aggression, and self-harm in individuals with PTSD and complex PTSD, illustrating the complex nature of self-harm within the context of trauma-related disorders.

In an effort to identify risk factors for deliberate self-harm among college students, Gratz, Conrad, and Roemer (2010) investigated various variables contributing to self-harm behaviors. Their study shed light on the importance of understanding risk factors within the broader population. This self-report study examined the risk factors for deliberate self-harm among college students. Results indicated that insecure attachment, childhood separation, emotional neglect, sexual abuse, and dissociation were significant predictors of self-harm. Substantial gender differences in the risk factors for self-harm behavior were also revealed. Watters and Yalch (2022) examined the relative effects of sexual assault and

other traumatic life events on self-harm, providing insights into the differential impact of various types of traumas on self-harming behaviors.

Furthermore, Harned, Najavits, and Weiss (2010) explored self-harm and suicidal behavior in women with comorbid PTSD and substance dependence, highlighting the complex interaction between trauma, mental health disorders, and self-harm. McAllister (2003) conducted a critical review, delving into the multiple meanings of self-harm, emphasizing the need to understand the diverse motivations underlying this behavior.

Skegg (2005) offered a comprehensive overview of self-harm, considering sociocultural factors, personal experiences, and psychological processes involved. This work emphasized the need to approach self-harm from a holistic perspective. Stänicke (2021) contributed to a nuanced understanding of self-harm among adolescent girls, exploring the punished self, the unknown self, and the harmed self as potential underlying mechanisms.

However, despite the existing body of literature, there remains a significant gap in research specifically examining the relationship amongst self-compassion, psychological trauma and self-harm among women in Turkey. This thesis aims to address this gap and contribute to a more comprehensive understanding of the intricate dynamics between psychological trauma, self-compassion, and self-harm within this specific population.

By synthesizing and analyzing the findings from the aforementioned articles, this study endeavors to shed light on the potential buffering effect of self-compassion on the relationship between psychological trauma and self-harm behaviors among women in Turkey. Understanding this moderating role can have critical implications for the development of tailored interventions and support systems that effectively address the unique needs of this population, ultimately promoting psychological well-being and reducing self-harming behaviors.

Furthermore, exploring the specific cultural and contextual factors in Turkey that influence the relationship between trauma, self-compassion, and self-harm can provide valuable insights into the interplay of these variables within a distinct cultural setting. This research can contribute to the development of culturally sensitive strategies for prevention, intervention, and treatment aimed at reducing self-harm and supporting women in their healing process.

According to Linetsky et al., (2024), the results revealed that midwives who exhibited low levels of self-compassion and high levels of self-criticism were most susceptible to developing symptoms of PTSD. Furthermore, these midwives exhibited a profound tendency to catastrophize pain, a behavior that was strongly linked to the likelihood of experiencing post-traumatic symptoms. Compassion is widely recognized as a crucial factor in several domains, particularly within the healthcare sector. The concept of compassion includes cognitive aspects, as well as emotional and behavioral experiences that drive the inclination to safeguard others who are vulnerable and experiencing hardship (Raab, 2014). Self-compassion stems from the experience of personal pain and the inclination to assist and restore oneself. It encompasses contrasting, constructive and negative aspects such as benevolence versus self-criticism, humanity versus self-isolation, self-awareness, and others (Neff, 2003). Concurrently, the adverse aspects of self-compassion are associated with increased self-criticism and self-judgment (Montero-Marin et al., 2016). An alternative explanation for how self-compassion alleviates the impact of stressful situations is by diminishing rumination and transforming it into catastrophizing thinking, which is marked by an unwavering fixation on past events that fails to alleviate distress.According to Braun et, al. (2023), experimental research indicates that self-compassion training can enhance the overall well-being of women who have experienced domestic and sexual violence (Allen, Robertson, et al., 2021) and alleviate feelings of guilt and shame associated with trauma in individuals with substance use disorder (SUD) (Held et al., 2018). Two recent meta-analyses, conducted by Ferrari et al. (2019) and Luoma et al. (2013), have shown that self-compassion-focused therapies had a moderate impact on symptoms of depression and PTSD. The same research also shows that Current strategies for enhancing self-compassion include Compassion Cultivation Training (CCT) as proposed by Jazaieri et al. (2014), Compassion-Focused Therapy as outlined by Gilbert (2010), and Mindful Self-Compassion Training as reviewed by Germer & Neff (2019). These treatments frequently combine meditation techniques with psychoeducational and experiential activities, as well as relational therapies.

In conclusion, understanding the moderator role of self-compassion in the relationship between psychological trauma and self-harm is crucial for developing effective prevention and intervention strategies. Future research should continue to explore this relationship, considering cultural and contextual factors that may influence the experiences of trauma-affected women in Turkey. By addressing self-compassion as a protective factor, society can support and empower women in their journey towards healing and recovery. The integration of self-compassion interventions within mental health services can pave the way for a comprehensive approach to address the complex interplay between trauma, self-compassion, and self-harm among women in Turkey.

Research Questions

- What are the prevalence rates of PTSD and CPTSD in the studied group?
- How do self-compassion levels correlate with the levels of PTSD and CPTSD symptoms?
- What is the prevalence of traumatic events in the studied sample?
- What is the prevalence of self-harm in the studied sample?
- Is there a relationship between the trauma type and self-harm method?

Method

Subjects and Procedure

This research was performed by 100 Turkish women between the age of 18-35. 76 was included for the analysis due to trauma definition according to DSM-5. DSM-5 (2013), shows that trauma definition requires actual or threatened death, serious injury, or sexual violence. The data of some participants we excluded on the basis of their answers to question about trauma in ITQ. Some description of trauma did not fulfill DSM-5 criterion A definition (e.g. divorce of the parents). The demographic questions were age, socio-economic status, marital status and education level. Questionnaire was created in Google Surveys. It sent to participants via social media platforms (Facebook, Instagram) and also with the help of woman rights non-governmental organization.

Participants

Seventy-six females participated in the study. Table 1 presents distribution of participants' age.

Table 1. Participants' structures

Age	*n*	%
18-25	25	32.9
26-30	36	47.4
31-35+	15	19.7
Total	76	100
Income	*n*	%
Low Income	16	21.1
Middle Income	49	64.5
High Income	11	14.5
Total	76	100
Education	*n*	%
First School	7	9.2
Middle School	19	25.0
High School	3	3.9
University and Higher	47	61.8
Total	76	100

The most participants were females aged 26-30.Table 2 presents distribution of participants' income level.Majority of participants considered their income middle.Forty-three females (56.6%) were in a relationship, 33 participants (43.4%) were singles. Majority of participants completed university or higher education.

Research Tools

The questionnaires used were PDS-5, Self-Harm Scale, International Trauma Questionnaire and Self- Compassion Scale.

Posttraumatic Diagnostic Scale (PDS-5)

PDS-5 is a 24-item self-report measure, evaluates the intensity of PTSD symptoms in the past month based on DSM-5 criteria created by Foa et al. (2016). The PDS-5 opens with two trauma screening questions to evaluate the individual's trauma history and pinpoint a specific traumatic event. The questionnaire includes an item for each of the 20 DSM-5 PTSD symptoms, together with four additional items that inquire about the discomfort and hindrance caused by PTSD symptoms, as well as the development and persistence of these symptoms. The frequency and severity of symptom items are assessed using a 5-point scale, with scores ranging from 0 (Not at all) to 4 (Severe, occurring 6 or more times a week). Details on the threshold for determining a likely PTSD diagnosis can be found in the psychometric study included in the Reference section shown below. It is adapted into Turkish version by Işıklı (2022). Işıklı's study done with 90 people, 34 women and 56 men. The scale's Cronbach's alpha value in the Turkish adaption research was .85.

Self-Compassion Scale

The capacity to feel the same compassion for oneself as for others is known as self-compassion. Neff (2003b) created the scale, formerly known as the "self-compassion scale". The scale's goal is to gauge each person's level of self-compassion, or self-compassion in general. The measure has 26 items, and each question is rated on a Likert scale of 1 to 5. Self-compassion, self-judgment, shared human experiences, awareness, isolation, and over-identification are the six sub-dimensions of the scale. The sub-dimensions' Cronbach's alpha values range from .78 to.81, while the scale's overall Cronbach's alpha value is.92. Sümer et al. (2008) modified the scale for the Turkish population. The "self-understanding scale" is the name given to the scale in Turkish literature. The scale's Turkish translation comprises 24 questions across one dimension. The evaluation of the questions is done using a 5-point Likert 42 scale. The scale's Cronbach's alpha value in the Turkish adaption research was .92.

The Inventory of Statements About Self-injury

The Inventory of Statements About Self-injury is adapted to Turkish by Bildik et al. in 2012. According to Bildik et al, (2012), non-suicidal self-injury (NSSI) is the deliberate and often repetitive damage of one's own body tissue without suicidal intent. In line with earlier studies, component analysis of the functions scale revealed the 2-dimension original model's strong fit (2=243; s.d. = 59; NCI (2/sd) = 4; RMSEA = 0.08 (.07-.09); CFI=0.97; NFI=0.97). The ISAS was given to participants together with the Brief Symptom Inventory and Suicide Probability Scale in order to test the scale's construct validity, and the correlations with clinical constructs (such as suicidality, depression, and anxiety) were in the predicted direction. Additionally, the reliability study showed that the ISAS subscales had a good level of internal consistency. In light of the results, it was determined that the Turkish version of the ISAS might be utilized as a valid and reliable tool for evaluating non-suicidal self-injury in research and therapy contexts.

International Trauma Questionnaire

An 18-item self-report assessment, the International Trauma Questionnaire (ITQ) developed by Cloitre et al., (2018), specifically examines the fundamental characteristics of Post Traumatic Stress Disorder (PTSD) and Complex PTSD (CPTSD). Its development was aligned with the organizational concepts of the ICD-11. Hyland et al. (2017) evaluated the factorial validity of ICD-11 PTSD and CPTSD and implemented the ITQ as the first test to determine the discriminant validity of these variables. The respondents are requested to specify "the experience that causes the most distress to you" together with the time of its occurrence. Then they are requested to answer questions about symptoms and functionality. Item ratings are assigned on a 5-point scale from 0 (indicating "not at all") to 4 (indicating "extremely"). In relation to hypothesis 1, the ITQ PTSD scale (α = 0.87; ω = 0.88) and ITQ DSO scale (α = 0.90; ω = 0.90) exhibited high Cronbach's alpha and MacDonald's omega coefficients of reliability, indicating strong internal consistency. The International Trauma Questionnaire adapted to Turkish by Gündoğmuş et al. (2023). The Cronbach's alpha coefficient

showed satisfactory values for both the PTSD (α =.910) and Disturbances in Self-Organization (α =.867) measures. The study findings established the validity and reliability of the Turkish adaptation of the scale, making it suitable for use in both research and clinical settings.

Results

Descriptive statistics

Table 2 presents descriptive statistics for analyzed interval variable, i.e. mean values, standard deviation, minimum and maximum values and the values of Shapiro-Wilk test for verifying the assumption of normal distributions of analyzed variables.

Table 2. Descriptive statistics for analyzed variables

Variables	*M*	*SD*	*min*	*max*	*S*	*K*	*S-W*	*p*	□
Self-Kindness	2.99	0.72	1.20	4.60	-.32	.24	.97	.096	.48
Self-Judgement	2.77	0.74	1.20	5.00	.66	.93	.96	.011	.52
Common Humanity	3.39	0.93	1.00	5.00	-.43	-.44	.97	.043	.75
Isolation	2.70	0.69	1.25	4.00	.02	-.73	.97	.037	.33
Mindfulness	2.58	0.96	1.00	4.75	.64	-.30	.93	.001	.87
Over-Identification	2.83	0.64	1.25	4.00	-.42	-.11	.96	.031	.47
Self-Compassion	2.88	0.56	1.54	4.19	-.17	.54	.97	.047	.85
PTSD symptoms criterion B	7.50	4.08	1	15	.31	-.98	.94	.002	.88
PTSD symptoms criterion C	3.38	1.95	0	6	-.12	-1.03	.91	.001	.81
PTSD symptoms criterion D	6.72	3.75	0	15	.02	-.96	.97	.033	.76
PTSD symptoms criterion E	7.63	4.23	0	15	-.06	-1.00	.95	.004	.83
PTSD symptoms total	25.24	11.52	2	51	-.14	-.83	.97	.033	.91
Number of symptoms criterion B	2.43	1.83	0	5	.12	-1.27	.88	.001	-
Number of symptoms criterion C	1.05	0.86	0	2	-.10	-1.66	.77	.001	-
Number of symptoms criterion D	2.24	1.66	0	5	.20	-1.37	.88	.001	-
Number of symptoms criterion E	2.68	1.77	0	5	.02	-1.26	.88	.001	-
Re-experiencing in the here and now	5.53	2.06	2	10	.62	-.59	.91	.001	.74
Avoidance	6.46	2.26	2	10	.04	-.98	.94	.002	.87
Sense of current threat	6.04	2.45	2	10	.21	-1.06	.93	.001	.92
PTSD score	18.03	5.54	8	30	.40	-.42	.97	.062	.86
Affective dysregulation	6.24	2.09	3	10	-.17	-1.03	.92	.001	.42
Negative self-concept	6.18	2.58	2	10	-.13	-1.33	.92	.001	.74
Disturbances in relationships	2.86	1.15	1	5	.13	-.65	.92	.001	-
DSO score	15.28	4.95	7	25	-.16	-1.13	.95	.003	.79

M – mean value; *SD* – standard deviation; *min* – minimum value; *max* – maximum value; *S-W* – Shapiro-Wilktest for normality; *p* – statistical significance; α - Cronbach's α reliability coefficient

The values of Shapiro-Wilk test revealed statistically significant deviations from the normal distribution in the case of most variables with the exception of Self-Kindness and PTSD total score. Therefore, following statistical analyses were based on nonparametric statistical tests.

Types of traumas

Table 3 depicts the distribution of types of traumas in the current sample.

Table 3. Distribution of types of traumas

Type of trauma	*n*	%
Actual or Threatened Death	24	31.6
Serious Injury	14	18.4
Sexual Violence	38	50.0
Total	76	100

The most prevalent type of trauma in the current sample was sexual violence.
Table 4 depicts the distribution of the length of time since the trauma.

Table 4. *Length of time since the trauma*

Length of time	*n*	%
Less than 6 months	11	14.5
6-12 months ago	16	21.1
1-5 years ago	11	14.5
5-10 years ago	14	18.4
10-20 years ago	19	25.0
More than 20 years	5	6.6
Total	76	100

In most cases the trauma indicated happened 10-20 years ago.

Statements about self-injury

Tables 5 depicts the distribution of the numbers of times participants from the current sample intentionally performed each type of non-suicidal self-harming.

Table 5. Numbers of times participants from the current sample intentionally performed cutting, biting, burning, carving, swallowing dangerous substances and other self-harming behaviors

N	Cutting		Biting		Burning		Carving		SDS		Other	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
0-20	70	92.1	61	80.3	76	100	69	90.8	74	97.4	74	97.4
21-40	2	2.6	9	11.8	0	0	3	3.9	0	0	1	1.3
41-60	2	2.6	6	7.9	0	0	4	5.3	1	1.3	0	0
61-80	0	0	0	0	0	0	0	0	1	1.3	1	1.3
81-100	2	2.6	0	0	0	0	0	0	0	0	0	0
Total	76	100	76	100	76	100	76	100	76	100	76	100

SDS: Swallowing Dangerous Substances

Table 6. Numbers of times participants from the current sample intentionally performed pinching, pulling hair, severe scratching, banging or hitting self

Number	Pinching		Pulling Hair		Severe Scratching		Banging or Hitting Self	
of times	*n*	%	*n*	%	*n*	%	*n*	%
0-25	68	89.5	76	100	67	88.2	68	89.5
26-50	2	2.6	0	0	5	6.6	4	5.3
51-75	4	5.3	0	0	0	0	2	2.6
76-100	2	2.6	0	0	4	5.3	2	2.6
Total	76	100	76	100	76	100	76	100

Table 7. Numbers of times participants from the current sample intentionally performed interfering with wound healing

Number	Interfering with wound healing	
of times	*n*	%
0-25	68	89.5
26-50	2	2.6
51-75	4	5.3
76-100	2	2.6
Total	76	100

The most frequent type of self-harming behavior was biting.

Table 8 depicts distribution of behaviors indicated as main form of self-harm.

Table 8. Behaviors indicated as main form of self-harm

Behavior	*n*	%
none	46	60.5
Alcohol	4	5.3
Cutting	7	9.2
Biting	8	10.5
Burning	1	1.3
Chewing	1	1.3
Hair Picking	4	5.3
Hitting	5	6.6
Total	76	100

Biting was also indicated most frequently as the main form of self-harm. The age when the first act of self-harming was performed lied within ranged 5-20 years old (M=12.50; SD=4.77).
Table 9 depicts the distribution of the length of time since the most recent self-harming.

Table 9. Length of time since the most recent self-harming

Length of time	*n*	%
0-6 months	5	6.6
6-12 months	11	14.5
1-5 years	5	6.6
5+ years	7	9.2
missing data	48	63.2
Total	76	100

In most cases last self-harming behavior occurred 6-12 months before participating in the current study.
Table 10 depicts distribution of time elapsing from the urge to self-harm till acting on the urge.

Table 10. Distribution of time elapsing from the urge to self-harm till acting on the urge

Length of time	*n*	%
<1 hour	29	38.2
1-3 hour	4	5.3
3-6 hour	2	2.6
missing data	41	53.9
Total	76	100

In most cases the time elapsing from the urge to self-harm until acting on the urge was shorter than one hour.

Relationship between the trauma type and self-harm method

Table 11 depicts the distribution of behaviors indicated as main form of self-harm depending on the type of trauma experienced.

Table 11. Behaviors indicated as main form of self-harm depending on the type of trauma experienced

	Type of trauma					
	Actual or Threatened Death		Serious Injury		Sexual Violence	
Behavior	*n*	%	*n*	%	*n*	%
Alcohol	3	21.4a	1	25.0a	0	0.0a
Cutting	1	7.1a	3	75.0b	3	25.0a
Biting	6	42.9a	0	0.0a	2	16.7a
Burning	1	7.1a	0	0.0a	0	0.0a
Chewing	1	7.1a	0	0.0a	0	0.0a
Hair Picking	2	14.3a	0	0.0a	2	16.7a
Hitting	0	0.0a	0	0.0a	5	41.7b
Total	14	100	4	100	12	100

n – number of participants; % - group percentage; a, b – different letters indicate statistically significant differences on the significance level calculated on the basis of Bonferroni correction

On the basis of Pearson's chi-squared test for independence the statistically significant relationship between the type of trauma and the type of self-harm was detected, $\chi^2(12) = 22.18$, $p<.05$. With the use of multiple comparison test based on Bonferroni correction the differences regarding cutting and hitting were noted. Cutting was most prevalent in the group of females who experienced serious injury and hitting oneself was indicated as the main form of self-harm only in the group of females who experienced sexual violence (see Figure 1).

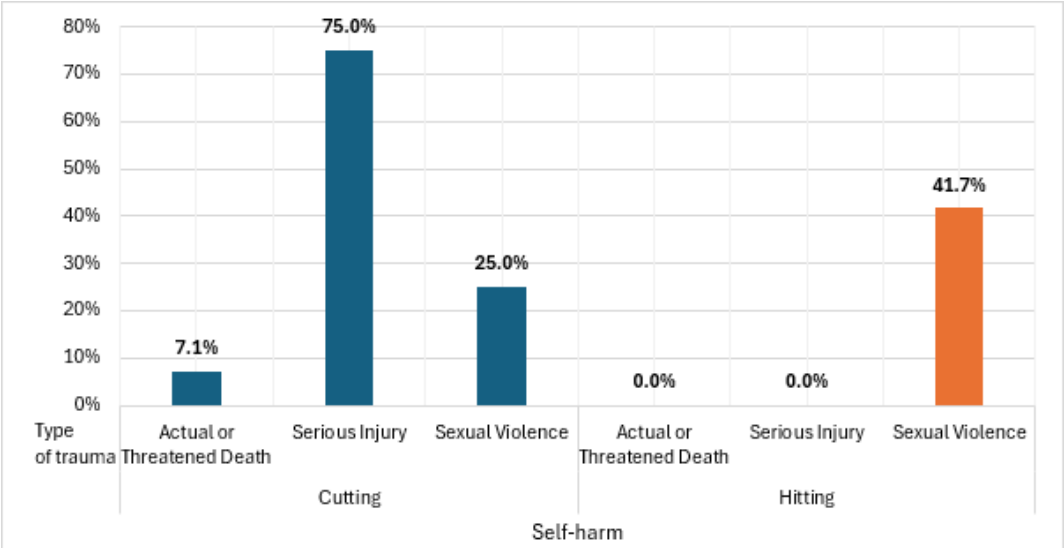

Figure 1. Cutting and hitting indicated as main form of self-harm depending on the type of trauma experienced.

Prevalence rates of PTSD and CPTSD

Thirty-two participants (42.1%) fulfilled the diagnostic criteria for PTSD in PDS-5. Thirty-six participants (47.4) on the basis of ITQ questionnaire could be indicated for probable Complex PTSD diagnosis. Twenty-two participants (28.9%) fulfilled criteria for both PTSD and CPSTD.

Intensity of self-harm and severity of PTSD and CPTSD symptoms

Table 12 depicts Spearman's rho correlation coefficients between time elapsing from the urge to self-harm till acting on the urge and the intensity of PTSD and CPTSD symptoms.

Table 12. Correlation coefficients between time elapsing from the urge to self-harm till acting on the urge and the intensity of PTSD and CPTSD symptoms

	Length of time	
Symptoms	ρ	*p*
PTSD symptoms criterion B	.350	**.039**
PTSD symptoms criterion C	-.165	**.344**
PTSD symptoms criterion D	.044	**.801**
PTSD symptoms criterion E	-.270	**.117**
PTSD symptoms Total	.071	**.684**
Re-experiencing in the here and now	-.384	**.023**
Avoidance	-.338	**.047**
Sense of current threat	-.121	**.487**
PTSD score	-.385	**.023**
Affective dysregulation	-.385	**.022**
Negative self-concept	.008	**.962**
Disturbances in relationships	-.036	**.838**
DSO score	-.169	**.331**

- Spearman's rho correlation coefficient; *p* – statistical significance

The time elapsing from the urge to self-harm till acting on the urge correlated positively with the PTSD symptoms intensity criterion B and negatively with Re-experiencing in the here and now, avoidance PTSD ITQ total score and affective dysregulation.

Level of self-compassion and severity of PTSD and CPTSD symptoms

Table 13 depicts Spearman's rho correlation coefficients between the levels of self-compassion and the intensity of PTSD and CPTSD symptoms.

Table 13. Correlation coefficients between the levels of self-compassion and the intensity of PTSD and CPTSD symptoms

	Self-Compassion						
Symptoms	Self-Kindness	Self-Judgement	Common Humanity	Isolation	Mindfulness	Over-Identification	Total
PTSD symptoms criterion B	-.291*	.259*	-.511**	.256*	.049	.126	-.196
PTSD symptoms criterion C	-.142	.397**	-.511**	-.003	.031	.054	-.094
PTSD symptoms criterion D	-.346**	.401**	-.390**	.330**	-.070	.130	-.107
PTSD symptoms criterion E	-.285*	.212	-.465**	.106	.132	.176	-.168
PTSD symptoms Total	-.319**	.381**	-.538**	.222	.019	.126	-.169
Re-experiencing in the here and now	-.182	.139	-.353**	.218	.147	.125	-.005
Avoidance	-.279*	.191	-.530**	.100	.138	.203	-.156
Sense of current threat	-.137	-.017	-.253*	.146	.055	-.012	-.242*
PTSD score	-.273*	.160	-.489**	.185	.129	.119	-.213
Affective dysregulation	-.292*	.186	-.416**	.026	.179	.297**	-.103
Negative self-concept	-.454**	.254*	-.457**	.247*	.203	.345**	-.127
Disturbances in relationships	-.209	.101	-.282*	.123	-.007	.168	-.094
DSO score	-.423**	.243*	-.466**	.169	.172	.341**	-.123

- Spearman's rho correlation coefficient; *p* – statistical significance

Common Humanity correlated negatively with all PTSD and CPTSD symptoms intensity. Self-Kindness correlated negatively with PTSD symptoms criterion B, D and E, avoidance, affective dysregulation, negative self-concept, DSO score and total intensity of PTSD symptoms. Self-Judgement correlated positively with PTSD symptoms criterion B, C and D, negative self-concept, DSO score and total intensity of PTSD symptoms. Isolation correlated positively with PTSD symptoms criterion B and D and negative self-concept. Over-identification correlated positively with affective dysregulation, negative self-concept and DSO score. The total level of self-compassion correlated negatively with the sense of current threat.

Discussion

This study shows that the group of females who suffered near death experience had the highest rates of cutting, while the group of females who experienced sexual abuse reported hitting oneself as the primary behavior of self-harm. According to Ford and Gomez (2015), systematic reviews of over 100 studies have identified childhood sexual abuse (CSA), other types of child maltreatment, and severe family dysfunction as risk factors for both non-suicidal self-injury (NSSI) and suicide in various age groups and populations (Klonsky & Moyer, 2008; Maniglio, 2011). Furthermore, a comprehensive analysis of 50 studies demonstrated that post-traumatic stress disorder (PTSD) was consistently linked to suicidal ideation (SA) (but not to completed suicides), regardless of the impact of other mental disorders such as depression (Krysinska & Lester, 2010). Furthermore, research has demonstrated that dissociation may act as an intermediary symptom between child abuse and both non-suicidal self-injury (NSSI) (Rodriguez-Srednicki, 2001; Swannell et al., 2012; Zoroglu et al., 2003) and shame-related injury (Freeman, Keesee, Thornton, Gillette, & Young, 1995; Tamar-Gurol, Sar, Karadag, Evren, & Karagoz, 2008; Zoroglu et al., 2003).

Bornovalova et al., (2011), indicates that the findings of their study suggest that the impact of childhood sexual abuse on deliberate self-harm (DSH) and suicidal attempts (SA) can be partially accounted for by the intensity of post-traumatic stress disorder (PTSD) symptoms. This aligns with prior research that have shown the explanatory function of PTSD symptoms in the association between childhood abuse and these behaviors (Thompson et al., 2000; Weierich & Nock, 2008). We can also see that self-kindness and all four PTSD symptoms clusters as well as PTSD total (PTSD probable diagnosis) has negative relationship in this research. According to Akin (2014), self-kindness, common humanity, and mindfulness appear to provide protection to individuals either when they bear personal responsibility for negative experiences or when these experiences are outside their control (Leary et al., 2007). Consequently, individuals can effectively cope with the negative consequences of various adverse events and situations.

As we can see in the results, common humanity also correlates even higher on negative basis with all four PTSD symptoms clusters (B, C, D, E) as well as with probable diagnosis of PTSD (total). Hoffart, Oktedalen, Langkaas (2015), indicates that given that compassion from others and self-compassion are crucial for modulating emotional responses to threat (Gilbert, 2000), cultivating self-compassion could be especially beneficial for those with PTSD. As we can see in the research done by Daneshvar, Basharpoor, Shafiei (2020), similar to our results, the MANOVA results indicated a significant difference in self-compassion between both groups, with lower levels observed in the group with PTSD compared to the group without PTSD. Consequently, persons with PTSD exhibited markedly reduced levels of self-kindness, common humanity, and mindfulness in comparison to those without PTSD. Conversely, people with PTSD expressed considerably increased levels of self-judgment, isolation, and over-identification.

As we can see, there is a high prevalence of PTSD and CPTSD in this study. We can also examine these results with culture perspective. Chentsova-Dutton and Maercker (2019) propose employing the notion of cultural scripts to examine culturally influenced reactions to severe stress. Cultural scripts are schemas, representing thoughts, cognitions, emotions, and behaviors that are sequentially organized and causally interconnected (Chentsova-Dutton & Maercker, 2019; Chentsova-Dutton & Ryder, 2019). They encompass both cognitive representations (e.g., beliefs, values, expectations) and observable, organized practices (e.g., mutually recognized behaviors). Normative scripts are socially sanctioned modes of feeling, thinking, or doing. In contrast, deviant cultural scripts encompass mental representations and activities that remain intelligible but are perceived as aberrant and unpleasant (Chentsova-Dutton et al., 2014) (Chentsova-Dutton & Ryder, 2019).

Limitations

The majority of the participants were belonging to the middle-income class. It would be more sufficient to have equal participants in each column.

Most unequal distribution was in the education level. First school and high school were in the minority part with very low percentages. Since education is a very important factor in understanding the world, future research can be more focused on this subject as well.

Since this study only focuses on Turkish woman, it can be more interesting to compare with a different culture. As mentioned before at the introduction part, Western and Eastern culture have significant differences about moral codes. Belief on ethics and moral subjects' effect on self-harm can be an important subject for future research and the field. Cultural factors can be a very important factor on self-compassion, self-kindness and self-judgment. One of the most important limitations on this research was the small sample. It could be more beneficial with larger samples.

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