CHILDHOOD TRAUMATIC EXPERIENCE AND SELF-HARM BEHAVIOR AMONG EMERGING ADULTS: ROLE OF PARENTAL ATTACHMENT AND DISTRESS TOLERANCE

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Candidate of **Master of Philosophy** at the National University of Modern Languages do hereby declare that the thesis **"Childhood Traumatic Experiences and Self-Harm Behavior among Emerging Adults: Role of Parental Attachment and Distress Tolerance"** submitted by me in partial fulfillment of MPhil degree, is my original work, and has not been submitted or published earlier. I also solemnly declare that it shall not, in future, be submitted by me for obtaining any other degree from this or any other university or institution.

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ABSTRACT

The present study was designed to investigate the impact of childhood traumatic experiences on self- harm behavior among emerging adults. Total sample of (*N* = 332) emerging adults including both male students (*n* = 143) and female students (*n* = 189) with age range of 18 to 29 years (*M* = 1.57, *SD* = 0.50) participated from educational institutes of Islamabad, Rawalpindi and Dera Ismail Khan in the study. In this study, Childhood Traumatic Questionnaire (CTQ; Berntein & Fink, 1998), Self-Harm Inventory (Vrouva et al., 2010), Adult Scale of Parental Attachment (ASPA; Snow etal., 2005) and Distress Tolerance Sacle (DTS; Simons & Gaher, 2005) were used. The results indicated that childhood traumatic experiences have significant positive correlation with self-harm behavior and insecure parental attachment with mother and father. Childhood traumatic experiences significantly negatively correlate with secure parental attachment with mother and father. Distress tolerance non-significantly negatively correlates with childhood traumatic experiences and non-significantly positively correlates with self-harm behavior. Secure parental attachment significantly negatively correlates with distress tolerance and significantly positively correlates with insecure parental attachment. T-test shows that there are no mean differences across gender for the studied variables. It was revealed that there are hardly any mean differences across age groups and family system, whereas high mean differences across marital status, current household and education-wise for the studied variables. Moderation analysis showed that secure parental attachment with mother and insecure parental attachment with mother and father significantly moderates the relationship between childhood traumatic experiences and self-harm behavior whereas, secure parental attachment with father does not moderate the relationship. Mediation analysis showed that distress tolerance (*b* = -.003, *CI* [-.01,.003], *p*<.05) did not mediate the relationship between childhood traumatic experiences and self-harm behavior. The study has implications for future educational and clinical practice and makes suggestions regarding clinical interventions that focus on childhood traumatic experiences and self-harm behavior for treatment purpose and secure parental attachment to

overcome maladaptive coping mechanisms as a way of reducing self-harm behavior. To lessen self-harming behaviors, clinicians can create therapeutic procedures that emphasize mending attachment relationships. The study advises doctors to use a strengths-based approach by focusing on non-pathological variables, which helps clients develop resilience and deal with hardship.

Keywords: Childhood Traumatic Experience, Self-Harm Behavior, Parental Attachment and Distress Tolerance.

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CHAPTER 1

1. INTRODUCTION

1.1 Context of the study

Abro (2023) reports that a thorough investigation by the Sahil Foundation revealed a startling 11% rise in the concerning number of child abuse cases in Pakistan in 2022, out of a total of 4,139 documented incidences. In addition, Pakistan is among the leading countries in the world battling the terrible problem of child sexual abuse (CSA). Regretfully, it has been claimed that every year, over 550,000 (0.55 million) youngsters in the nation experience maltreatment (The Nation, 2023). This startling figure highlights the critical need for strong action to stop child sex abuse in Pakistan. According to another report in Pakistan (2020), 2,960 child abuse cases with a 4% increase from 2019, with an average daily sexual abuse of over 8 children. (Sahil, 2020). In 2022, the district of Punjab had the most recorded cases of child abuse, while the district of Sindh stood second in place. Furthermore, the data indicates that the age ranges of 6–10 and 11–15 are particularly vulnerable, and that girls are more than boys to be victims of childhood traumatic experiences for both gender (55% of victims were female and 45% were male). The horrible reality of several types of child abuse, including rape, sodomy, attempted assault, child pornography, homicide after sexual abuse, and incest, was also brought to light by the secondary data. Pakistan's rising trend of child abuse calls for quick response and action.

Childhood maltreatment was discovered to be a risk factor for self-harm behavior in a comprehensive evaluation of research done in various age groups (Ford & Gómez, 2015). Additionally, a longitudinal research found that among teenage pupils, self-harm behaviour was linked to a higher history of maltreatment (Garisch & Wilson, 2015). The literature varies in its conclusions about the connection between adolescent self-harm

behaviour and various forms of abuse. According to estimates, early adolescents—between 13 and 23 percent of those in a community—young adults or teens getting medical attention for mental health issues—as well as girls relative to boys are more to have the self-harm behaviour than teenagers (Preyde et al., 2012). There is evidence based suggestion that individuals use to participate in self-harm behaviors on a regular basis are more likely to commit suicide than those who do not (Whitlock & Knox, 2007).

It is generally agreed upon that a specific risk factor for self-harm behaviour is childhood trauma (Liu et al., 2018; Wan et al., 2015). youngsters who suffer physical, mental, or sexual abuse as youngsters are left with physical and psychological scars that last a lifetime (Xie et al., 2023). Childhood traumas are the main triggers for a variety of emotional and psychological issues, such as mood disorders like depression, anxiety, and hopelessness, and self-harm behaviour that can last into adolescence and adulthood (McKay et al., 2021).Only emotional abuse during childhood was found to be directly linked to self-harm behavior in a study report assessing the specificity of childhood traumatic experiences such as childhood physical, sexual, emotional, and emotional neglect as factors linked with self-harm behaviour in a representive sample of adolescents admitted to hospitals (Thomassin et al., 2016). Strong correlations were found in the Glassman et al. research between emotional and sexual abuse and self-harm behaviour (Glassman et al., 2007). Many research has demonstrated an indirect link between childhood traumas and self-harm behaviour, with mediator factors being involved (Shenk et al., 2010; Zetterqvist et al., 2014).

A child with a complex trauma history can easily triggered and react intensely. Often lacking self-regulation and impulse control. Abused or neglected children often struggle with developing healthy attachments. This can lead to unpredictable, oppositional and extreme behavior. (engaging in high-risk behaviors). According to Anjum and Bano in

2018 study findings, there is a 20% higher likelihood of criminal activity among those individuals who has childhood traumatic experience compared to those people didn't have any traumatic experience. In a research study conducted in Pakistan generate results as Childhood traumas would have a negative correlation with psychological well-being and a positive correlation with psychological suffering. (Shafique & Malik, 2024) Self-harm behaviour are another major public health problem globally (Hawtan, 2005), particularly amongst young people (Cooper, 2005). According to an unofficial estimate, the number of deliberate self-harm cases in Pakistan has also dramatically grown, with estimates as high as one lac instances annually (Shahid et al., 2008). The identification and comprehension of the harmful precursors and outcomes that increase the likelihood of self-harm behaviour and suicide thoughts is an international public health priority (World Health Organization, 2014). According to a report by World Health Organization (WHO) in 2019, 10–20 million people attempt self-harm behavior every year around the world. The COVID-19 pandemic may be to blame for the most recent increase in the prevalence of NSSI.

According to preliminary research, among adolescent's rates of self-harm behaviour increased more significantly between 2020 and 2021 (by about 10%) than between 2011 and 2014 (by about 3%) (Zetterqvist et al., 2021). People have been self-harm behavior for thousands of years (Nock,2010). Adolescent self-harm behaviour are garnering global attention and concern. Empirical studies suggest that self-harm typically begins in adolescence (Nock, 2010) and is linked to a variety of psychological challenges (Jacobson, 2008; Nock, 2006), provides several intrapersonal and interpersonal purposes (Klonsky,2007). Adolescents and young people have the highest lifetime self-harm behaviour participation, whereas older persons report the lowest lifetime engagement (Swannell et al., 2014). However according to current research, there may be a rise in the occurrence of self-harm behaviour (Griffin et al.,2018; Wester et al.,2018). In comparative

to those who doesn’t self-harm, young individuals who self-harm have a much higher risk of unfavorable non-fatal and death outcomes, including suicide (Borschmann et al.,2017; Hawton et al., 2006). According to data from Ireland's National Self-Harm Registry, the number of self-harm rose by 22% among people aged 10 to 24 between 2007 and 2016, and it grew greater in women and girls. (Griffin et al., 2007-2016).

In England and Australia, the number of young people seeking care in general offices and emergency rooms following self-harm behaviour has surged over the last two decades. (Hiscock et al., 2018; Morgan et al., 2017). A research by McManus et al., the prevalence of lifetime self-harm behaviour increased from 2.4% to 6.4% between 2000 and 2014, with increases seen in individuals of all ages and genders. Between 2000 and 2014, the percentage of people who reported using self-harm behaviour to reduce uncomfortable emotions such tension, anger, anxiety, or sadness rose from 1.4% to 4.0% in men and boys and from 2.1% to 6.8% in women and girls. Compared to 51·2% in 2000 and 51·8% in 2007, 59·4% of participants who had participated in self-harm behaviour in 2014 reported no subsequent medical or psychiatric care contact. Compared to female participants and older individuals, male participants and those between the ages of 16 and 34 were less likely to have contact with health services The highest rise occurred in women and girls between the ages of 16 and 24 (from 6·5% to 19·7% in 2014) (McManus et al., 2019). According to 17·7% of women and girls between the ages of 16 and 24 who participated in the 2014 poll, this was the most often cited justification for engaging in self-harm behaviour (McManus et al., 2019). Although self-harm behaviour is now more common in England, the amount of service interaction that results are still modest. Approximately one in five females aged 16 to 24 reported having self-harm behaviour in 2014. Self-harm behaviour may have long-term effects, such as a higher risk of suicide, particularly if the activities are used as a coping mechanism over time. It is important to talk to young people about self-harm

without normalizing it. Primary care, education, and other agencies should provide assistance to young people in finding safer coping mechanisms for emotional stress.

Adolescents and young adults in Pakistan have lately shown an increased prevalence of self-harm behaviour. According to studies conducted in Pakistan, adolescents and young adults are the age group most at risk for self-harm behaviour (Khan, et al., 2002; Khan et al., 1996; Shekhani et al., 2018; Salman et al., 2014; Shahid & Hyder, 2008; Syed & Khan, 2008). The features of this demographic were highlighted in a recent scoping review that synthesized the research on self-harm behaviour in Pakistan that Females in a younger age group were more likely to self-harm (Shekhani et al., 2018). Remembering that this is the largest group of Pakistani people is vital (Mahar, 2014). In Pakistan, Kasusar and Khan (2020) looked at the risk factors for self-harm behaviour in young adults and adolescents. In the context of Pakistan, the most frequent procedures recorded in hospital emergency rooms are medication overdoses and poisonings for self-harming behaviour (Haider & Haider 2001; Waseem et al., 2004). According to a study results self-poisoning with pesticides and insecticides was discovered to be the most popular technique in both urban and rural locations. (Shekhani et al.,2018),

In summary, the mental health of Pakistani teenagers has been poor, as evidenced by recurrent episodes of anxiety and depression brought on by environmental variables. It is also emphasized that self-harm behaviour is more common in Pakistani teenagers and has been linked to an increase in suicidal thoughts as a result of poor mental health (Siddiqui, 2018). Research in Pakistan resulted that the Depression, Anxiety, and Stress Scale scores showed a substantial positive link, whereas the emotional intelligence, quality of life, and self-esteem scores showed a negative correlation with self-harm behaviour. Depression, anxiety, stress, and self-harm behaviour were mediated by self-esteem, quality of life, and emotional intelligence (Gull & Najam,2021).

Youth who have had adverse childhood experiences, such as abuse and broken attachments, are more likely to experience high emotionality or dissociative states. As a result, they may resort to extreme behaviours like self-harm behaviour or other behaviours to express or control their emotions (Gonzales & Bergstrom, 2013). An authoritarian parenting style, characterized by levels of control and demands are high and levels of warmth and affection are low, can increase a child's chance of developing self-harm behaviour (Baetens et al., 2014). We have looked at this in particular in relation to the importance of childhood traumatic experiences, role of parental attachment, and the ability to tolerate distress. Women are one who are more sexually abused, compared to men (Cavanaugh et al., 2015). A research studies results show Individuals who were abused as children have more trouble forming and sustaining healthy relationships, controlling their emotions, and using effective coping mechanisms when faced with significant stressors (Tyler et al., 2021).

Young people comparatively at greater risk for self-harm behaviour due to developmental issues (Burton, 2019). As a result of time and again experiencing childhood distress, particularly have disturb carer attachment, individuals who experience childhood traumatic experiences, are more likely to involve in self-harm behaviour during teen times. (Gonzales & Bergstrom 2013). Problematic connections with carers and other attachment disorders can lead to emotional dysregulation, which is one of the contributing factors to self-harm behaviour.

Adolescents who are less able to tolerate discomfort and who react to stressful events with greater degrees of psychological anguish are more involve in self-harm behaviour (Anestis et al., 2013; Najmi et al., 2007). It has also been discovered that those who self-harm also experiences negative thoughts and emotions (Najmi et al., 2007) and have a decreased capacity to handle discomfort (Nock & Menes, 2008). As a result,

adolescents who experience higher levels of psychological discomfort may turn to self-harm behaviours as a coping strategy (Baetens et al.,2014) and well as younger and older adulthood (Briere & Gil 1998; Klonsky, 2009). Moreover, self-harm behaviour can support self-punishment (such as the self-punishment model) as a means of facilitating emotional regulation (Klonsky, 2007). Ultimately, self-harm behaviour can alleviate distress by reducing negative feelings (like guilt) and promoting a happier emotional state (like relief).

Hence it is crucial to comprehend the psycho-social elements that contribute to self-harm behaviour in order to develop a more successful prevention strategy. Psychosocial variables are important in the development of self-harm behaviour conduct in teenagers. In order to lessen their negative effects on the mental health of self-harm behaviour individuals, it is crucial to take into account the influence of psychosocial elements, such as interpersonal relationships, scholastic pressure, and societal circumstances. Interpersonal relationships and emotional regulation, such as suppressed feelings, self-punishment, internal hostility, self-sensitization, and developing self-control, are the driving forces behind self-harm behaviour. Since it goes beyond attention-seeking and their methods of expressing psychological discomfort, this behaviour has been stigmatized and requires a thorough response (Shahwan et al., 2021). According to a Study conducted in Pakistan found varying associations between self-harm behaviour and unemployment (Shekhani et al., 2018).

1.2 Rationale

The present study has been designed to investigate the association between childhood traumatic Experience, self-harm behaviour, parental attachment and Distress tolerance among emerging adults.

As per report details, out of 4,139 documented occurrences, a stunning 11% increase in the alarming number of child abuse instances in Pakistan in 2022 was found, according to a detailed research conducted by the Sahil Foundation (Abro, 2023). According to World Health Organization (WHO) 2022 report estimates, 300 million children, or about 3 out of 4 of them, between the ages of 2 and 4 experience physical abuse and/or psychological abuse on a daily basis at the hands of their parents or other carers.A child with a complex trauma history can easily triggered and react intensely. Often lacking self-regulation and impulse control. Abused or neglected children often struggle with developing healthy attachments. This can lead to unpredictable, oppositional and extreme behavior (engaging in high-risk behaviors). Research has repeatedly demonstrated that emotional regulation, attachment patterns, and distress tolerance are all greatly impacted by childhood trauma, and these traits are crucial in the development of self-harm behaviors (Anda et al., 2006; Felitti et al., 1998).

Adolescents and young adults in Pakistan have lately shown an increased prevalence of self-harm behaviour. According to studies conducted in Pakistan, adolescents and young adults are the age group most at risk for self-harm behaviour (Khan, et al., 2002; Khan et al., 1996; Shekhani et al., 2018; Salman et al., 2014; Shahid & Hyder, 2008; Syed & Khan, 2008;). Self-Harm behaviour is a major global public health problem under-researched in Pakistan due to religious and legal implications. In Pakistan, there is currently a dearth of epidemiological data and little study on self-harm behavior (Shekhani et al., 2018).

Young people may be at risk for self-harm behaviour due to developmental issues (Burton, 2019). As a result of persistent childhood distress, particularly disrupted carer attachment, individuals who experience early childhood trauma and abuse, also known as

adverse childhood experiences, are more likely to engage in self-harm behaviour during adolescence. (Gonzales & Bergstrom 2013).

Most of Previous Pakistani studies highlight pathology as a leading factor for self-harm tendencies, such as individuals with mental health issues are more likely to engage in self-harm behaviour. A study conducted in Pakistan results showed that intentional self-harm behaviour was substantially related with stress, anxiety, and depression (Meezab et at., 2021). However, few studies are available in Pakistan on childhood traumatic experience and self-harm behavior among emerging adults.

This study also explains the importance of distress tolerance in self-harm behavior among emerging adults. To avoid emotional distress, people may engage in more dangerous or risky behaviours, which might have major long-term implications (Van Dijk, 2013).

The researchers will benefit greatly from this study in several ways. The purpose of this study is to explore relationship between childhood trauma and psychological factors. This knowledge can help identify specific pathways through which trauma may lead to self-harm behaviors. To study role of distress tolerance as mediator and of parental attachment as moderator in relationship between childhood traumatic experience and self-harm behavior among emerging adults would be an attempt to address the previous literature gap particularly in Pakistani context.

1.3 Statement of the Problem

Traumatic events throughout childhood can have a lasting effect on a person's capacity for self-harm behaviour, distress tolerance, and connection with their parents. A healthy parental bond is frequently disrupted by traumatic experiences, such as physical, emotional, or sexual abuse, which leaves victims feeling insecure and distrustful. Because they may not have picked up useful coping skills from their carers, this disruption in

attachment can seriously lower a person's capacity to bear suffering. So, as a maladaptive way to cope with extreme emotional anguish and misery, these people could resort to self-harm behaviour.

Extensive research has demonstrated that self-harm behaviours are linked to insecure attachment patterns, which are frequently the result of traumatic childhood events. A study discovered that teenage self-harm behaviour was more common among adolescents who had experienced childhood trauma and insecure attachment because of their lowered distress tolerance (Baetens et al., 2014). Studies show that those who have experienced interpersonal trauma in the past are far more likely to self-harm than people who have not. According to a study people who experienced abuse as children were more likely to self-harm behaviour as adults and adolescents. (Glassman et al.,2007).

Numerous undesirable effects, such as mental health problems, substance misuse, and chronic physical health concerns, have been linked to such traumatic childhood experiences, according to studies. According to a study finding the groundbreaking adverse childhood events Study found a significant association between the quantity of negative events and the higher risk of a variety of health issues as an adult (Felitti et al.1998). Another research study finding have brought attention to the convergence of data from epidemiological and neurobiological research, demonstrating how early trauma may change the structure and function of the brain, resulting in problems with behaviour, emotion management, and cognition (Anda et al.,2006). This finding emphasizes the critical need for focused interventions that address the underlying trauma in order to effectively reduce self-harming behaviours.

1.4 Research Objectives

The aim of the present study is to accomplish the following objectives:

- To examine the relationship between childhood traumatic experiences, self-harm behavior, parental attachment and distress tolerance among emerging adults.
- To investigate the impact of childhood traumatic experience on self-harm behaviour.
- To Investigate the moderating role of parental attachment in the relationship between childhood traumatic experiences and self-harm behavior among emerging adults.
- To Investigate the mediating role of distress tolerance in the relationship between childhood traumatic experiences and self-harm behavior among emerging adults.
- To examine the role of demographic characteristics in the study variables.

1.5 Research Questions

Q1: Do childhood traumatic experiences, distress Intolerance and parental attachment style predicts self-harm behavior among emerging adults?

Q2: Does childhood traumatic experiences effect distress tolerance among emerging adults?

Q3: Does distress tolerance effect self-harm behavior among emerging adults?

Q4: What role distress tolerance plays between childhood traumatic experiences and self-harm behavior among emerging adults?

Q5: What role parental attachment plays between childhood traumatic experiences and self-harm behavior among emerging adults?

1.6 Alternative Hypotheses

H1: Childhood traumatic experiences have positive relationship with self-harm behavior, and insecure parental attachment (i.e., avoidant and anxious) among emerging adults.

H2: Childhood traumatic experiences have negative relationship with secure parental attachment and distress tolerance among emerging adults.

H3: Distress tolerance mediates the relationship between childhood traumatic experiences and self-harm behavior among emerging adults.

H4: Secure parental attachment decreases the effect of childhood traumatic experiences on self-harm behavior among emerging adults.

H5: Insecure parental attachment (i.e., avoidant and anxious) exacerbate the effect of childhood traumatic experiences on self-harm behavior among emerging adults.

1.7 Conceptual Model of the Study

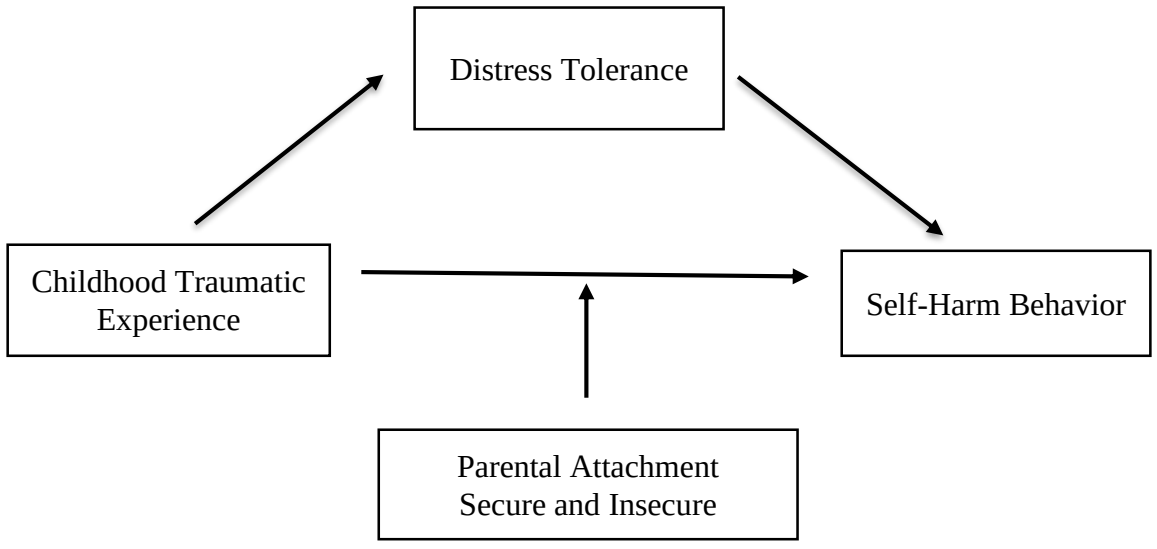

Figure 1. showing the relationship of childhood traumatic experiences and self-harm behavior among emerging adults along with the role of parental attachment and distress tolerance.

1.8 Significance of the Study

A large number of children are impacted by the widespread global epidemic of child abuse each year (UNICEF, 2023). In Pakistan, the situation is similarly dire. Abbas and Jabeen's 2020 retrospective study revealed alarming data on child abuse, with 41% of respondents reporting sexual abuse as a child, despite an equal proportion of male and female participants. It has become a serious issue for Pakistan, as eight children are abused every day, according to media reports (Faraz & khan, 2022). The trend of increasing child abuse in Pakistan requires immediate attention and intervention. Also in 2019, eight hundred innocent children in Pakistan were the victims of sexual assault (Faraz & khan, 2022). Therefore, the current study highlighted pertinent recommendations for combating child maltreatment.

Finding of Pakistan research study showed the indirect effect of emotional neglect on self-harm behaviour was mediated by low distress tolerance, low self-compassion, high self-disgust, and resulting high emotion regulation difficulty (Yasemin & Mujgan, 2023). Strategies enhancing distress tolerance and parental attachment can mitigate childhood trauma, reduce self-harm behaviors, and improve Pakistani youth's mental health and well-being through long-term implementation.

A research in China concluded there was a noticeably positive correlation between child abuse and self-harm behaviour. (Wang & Liu, 2023). The study's emphasis on self-harm behaviour may raise Pakistan's understanding of mental health issue, through illuminating the link between self-harm and childhood trauma, so this research can contribute to de-stigmatizing mental health concerns and fostering community dialogue on mental health.

According to Shekhani et al. (2018), the review revealed a deficiency of data concerning the clinical features of self-harm in Pakistan. There is a dearth of information

about self-harm behaviour in Pakistan. Data collection on self-harm is hampered by a number of factors, such as the absence of a research infrastructure and the stigmatized and unlawful nature of self-harm behaviour in this nation. this study will help in filling literature gap in regard to self-harm behavior specially among emerging adults.

1.9 Operational definitions

1.9.1. Childhood Traumatic Experiences.

Childhood trauma exposure is frequently defined as physical, sexual, and/or emotional abuse, or physical and/or emotional neglect prior to the age of eighteen. However, childhood trauma exposure can also include more general trauma and household dysfunction, such as a serious accident, witnessing parental drug abuse, or the death of a parent. (Bernstein et al., 1997). For assessing childhood traumatic experience will be using child trauma questionnaire developed by Bernstein and Fink in 1998.Whereas higher score by person on scale indicates more childhood traumatic experiences in them.

1.9.2. Self-harm Behavior.

Self-harm behaviour is defined as the intentional, direct damage or change of body tissue without conscious suicidal intent. (Favazza, 1998; Winchel & Stanley, 1991). For assessing self-harm behaviour will be used, which includes two subscales risk taking and self- harming behavior. Whereas higher score by person on each subscale indicates risk taking and self-harming behavior in them.

1.9.3. Parental Attachment.

Parental Attachment is a specific and limited component of a kid's relationship with his or her carer that is concerned with keeping the youngster safe, secure, and protected (Bowlby, 1969). To evaluate parental attachment, style the adult Scale of parental attachment scale will be used, which includes two subscales as secure parental attachment and insecure parental attachment for both father and mother separately. A higher score on

each subscale indicates that the adult and parent has a secure or insecure parental attachment style.

1.9.4. Distress Tolerance.

Distress Tolerance is described as an individual's actual or perceived ability to encounter and tolerate unfavorable psychological states (Simons & Gaher, 2005). The Distress Tolerance Scale will be used to assess distress tolerance, with a higher score indicating lesser distress tolerance.

CHAPTER 2

2. LITERATURE REVIEW

Many children, regardless of gender, face severe infringement of their rights and persistent physical and emotional trauma, hindering their growth and development. They are exposed to "Child Abuse" and neglect, compromising trust, self-esteem, and causing fear and insecurity (Siegel, 2013). According to research studies results show individuals who were abused as children have more trouble forming and sustaining healthy relationships, controlling their emotions, and using effective coping mechanisms when faced with significant stressors (Tyler et al., 2021). Apart from that, another research study regard prevalence of trauma from stressful events that was conducted in India and data was conducted from 693 Kashmiri students The study found that 33.3% of respondents experienced high traumatic exposure, 23.7%) experienced extremely high exposure, 33.5% experienced moderate exposure, and 9.5% experienced low exposure during the Kashmir conflict. Traumatic events were highest in feeling stressed, fear of search operations, witnessing protests, being hit by explosives and exposure to violent media portrayals (Dar et al., 2022).

2.1 Childhood traumatic experiences

According to American Psychological Association, trauma is the emotional reaction to a dreadful incident such as an automobile accident, a criminal act, a natural disaster, emotional or physical abuse, neglect, being the victim of violence, losing a loved one, a war, and more. Following an incident, shock and denial are common reactions. Unpredictable feelings, memories, strained relationships, and even physical symptoms like headaches or nausea are examples of longer-term effects. People respond to comparable occurrences differently because subjective experiences vary from person to person. The

majority of people who go through potentially traumatic experiences don't end up psychologically traumatized, however they could feel upset and suffer (Storr et al.,2007).

According to earlier research, childhood trauma raises the likelihood of engaging in risky behaviours including drug misuse (Skinner et al., 2016; Worsley et al., 2018). This is mostly due to the possibility that adolescents who suffered trauma as children may form insecure attachments, which can have detrimental effects on their emotions and behaviour (Forster et al., 2021). According to a child maltreatment report 2019 in USA approximately 80% of cases of child abuse take place in the home, when parents or other people who have a big influence on the kid commit the abuse.

Child abuse is a widespread issue in society that has an impact on a large number of kids worldwide. A review found that the estimated global prevalence of childhood maltreatment was 226/1000 for physical abuse, 363/1000 for emotional abuse, 163/1000 for physical neglect, and 184/1000 for emotional abuse (Stoltenborgh et al., 2015). Overall, these rates were found to be high. In 2020, there were 1841 abused children and adolescents in Portugal, with 59.7% of them being female, according to the Portuguese Association of Victim Support (APAV, 2021). It's likely that these figures understate the situation. Because incidents are sometimes underreported or go unrecognized, it might be difficult to pinpoint the precise prevalence of child abuse and neglect (Gubbels et al.,2021).

It is essential to comprehend the relationship between self-harm, distress tolerance, parental attachment, and early trauma in order to create therapies and support networks that work. Adolescents who have experienced trauma may still be affected long into emerging adulthood, leading to more complicated social interactions and a greater sense of autonomy. According to a 1998 study on adverse childhood experiences conducted by Kaiser Permanente and the Centers for Disease Control and Prevention, childhood traumatic experience are at the core of many social, emotional, and cognitive impairments that

increase the risk of engaging in unhealthy self- harm behavior, low life potential, and premature death (Kaiser,1998).

Imran et al. (2020), have examined the factors that contribute to child labor, shedding light on things like parental job status, family income, and parental education. This study draws attention to the financial side of child abuse and the way that poverty forces kids to labor. various factors might affect the occurrence of child abuse in various places, including socioeconomic status, cultural norms, awareness levels, access to education, and the efficacy of child protection measures (Naeem et al., 2019). Abuse in childhood, including both physical and emotional abuse, can result in a wide range of physical and mental health issues. These problems include a variety of conditions, such as common mental illnesses like depression and anxiety, PTSD, self-harming behaviours, personality pathology marked by disruptions in an individual's self-concept and interpersonal relationships, psychosis involving a disassociation from reality, and even sexually transmitted diseases due to the increased vulnerability and risky behaviours frequently seen in those who have experienced childhood abuse (Hyder, 2007; Naeem et al., 2019; Kadir, 2019). These early traumatic experiences can have a detrimental effect on one's health, resulting in long-term mental health issues (Christ et al., 2019). Furthermore, the way persons who experienced childhood abuse react to other people as adults may be permanently impacted by these traumatic events (Rueness et al., 2020).

Research has shown that youth who have experienced trauma are twice as likely to acquire a mental health illness than youth who have not experienced trauma (Lewis et al., 2019; Marshall et al., 2013). According to research studies results show Individuals who were abused as children have more trouble forming and sustaining healthy relationships, controlling their emotions, and using effective coping mechanisms when faced with significant stressors (Tyler et al., 2021). One of the biggest risk factors for depression and

self-harm is experiencing childhood traumas, which include abuse, neglect, and dysfunctional households. Childhood traumatic experiences are prevalent in the general population (Bellis et al., 2014; Hughes et al., 2017; Russell et al., 2021). Children who experience emotional trauma before the age of four find it harder to develop trust and social ties with others as they grow older. Furthermore, when someone experiences emotional trauma as an adult, they are more likely to experience the consequences.

Traumatic coupling in this process turns the innocuous stimulus into a trigger—a term used to refer to a recall of a traumatic event. These may result in unpleasant or even painful sensations. People's capacity to control their emotions and negotiate relationships, as well as their sense of safety, self-efficacy, and self are all negatively impacted by reliving. According to research, people who have gone through a traumatic incident may try to reduce the symptoms of the disease by using obsessive-compulsive behaviours, including compulsively checking for safety (Gershuny et al.,2003). Disasters that are man-made, technical, or natural, such as war, abuse, violence, car crashes, or medical issues, can all result in trauma (Neria et al., 2008).

The term "vicarious trauma" (VT), coined by Irene Lisa McCann and Laurie Anne Pearlman, refers to the way trauma therapists are affected by working with traumatized clients. Charles Figley was the one who first identified the phrase "secondary traumatic stress" to describe this occurrence (McCann, 1990; Russo, 2020). Anger, anxiety, grief, and embarrassment are among the feelings that some trauma survivors find difficult to control; this is especially true if the trauma happened while the person was young (Mandel et al.,1993).

The idea of transgenerational trauma is frequently linked to the studies of several academics and scientists who have investigated the possibility of trauma's effects being passed down across generations. Judith Herman, a renowned psychiatrist and trauma

expert, has significantly contributed to the study of trauma, particularly its transgenerational effects. Herman investigates how trauma survivors may pass on the effects of their experiences to the following generation in her seminal work "Trauma and Recovery" (1992), focusing on the setting of relationships and families. Dori Laub, a psychoanalyst, has explored the impact of Holocaust survivors on transgenerational trauma. Maria Yellow Horse Brave Heart, a social work researcher, has focused on historical trauma's impact on Native American communities. Vamik Volkan, a psychiatrist and psychoanalyst, has studied the transmission of collective trauma, highlighting how shared traumas shape community identity and relationships. Many research has looked at the impact of child abuse on early children, but the effects on subsequent generations have received less attention. Specifically, little is known regarding 1) the potential relationship between behavioral symptoms in children and the carers' history of abuse or trauma as children, and 2) the protective and risk variables that play a role in this transmission process. These kinds of studies may shed light on the reasons why some abused children have behavioral issues while others manage to overcome hardships. In fact, some kids manage to operate at somewhat normal levels even while their carers ignore or mistreat them (Cicchetti, 2013). According to some recent research, children's metalizing skills play a significant role in their resilience when it comes to trauma (Ensink et al., 2017). Incoherent mental images of oneself and others indicate disorganized attachment states of mind, which are indicative of metallization impairments and are common in populations of abused people (Barone & Carone, 2020; Milot et al., 2014).

Adverse outcomes for maltreated children are numerous and include insecure or disordered attachment (Cyr et al., 2010), difficulty regulating emotions (Alink et al., 2009), and a variety of behavioral symptoms like internalizing and externalizing problems (e.g., Clarkson, 2014; Rosen et al., 2018). Preschoolers that have externalizing issues include

those who exhibit aggressive behaviours, conspicuous disobedience, excessive activity, and poor impulse control (Campbell et al., 2000). Anxiety, sadness, social distancing, and withdrawal are key characteristics of internalizing symptoms (Slattery et al., 2000).

Hungarian psychotherapist Sándor Ferenczi is renowned for his work on trauma theory and made substantial contributions to the profession. His 1933 study, "Confusion of tongues between adults and the child," is one of his most important contributions to this field. Ferenczi talked on how difficult life events, particularly those involving sexual abuse as a kid, might cause misunderstandings when it comes to adult-child communication. He underlined how crucial it is to acknowledge and deal with trauma's effects in the therapeutic alliance.

A research study was conducted in Germany included 2498 participants and research study was conducted on effect of childhood traumatic experiences on self-harm. And according to research results finding there was positive significant relationship between variable and finding state that the self-harm behavior group's participants reported much higher instances of child abuse. And emotional abuse was considered to be adored by 72% of all participants with self-harm behavior (Brown et al., 2018). Moreover, another research was conducted on role of childhood traumatic experiences as risk factor for self-harm behaviour and sample consisted of 184 patients out of which 83 declined and 98 forensic patients were included for research study in Sweden and results established are that During file checks, 57.2% of individuals disclosed physical abuse, 20% revealed sexual abuse, and 43% reported being repeatedly bullied by their classmates as children. Self-harm behaviour was also linked to parental drug usage. An increased likelihood of self-harm behaviour was predicted for each extra childhood traumatic experiences. (Laporte et al., 2023).

According to a research study about childhood Traumatic experience and self-harm

in adults with clinical depression and non-clinical controls" that was conducted in Pakistan (N=100) results indicated that a significant positive correlation between self-harm and childhood trauma, but only in clinically depressed adults (Younas et al., 2023). Furthermore, according to a research results finding established that Unfavorable childhood experiences were linked to increased drug use and decreased psychological well-being. Substance abuse and psychological well-being, however, had no relationship and didn't explain the indirect effects of traumatic childhood events on adjustment. This results predicted through a Pakistani research study with sample size 595 Pakistani university students. (Hanif et al., 2023). People who have experienced trauma may find it difficult to form friendships, which leaves them feeling isolated and alone. Self-harm is a coping strategy used by people to deal with strong emotions or to feel in control of their suffering (Chen & Patterson, 2015; Klonsky, 2007). Self-harming behaviours have the potential to temporarily numb or shield persons from emotional anguish.

There isn't many research in Pakistan that examine the connection between self-harm and traumatic childhood experiences. Even while traumatic experiences like abuse, domestic violence, and conflict exposure are common, there is still a dearth of study on the subject. The scant literature to date indicates a robust correlation between self-harming behaviours as a coping strategy for unresolved emotional distress and early trauma. The lack of statistics, however, makes it difficult to fully comprehend the extent of the problem, especially in light of Pakistan's distinct sociocultural issues, which include stigma around mental illness and restricted access to psychiatric care. This emphasizes how urgently the nation needs more targeted research and initiatives.

2.2 Self-Harm Behavior

Self-harm behavior is one of the emerging issues in public health. According to Nock and Favazza (2009), it is characterized as a range of intentional self-inflicted bodily

damage that does not entail suicidal thoughts, does not include socially acceptable actions like body alteration, tattooing, or piercing, and causes mild to severe bodily pain. Acts such as skin-cutting, punching, biting, burning, scratching, carving, slamming, and scraping are all included in self-harm behaviour (Zetterqvist, 2015). Between 9% and 36% of teenagers have lifetime prevalence of self-harm behaviour (Gholamrezaei et al., 2017; Mannekote et al., 2021). It is a widespread tendency among teenagers and young adults, usually starting in early to middle adolescence (Brown & Plener, 2017). It is crucial to comprehend the etiological elements that contribute to self-harm behaviour. Negative consequences, including as psychopathology and suicide, have been found to be more common among adolescents who participate in self-harm (Taylor et al., 2018).

Self-harm behavior, Self-injurious behavior, nonsuicidal self-injury, and self-injury are words used to characterize deliberate tissue damage that is often done without suicidal intent. (McAllister, 2003). Self-harm is a behavior causing intentional harm to self by directly injuring (as cutting, burning and hitting) to one's own skin tissues without suicidal intentions. Any behaviour used to injure oneself, regardless of motivation, was considered self-harm by National Institute for Health and Excellence in 2022. It is becoming a bigger public health problem, particularly for kids and teenagers (Lockwood et al., 2018). In just ten years, England's lifetime prevalence rates rose from 2.4% to 6.4% (Borschmann & Kinner, 2019). There are distinctions established between self-harm behaviour with and without suicidal intent. In the United States, the recommended term is nonsuicidal self-injury, which describes self-harming behaviour without suicidal intent by School of Behavioral Health in 2021. Self-harm has a substantial negative impact on the general public since it is linked to a higher risk of suicide as well as illness, low educational achievement, poor employment prospects, and a worse quality of life (Hetrick et al., 2019).

Self-harm behaviour is becoming more widely acknowledged as an embodied event

that is fundamentally psychological, emotional, and social in addition to being a physical experience (Hasking et al., 2017; Klonsky et al., 2014). Adolescents who engage in self-harm frequently do so to deal with and express mental agony, typically by externalizing extreme discomfort that they find intolerable (Miller et al., 2021). Adolescence is a time when emotional development processes related to these processes might give rise to the start of self-harm behaviour (Hawton et al., 2012). Subsequently, persistent impulses to commit self-harm are sustained by relationship problems, emotional dysregulation, and insufficient alternative coping strategies to replace the occurrence (Miller et al., 2021). In the past, self-harm and suicidality have been mistakenly associated; however, recent research has demonstrated that many instances of self-harm include people trying to manage their misery and/or suicidal thoughts rather than trying to take their own lives (Miller et al., 2021). However, self-harm behavior is a powerful predictor of suicidality, particularly when it is more severe and protracted (Anestis et al., 2013). Providing adequate assistance to persons who self-harm is crucial in order to optimize their mental health and overall quality of life. Regrettably, a lot of people are reluctant to come forward and seek professional assistance out of concern for stigmatizing reactions, which might include misinterpreting the reasons for their actions. Because of this, self-harm is frequently an issue with invisible health (Hasking et al., 2017).

Numerous variables that have been linked to self-harm behaviour have been examined in clinical investigations. These factors include psychological traits (including negative emotionality, emotion skills deficiency, and self-derogation), psychiatric diseases, environmental circumstances from infancy, and advertisements (Klonsky, 2007). Studies that take psychological aspects into account have discovered that early-life traumatic experiences might affect a person's urge to self-harm behaviour by affecting their capacity to manage stress and regulate their emotions (Lovell & Clifford, 2016). Childhood abuse

is a substantial risk factor for self-harm behavior, according to a comprehensive review (Serafini et al., 2017).

According to Herman (1997) and Santa Mina & Gallop (1998), self-harm behavior is an effort to cope with intense feelings of dissociation or being imprisoned, powerless, and "damaged," as well as with mental or physical discomfort that appears overpowering. In addition to substance misuse, self-harm behavior is linked to prior childhood sexual abuse and other types of trauma. Self-harm behavior is more common among those who have had several early trauma experiences than in those who have just had one adult trauma event (such as a catastrophic vehicle accident or a community-wide disaster). Substance misuse, self-harm behaviour and eating disorders are strongly correlated (Claes & Vandereycken, 2007). In another research study that was conducted in 2023 included 374 participants out of which 287 reported self-harming behavior exploring complex relationship between childhood traumatic experience and self-harm and its results state that self-harm was positively correlated to severity of childhood trauma (Norton et al, 2023). Emerging adulthood (ages 18–29) had greater rates of self-harm than any other stage of adulthood, encompassing both suicide attempts and self-harm behaviour (Kessler et al., 2005; Prinstein, 2008).

Robin Connors (1996) identified four functions of self-harm behavior in relation to trauma: re-enactment, expression of feelings and needs, reorganization of the self, and management of dissociative processes. Self-harm behavior is used to experience physical pain, express feelings, restore balance, and manage dissociative processes, allowing individuals to feel in control of their emotions. In a research study that was conducted in 2023 included 374 participants out of which 287 reported self-harming behavior exploring complex relationship between childhood traumatic experience and self-harm and its results state that self-harm was positively correlated to severity of childhood trauma (Norton et al.,

2023). Another research study was conducted in Germany included 2498 participants and research study was conducted on this title impact of child maltreatment on self-harm behaviour. And according to research results finding there was positive significant relationship between variable and finding state that the self-harm behavior group's participants reported much higher instances of child abuse. And emotional abuse was considered to be adored by 72% of all participants with self-harm. (Brown et al., 2018). Research finding also shown that, among the many childhood traumatic experiences types, emotional abuse was significantly linked to self-harm in adulthood. (Holden et al., 2022). Furthermore, according to a research study that was conducted on finding relationship between childhood trauma and self-harm behaviour in which total 428 participants from University undergraduate and from community number of participants were 533. So the results were there is positive correlation between childhood traumatic experiences and non-suicidal self-harm with increase in self-harm behaviour with presence of depression and psychache (Holden et al., 2022).

According to another research study on childhood adversity, puberty timing and self-harm conducted at UK in 2021 for which 6698 participants between 16 to 21 age range were selected and results finding state that participants' chance of self-harm increased by an average of 12–14% for each extra kind of adversity by 16. When the outcomes were suicidal thoughts and self-harm, the relative risk estimations were higher for the direct impacts. There was no proof that the relationship between self-harm and childhood adversity was mediated by an earlier pubertal age. (Russell et al., 2021). Moreover, according to another cross sectional research design which investigate adverse childhood experience and adult self-harm in a female forensic population in 2022 established that patients have high prevalence of childhood traumatic experiences and self-harm behaviour even though there is positive correlation between both of it as moreover more childhood

traumatic experiences lead individual to higher likelihood of self-harm behaviour in adulthood.

According to a research study finding results indicated that the greatest chances of self-harm behaviour were linked to parent mistreatment with dysfunction. Whether these relationships were mitigated by the protective effects of perceived social support from peers and teachers (Forster et al., 2020). Finding of research study found that childhood abuse was both directly and indirectly related to self-harm via attachment pathways. (Maria et al., 2022). Furthermore, a research was conducted to studied association between adverse childhood experience and self-harm behaviour among Chinese adolescence (N=562) with depression issue, so the finding established were a number of childhood traumatic experience were linked to higher odds of exposure among depressed adolescents with self-harm behaviour, including sexual abuse, physical abuse, emotional neglect, emotional abuse, carer divorce/family separation, carer treated violently and carer substance abuser. Compared to the low childhood traumatic experience class, self-harm behavior was more common in the high/moderate childhood traumatic experiences class, especially in the high childhood traumatic experiences class. (Wang et al., 2023). Moreover, another research "the relationship between emotional neglect and self-harm behavior among middle school students in China" results finding stated that there is positive relationship between emotional neglect and self-harm behaviour. Also finding concluded Pupils with a history of emotional neglect had greater rates of self-harm behavior than those without such a background. (Hou et al., 2023).

According to a Chinese research study (N=536) finding indicated that in the previous year, 22% of people had self-harm behavior. The findings demonstrated a substantial relationship between child maltreatment and both mental co-morbidity and emotion dysregulation. Additionally, there was a strong relationship between emotion

dysregulation and both psychiatric co-morbidity and positive and negative reinforcement. If they had suffered a great deal of abuse as children in the past, their inability to control their emotions may have contributed to their self-harm and increased psychological suffering. (Wong & Chung, 2023).

One more research was conducted to study self-harm as coping mechanism in adolescence sample included 2,280 aged between 11 to 19. Results established and the findings show that, of the 45.2% overall prevalence, girls from non-traditional homes who started self-harming at a young age are the most susceptible category. Torturing oneself with self-defeating ideas was the most common type of self-harm among teenagers, followed by both direct and indirect physical self-harm behavior. (Demuthova & Demuth, 2020).

According to the experiential avoidance model self-harm behavior is a coping strategy used by people to avoid feeling what they are experiencing on the inside. It implies that triggering strong feelings may cause a change in behavior towards avoidance, with self-harm acting as a short-term comfort from suffering. This strengthens the tendency towards self-destructive actions, turning them into a reflexive flight mechanism (Chapman et al., 2006). a research study conducted in 2020 included 531 universities student's participants. The study discovered a clear correlation between self-harm behavior and negative and positive affectivity, as well as the evaluation and absorption components of distress tolerance. Appraisal and positive affectivity distinguish between those with a lifetime, recent, and non-history of self-harm behaviour, while negative affectivity is inversely correlated with self-harm (Slabbert et al.,2020).

According to Klonsky (2007), self-harm has been implicated in a number of interpersonal functions, including communicating distress, evoking social support, escaping unwanted situations or demands, asserting autonomy, demonstrating strength, and

seeking acceptance or belonging within a group. The link between self-harm and family relationships has been explained by a variety of ideas. Numerous theories recognize that self-harm involves emotional control (Nock, 2009). Self-harm is understood by cognitive theorists to be the consequence of deficiencies in problem-solving abilities (Nezu et al.,2010). Adolescence, a time of transition from dependency to independence that brings with it a rise in interpersonal demands and expectations, is when engagement in self-harm behavior usually manifests (Cohen et al., 2013). While most teenagers are able to adjust to their changing circumstances by developing healthy coping methods, some find it difficult to deal with these changes and resort to self-harm as a coping technique (Wadsworth, 2015).

Numerous meta-analyses have repeatedly demonstrated a connection between self-harm behaviour and childhood traumatic experience, which includes emotional, physical, sexual, and neglect abuse (Liu et al., 2018). Turner et al. discovered that the kind of maltreatment most closely linked to young people's ideas of self-harm is emotional abuse (Turner & Colburn, 2022). Furthermore, among both adolescents and adults, a meta-analysis conducted and presented strong evidence that emotional abuse throughout childhood had a stronger correlation with self-harm behavior than other forms of abuse (Liu et al., 2018). Self-harm behaviour may arise as a result of these modifications to the emotional and reward systems (Cummings et al.,2021).

Research have shown that the association between emotional abuse experiences as a kid and self-harm behavior is mediated by inadequate emotion expressivity rather than emotion coping (Thomassin et al.,2016). Physical neglect and other forms of childhood maltreatment can raise the risk of self-harm behaviour overall, but a meta-analysis that included people who had only experienced physical neglect as children found a less significant relationship with self-harm behavior (Liu et al., 2018). Part of the difference in

the effects of emotional and physical abuse on self-harm behavior might be related to cultural variables. To be more precise, physical neglect and even light corporal punishment are occasionally seen as useful tactics for building children's resilience in the context of traditional Chinese teaching.

A study conducted a meta-analysis which found that the prevalence of lifetime self-harm behaviour was 17% in adolescents, 13% in younger people, and 5% in older persons globally (Swannell et al.,2014). Between 1-4 percent and 6% of individuals in the US have admitted to participating in self-harm behavior (Klonsky, 2011). According to estimates from a number of different research, the prevalence of self-harm behavior in adults is between 14% and 18% (Klonsky, 2011; Muehlenkamp et al., 2012). Self-harm behavior typically manifests at an age between 12 and 15 years old, with the age group between 14 and 24 years old having the greatest frequencies of the condition (Ammerman et al., 2018). In fact, pre-adolescence or adolescence is when 90% of young people who self-injure first do so. However, some self-injurers start before the age of 12 (including youngsters as young as age seven), while other self-injurers start later in life (Gluck, 2012). More severe and protracted self-injury is linked to early-onset self-harm behavior (Ammerman et al., 2018).

Biswas et al. (2020) discovered a positive correlation between teenagers' self-harm behavior and higher degrees of parental supervision in their population-based investigation spanning 82 nations. According to research study recognizing teenagers who intentionally harm themselves is essential for early intervention (Duarte et al.,2020). Self-harm behavior and self-injury are more prevalent among female teenagers, who are generally more likely to have internalizing issues (Biswas et al., 2020; Lüdtke et al., 2017; Voss et al., 2019). According to Oktan (2017), self-harm conduct is significantly regressed by body image.

Between 9% and 36% of teenagers have lifetime prevalence of self-harm behavior

(Gholamrezaei et al., 2017; Mannekote et al., 2021). It is a widespread tendency among teenagers and young adults, usually starting in early to middle adolescence (Brown & Plener, 2017). It is crucial to comprehend the etiological elements that contribute to self-harm behavior. Numerous variables that have been linked to self-harm behaviour have been examined in clinical investigations. These factors include psychological traits (including negative emotionality, emotion skills deficiency, and self-derogation), psychiatric diseases, environmental circumstances from infancy, and advertisements (Klonsky, 2007). Studies that take psychological aspects into account have discovered that early-life traumatic experiences might affect a person's urge to self-harm by affecting their capacity to manage stress and regulate their emotions (Lovell & Clifford, 2016). Childhood abuse is a substantial risk factor for self-harm behaviour, according to a comprehensive review (Serafini et al., 2017).

A research study results found that positive and negative affectivity, as well as the aspects of distress tolerance related to absorption (allocating attention to discomfort) and evaluation (i.e., negative judgements of distress), were directly linked to self-harm behaviour (Slabbert et al., 2020). A research study in Pakistan on title “A Qualitative Exploration of Intentional Indirect Self-Harm on Adolescents” result are numerous significant themes were found in the investigation. Various self-harm behaviours, such as beatings, cutting, overeating, snatching, drug use, rapid driving, punching, vomiting, riding a motorbike, impatience, emotional discomfort, and smoking, are included in intentional indirect self-harm, including the secondary themes. The adolescents stated that they participated in these activities as a coping mechanism for feelings of inadequacy, mental discomfort, and a lack of parental support. The study also discovered that major barriers to receiving treatment include the absence of supportive resources and cultural stigmas associated with mental health (Niazi & Rohail, 2024). The 12-month and lifetime

prevalence of self-harm behaviour in non-clinical groups, respectively, varied from 3.2% to 44.8% and 21% to 33% in a report of South Asia included 8 countries (Haregu et al., 2023). A research study results in Pakistan stated mental health professionals view intentional self-harm as traumatizing, but they also see it as a means of helping teenagers manage their internal and external environments and get rid of unpleasant feelings.

Regarding whether there are gender differences in self-harm behaviour, there is conflicting information. While some research (Plener et al., 2009) show no gender differences in self-harm behaviour, others (Barrocas et al., 2012) suggest a higher frequency in females. In relation to other sociodemographic factors, a study discovered that those who reported having trouble paying for needs had a higher likelihood of filing for self-harm behaviour than people who did not (Nixon et al., 2008). But according to a different study, teenagers with high socioeconomic status are also likely to have self-harm behaviour (Yates et al., 2008).

The Diathesis-Stress Model states that the likelihood of self-harm behaviour is influenced by the interaction between personal susceptibility traits like emotion dysregulation and external stressors such childhood trauma (Nock, 2010). Childhood trauma is a major stressor because it can exacerbate pre-existing vulnerabilities such as emotional dysregulation and increase the risk that someone will use self-harm behaviour as a maladaptive coping strategy (Linehan, et al., 1993). This theoretical paradigm recognizes the intricate relationships that exist between emotional dysregulation, childhood trauma, and adult self-harm behaviour (Linehanet al., 1993).

There is essentially no literature on self-harm behaviour in Latin American nations, and Mexico in particular (Thyssen & Van, 2014). A small number of research have started to look at this subject recently. In Mexico City, studied self-harm behaviour in a population sample of young people ages 11 to 17 (Albores et al., 2014).

Individuals that engage in self-harm behaviour are regarded to be emotionally illiterate, which mostly resulting in the development and maintenance of ineffective coping behaviours. The most commonly used explanation for self-harm behaviour state that self-injurious behaviour as a mechanism to release unavoidable emotions such as anger, anxiety, or pain to reduce negative affect which is generated by any negative situation or experience. Affective Feelings of anger and/or frustration out of stress are thought to become unmanageable from this perspective, and the individual motivation to engage in self-harming behaviour is to cope with negative feeling or cognition so can gain a sense of internal stability and relief, thereby escape the unmanageable negative feelings or cognitive experience (Klonsky & Muehlenkamp, 2007; Rodriguez, 2001). This is in contrary to healthy coping skills, in which people learn effectively manage their negative emotions through self-relaxation, emotion acceptance, and modelling. Self-punishment and attention-seeking behaviours are two further postulated but under-reported motivations for self-harm behaviour (Klonsky et al., 2014).

Understanding the causes of growing adult self-harm behaviour in Pakistan is essential, especially in light of traumatic childhood experiences. Exposure to interpersonal violence, emotional and physical abuse, neglect, and the death of important family members throughout childhood are among the critical causes. These traumatic events can leave profound emotional scars that become visible when someone self-harms to relieve stress, sadness, and unresolved sorrow. Further exacerbating these behaviours are societal issues such as unemployment, academic pressure, and poverty. The stigma associated with mental health in our culture frequently deters people from getting treatment, which leads to feelings of powerlessness and loneliness that encourage self-harming behaviours. These elements emphasize how critical it is to treat childhood trauma and offer mental health services in order to reduce the likelihood that emerging adults may hurt themselves.

2.3 Parental Attachment

Individual socialization and development take place primarily in the family, and the family system is crucial to the psychological and behavioral development of each individual (Bronfenbrenner, 1979). Individual problem behaviour and parental attachment levels have been shown to be significantly correlated negatively in a number of empirical investigations (Chen et al., 2015).

A stable parental attachment is one of the most significant traits linked to psychological well-being when taking Bowlby's Attachment Theory into account (Braga & Gonçalves, 2014). Research indicates that insecure attachment is a risk factor for self-harm behavior (Cassels et al., 2019) and that attachment issues are essential to self-harm behavior (Molaie et al., 2019). Securely attached babies and early kids exhibit greater levels of independence, emotional control, social skills, and mental well-being. However, mistreatment and neglect cause children and newborns to develop unstable bonds (Gandhi et al., 2016).

Strong evidence suggests that early socioemotional development, particularly emotion control, is predicted by a child's parenting style (Cassidy, 1994; Thompson & Meyer, 2014). According to data from longitudinal research, children's subsequent regulating abilities are predicted by the quality of their early parent-child connections, namely their sense of security and warmth from their parents (Boldt et al., 2020; Choe et al., 2013).

Warmth, sensitivity, regular caregiving, and contingent responsiveness are characteristics of parent-child relationships that have been closely linked to children's development of critical socioemotional abilities, such as emotion control (Cassidy, 1994; Yagmurlu & Altan, 2010). A study conducted a meta-analysis of over 70 empirical studies and found that children who are securely attached typically benefit from parents who are

consistently sensitive and responsive, as this helps the child acquire increasingly adaptive regulatory skills (Cooke et al., 2019).

Trauma is the most damaging element in an attachment connection, according to Fonagy (2010). In the event that parents do not assist their children in managing their concerns, the development of the brain will be hindered. Furthermore, rather than creating a safe haven in their minds, children who witness traumatic events involving their parents are likely to create mental images of them that are hostile and terrifying, causing them to feel pain and negativity all the time (Coffino et al., 2013). They are also continuously informed on how to assist the caretakers and what their next move will be. The suffering that newborns endure when their bonds are shattered has an impact on how they develop. Unprocessed trauma impairs mental health and has an impact on newly formed relationships: Youngsters favor partnerships that result in fresh traumas (Roberts et al., 2013).

According to Froster-Bombik (2002), children who are categorized as insecure-resistant exhibit ambivalent behaviours. They ask for an excessive amount of care, yet they don't feel comfortable or comforted in the end. While the majority of newborns have well-organized methods, certain infants' systems seem to disintegrate to the point that no clear approach is discernible. Children that are labelled as disorganized frequently exhibit inconsistent behaviours under stress, including approaching and then freezing, expressing fear, and stereotyping (Main & Solomon, 1990). Prior research has also demonstrated a link between higher degrees of negative childhood experiences and insecure attachment patterns and a higher incidence of sickness (Felitti et at.,2002; Maunder. et al.,2001).

Assisting individuals in transitioning from insecure to more secure attachment patterns, certain therapies also directly address the attachment type of the person (Dansby et al., 2020; Jańczak, 2024; Roisman et al., 2002; White, 2020). Many favorable

consequences for one's mental and physical health are linked to secure connection (Holt et al., 2018; Huh et al., 2017; Smagur et al., 2018; Woodhouse et al., 2015). According to a research has verified that mental health in emerging adulthood is impacted by both prior formative experiences and present relationship situations. Early life trauma, parent-child conflict, and parental psychopathology all have a particularly significant impact on the mental health of emerging adults (Howell, 2024).

One of the most important aspects of comprehending the connection between traumatic childhood events and self-harm behaviour in Pakistan is the importance of parental attachment. According to research, stable parental connection can operate as a buffer against the detrimental psychological effects of trauma, such as self-harm. On the other hand, the effects of traumatic events can be worsened by insecure attachments to parents or a lack of emotional support, which can result in emotional instability, self-destructive behaviours, and feelings of worthlessness. Building solid, encouraging parent-child ties can be especially helpful in Pakistan, where traditional family arrangements have a big impact on people's emotional development. Improving the knowledge and engagement of parents can lessen the impact of trauma experienced as a child, encourage better coping strategies, and lower the rate of self-harm in emerging adults. Therefore, enhancing parental connection through interventions may be a crucial first step towards ending Pakistan's trauma and self-harm cycle.

2.4 Distress Tolerance

When a person is experiencing severe mental discomfort, they may do anything to avoid experiencing that suffering. Self-harming behaviours such as cutting oneself directly, not confronting or avoiding the issue, using drugs as coping to one’s situation, or not accepting that the stressor exists are examples of such activities (McKay et al., 2007). To avoid emotional distress, people may engage in more dangerous or risky behaviours, which

might have major long-term implications (Van, 2013).

A person's limbic system got triggered when it goes on high alert during a perceived or genuine problem (Koons, 2016). When a person is upset already than it is difficult to use rational affective coping skills as mechanism to deal with stresses (McKay et al., 2007). A person's limbic system is triggered and they go on high alert during a perceived or genuine crisis (Koons, 2016). When a person is already upset, it is difficult to practice adaptive coping skills (McKay et al., 2007). Similarly, in a sample of urban teenagers, cumulative exposure to violence (including family and community violence) was linked to a reduced threshold for behavioral distress (Heleniak et al., 2021). This is in line with a growing body of studies that shows a critical link between childhood abuse and adult mental health issues is a decreased distress tolerance (Robinson et al., 2021).

Additional distress tolerance research has concentrated on more comprehensive emotion dysregulation indices, which identify groups of associated issues with emotion regulation, such trouble choosing or accessing a coping mechanism during stressful situations (Gratz & Roemer, 2004). Higher distress tolerance measured by performance on demanding behavioral tasks, including speeded mental arithmetic was found to be adversely connected with a variety of self-reported emotion-regulation issues in populations of smokers and binge eaters (Brandt et al., 2012; Eichen et al., 2017).

Many psychosocial problems, such as depression and trauma, are associated with distress tolerance (Ellis et al., 2012; Berenz et al., 2018). According to research by Ellis, Vanderlind, and Beevers (2012), people with major depressive disorder are less tolerant of discomfort than people without the illness. A researcher showed no significant difference in young men and girls' distress tolerance, while results on distress tolerance across sexes varied among investigations (Cummings et al. 2013).

According to a study 397 college students, aged 18 to 30, were included in the

sample. Using both paper-pencil and online techniques, participants filled out self-report questionnaires measuring distress tolerance, emotion regulation difficulties, childhood abuse, self-compassion, self-disgust, and self-harm behaviour. The indirect effect of emotional neglect on self-harm behaviour was mediated by poor distress tolerance, low self-compassion, high self-disgust, and therefore significant emotion regulation difficulties (Erol & Inozu, 2023).

Leyro, Zvolensky, and Bernstein (2010) have defined two broad kinds of distress tolerance that are conceptually distinct from one another. As a result, two methodological studies on distress tolerance have been published. Specifically, non-self-report (also known as bio behavioral) research has concentrated on the behavioral ability to tolerate acute unpleasant situations, whereas self-report research has highlighted the generalized perceived capability to withstand aversive states. People who are less able to tolerate suffering may react to stressful situations and situations in an unhelpful way. Because of this, people with less distress tolerance might try to stay away from unpleasant feelings and/or associated aversive situations.

Distress tolerance becomes even more important in the Pakistani environment, where there is a lack of information about mental health. When emerging adults don't have appropriate coping mechanisms, they could self-harm to get relief from their anxiety. Research on the development of distress tolerance through psychological therapies, such cognitive behaviour therapies and mindfulness practices, can help lower the rate of self-harm among those who have experienced childhood trauma. Increasing distress tolerance can also help people learn more effective coping mechanisms for their emotional suffering, which will ultimately benefit society as a whole by lessening the long-term effects of trauma-related self-harm. Distress tolerance is therefore a crucial topic for investigation and treatment in Pakistan's mental health system.

2.5 Related Researches

Early exposure to multiple traumas has a cumulative and pervasive effect that frequently leads to complex symptomatology, which includes post-traumatic stress disorder and a variable set of symptoms such as difficulties in the relational context, dissociative experiences, negative self-image, and self-regulatory disturbances. This combination of symptoms is known as complex- post traumatic stress disorder (Lawson,2013; Van, 2002). Children and adolescents who engage in self-harm behaviour are more likely to have a variety of detrimental mental health effects. A fifth of young people say they have participated in self-harm behaviour, with the start usually being between the ages of 13 and 14 (Esposito et al., 2023). In addition to reporting higher levels of mental health issues, youth who participate in self-harm behaviour also report higher levels of interpersonal difficulties, a worse sense of school connectedness, and inferior academic achievement.

Teens participate in self-harm behaviour for a variety of reasons. Emotion regulation refers to the act of temporarily reducing severe or overpowering unpleasant emotions (BragerLarsen et al., 2024; Cipriano et al., 2017). This is one of the main motives. Self-harm behaviour may also work as a diversion from other issues by giving a person a sense of control over their body and thoughts. As a kind of self-punishment or self-directed rage, people occasionally self-injure. Self-harm behaviour can also elicit emotions to counteract emotional numbness and could be a means of social interaction (Klonsky et al., 2014).

In 2024 a study was conducted sample was one hundred and thirty-one South Korean minors, ages 10 to 18, were victims of sexual abuse. The findings suggest that, rather than increasing emotional impulsivity, posttraumatic symptoms, at least in teenagers who have experienced sexual abuse, cause self-harm through negative cognition. These results imply that rather than self-harming as an impulsive reaction to strong emotions,

adolescents who have experienced sexual abuse and are experiencing posttraumatic symptoms are more prone to do so as a result of negative thoughts about themselves and the outside world (Choi & Song, 2024).

Traumatic childhood and adolescent experiences that occur in individuals under the age of eighteen. These experiences may include physical, emotional, or sexual abuse. These negative experiences frequently result in behavioral health issues that can appear at any moment throughout a person's lifespan due to intricate and poorly understood psychological mechanisms. Psychiatric disorders including anxiety and depression as well as dangerous habits like drug and alcohol abuse, smoking, hazardous sexual behaviour, self-harm, and interpersonal aggression are examples of behavioral health issues (Felitti et al., 1998). Childhood traumatic experiences have been linked to poor health outcomes as well as less favorable social and economic chances in later life. This association is "grade-dosed," which means that an individual's likelihood of experiencing bad consequences increases with the number of childhood traumatic experiences they have. Many of these detrimental effects are related to behavioral health, such as experiencing psychological issues (such as depression and anxiety) and participating in risky behaviours (such as drug abuse, smoking, inactivity, self-harm behaviour and suicide, interpersonal violence, and taking risks with one's sexual health) (Felitti et al., 1998; Hughes et al., 2017; Merrick et al., 2019).

In 2023, conducted an umbrella analysis to compile the data from meta-analyses and systematic reviews that looked at the protective and risk variables for youth self-harm. Childhood traumatic experiences, depression/anxiety, bullying, trauma, mental diseases, drug abuse/use, parental divorce, strained family dynamics, a lack of friends, and exposure to self-harm behaviour in others were the most commonly found risk factors for self-harm in young people (McEvoy et al., 2023).

Childhood traumatic experiences increases the risk of suicide thoughts and actions in severe situations (Witt et al., 2020). Some teenagers who experienced childhood traumatic experiences as youngsters may utilize the self-harm behaviour to help them process their feelings or recover control (Park & Hurr, 2022). Research has demonstrated that childhood traumatic experiences, when parents or other adults neglect to provide a kid with the required emotional or physical care, can result in feelings of worthlessness, emptiness, and self-blame in the child. They see self-harm behaviour as a helpful coping strategy for these emotions, but it is not suicidal (Zheng et al., 2023).

Childhood traumatic experiences results in strong, uncontrollable emotions that are overpowering and severe. When traumatized children grow into teenagers and adults, they resort to self-harm as a coping strategy for their intense feelings or as a way to ease their emotional pain since they are unable to build healthy coping mechanisms for handling strong emotions (Zhu et al., 2014). Early life trauma is the cause of low self-esteem and emotions of unworthiness. Teens with low self-esteem use the self-harm behaviour as a kind of self-punishment or as reinforcement for their low self-esteem (Kim & Lee, 2018). Emotional flashbacks, which cause the victim to feel powerless and in control, are a byproduct of trauma. These flashbacks occur when past emotions resurface in response to stimuli. Adolescents who are going through such intense emotional memories should try to stay grounded by using the self-harm behaviour (Holden, 2022).

A research study was conducted in Pakistan 2023, to examine the relationship between self-harm behaviour and childhood traumatic experiences, with a focus on examining the function of emotion dysregulation as a mediator. Sample of 267 young individuals, ranging in age from 18 to 35. The study's findings show that non-suicidal self-injury was strongly predicted by childhood trauma. Moreover, a moderating role for emotion dysregulation was played by childhood trauma in relation to self-harm behaviour

(Fatima & Azam, 2023).

A Pakistan research study was conducted to evaluate the relationship between traumatic life events and self-harm in women prisoners of Pakistan. It was proposed that women incarcerated are more likely to self-harm if they had experienced trauma in their lives on a regular basis. Purposive sampling was used in the correlational investigation. The study sample consisted of 38 female collected from Kot Lakhpat Central Jail, Lahore-Pakistan. Less family support while incarceration was found to be significantly positively linked with self-harm. (Rana & Khan).

In previous research studies to knowing how childhood traumatic experiences affect youth self-harm behaviour, a systematic review was carried out, and five databases were searched for published studies assessing childhood traumatic experiences and self-harm behavior in young people under the age of 21. 21 distinct papers were included in this systematic review following the screening of 247 publications. Finding were as increasing childhood traumatic experiences score, had statistically significant correlation with self-harm behaviour. (Mehendale et al., 2024)

A research was conducted in Tehran on 2021 which predicted social emotional competence based on childhood trauma and distress tolerance consisted of 326 Iranian male and females selected by convenient sampling technique through online platform and results state that distress tolerance has been shown to be predictive of social emotional competence. (Farahani et al., 2022).

Moreover, a research was conducted in 2023 included 3142 Spanish adolescence participants between 12 to 18 age range to find mediating role of parental attachment in relationship between child to parent violence and cumulative childhood adversity result established that there is significant association between child-parent violence, childhood traumatic experiences and insecure parental attachment (Navas & Cano, 2023).

Furthermore, results of research study established that there is significant effect of higher acceptance of childhood traumatic experiences lead to poor distress tolerance which causing higher drinking of alcohol to cope (Norton et al., 2023).

In 2023 a research was conducted on finding mediating role of distress tolerance as tolerance for psychological pain in relationship between childhood traumatic experiences to suicidal ideation include substance abused individual, sample consisted of 102 adults and results finding state that the relationship between childhood traumatic experiences and suicide ideation was shown to be totally mediated by depressive symptoms and distress tolerance (Martins et al., 2023).Furthermore, another research was conducted to study "mediating role of distress tolerance" sample included 437 community individuals and 316 college students participated and research result finding established that among the community sample, the association between various forms of traumatic experiences, suicidal thoughts, and childhood traumatic experiences was mediated by distress tolerance. With the exception of sexual abuse, the college sample found that experiencing and managing distress tolerance moderated the association between various forms of traumatic events, childhood traumatic experiences, and suicide thoughts (Passos et al., 2023).

According to a Pakistani research finding results established that self-harm behaviour was found to be substantially positively correlated with thoughts of suicide as well as mental health issues such stress, anxiety, and depression. In healthy adults, self-harm behaviour was also strongly correlated with mental health issues. Adults who intentionally self-harm have lower levels of mental health issues including stress and depression than normal adults do. Suicidal thoughts were more common in people who self-harmed than in persons who behaved normally. Conclusion: In both normal and deliberate self-harming adults, there was a high correlation between intentional self-harming and suicidal behaviour as well as mental health problems (Muhammad et al.,

2021).

Meanwhile, a research study finding revealed that Lower distress tolerance was substantially linked with childhood traumatic experiences and participant’s details were 385 numbers, aged range between 18 and 48 (Russo et al., 2023). According to the research finding results established that high levels of parental rejection and overprotection were related to lower distress tolerance and higher levels of psychological distress (Sadia et al., 2021). Furthermore, a research was conducted to study mediating role of distress tolerance in association between childhood traumatic experience and self-harm behaviour, sample included 397 college students, aged 18 to 30 and results stated that Low distress tolerance acted as a mediating factor in the emotional neglect's indirect impact on self-harm behaviour (Erol & Inozu, 2023)

Exposure to abuse or neglect in childhood can have detrimental effects on expectant parents' pregnancies, which can negatively impact their experience of parenting and have implications for the growing fetus. This study looked at the relationships between psychiatric symptoms, prenatal attachment, and expecting parents' perceptions of their own parenting skills and their exposure to abuse or neglect as children. There were 322 participants (78% female), 91 of whom were adults who had experienced abuse or neglect as children. The study found that individuals who experienced abuse or neglect as children had considerably greater levels of symptoms across all mental health indices compared to those who were not exposed to such events. Additionally, the results demonstrated that poor mental health is a direct result of childhood abuse or neglect, and that low parental confidence and prenatal attachment are related to poor mental health not to childhood traumatic experiences (Berthelot et al., 2020).

In this study, adolescents with self-harm behaviour were compared to their healthy peers in terms of parental connection and childhood traumatic experiences. The study

included fifty 14 to18 year old adolescents with lifelong self-harm behaviour and fifty healthy peers. Research revealed that patients with self-harm behaviour had greater trauma ratings than those without. the care and control sub-dimensions of maternal attachment and certain subtypes of childhood trauma were shown to be significantly correlated with the autonomic and social functions of the self-harm behaviour (Bahali et al., 2024).

Additionally, a longitudinal research found that among teenage pupils, self-harm behaviour was linked to a higher history of childhood traumatic experiences (Garisch & Wilson, 2015). The literature varies in its conclusions about the connection between adolescent self-harm behaviour and various forms of childhood abuse. Only child emotional abuse was found to be directly linked to self-harm behaviour in a study assessing the specificity of childhood traumatic experiences as factors associated with self-harm behaviour in a sample of adolescents admitted to hospitals (Thomassin et al., 2016). Strong correlations were found in the Glassman et al. research between emotional and sexual abuse and self-harm behaviour (Glassman et al., 2007). The relationship between childhood traumatic experiences and self-harm behaviour is supported by these research results, yet there are variations in the kinds of abuse. Variables including retroactive trauma inquiry, variations in the way individuals perceive their own trauma, and protective factors against trauma might account for discrepancies in study findings.

The increased risk of self-harm behaviour among vocational college students is an issue of national concern. Childhood trauma is seen under the self-harm behaviour benefits and obstacles model as a significant vulnerability factor that affects self-harm behaviour through poor self-schema. Thus, research into potential protective variables is required to guide self-harm behaviour therapies. According to research study 898 students, ages 18 to 23, who were enrolled in technical colleges filled out questionnaires. The findings showed that negative self-schema and direct childhood trauma were both significant predictors of

self-harm behaviour (Yang et al., 2024).

Prior studies have connected negative childhood experiences such as abuse and neglect with self-harm. Even with the wealth of research on self-harm, it is crucial to look at psychological factors that may indicate recurrent self-harming behaviours in those who have experienced childhood trauma. Online recruitment was used to assemble a worldwide sample of 374 individuals (of whom 287 reported purposeful self-harm) using relevant mental health and research websites. Result generated as the degree of early trauma, maladaptive emotion control techniques and dissociation characteristics were all positively connected with self-harm (Gallagher et al., 2024).

Moreover, the relationship between childhood traumatic experiences and positive childhood experiences and mental health outcomes in populations of Europeans that are nationally representative has not been extensively studied. The Northern Ireland Youth Wellbeing Survey (NIYWS) was a household survey that was performed between June 2019 and March 2020, using stratified random randomization. The analysis is based on data (n = 1299) from teenagers between the ages of 11 and 19. The following mental health outcomes have prevalence rates: self-harm (10%), suicide thoughts (12%), and common mood and anxiety disorders (16%). Suicidal thoughts, self-harm, and common mood and anxiety disorders were all independently predicted by childhood traumatic experiences and positive childhood experiences (Bunting et al., 2023).

Childhood traumatic experiences are thought to play a role in the rise in the prevalence of self-harm behaviour and suicide attempts among adolescent and young adult Latinx communities in comparison to other racial and ethnic groups in recent years. According to research study results Using mother and paternal attachment security as moderating factors, the study looked at the significance of childhood traumatic experiences as a risk factor for self-harm behaviour or suicide attempts in a sample of Central American

migrant high school students. It was discovered that maternal attachment security acted as a buffer against the relationship between childhood traumatic experiences and a history of self-harm behaviour or suicide attempts, but not paternal attachment security (Walker et al., 2023). In central China, 1795 teenagers were included in this research. Results of this study generated as self-harm behaviour is directly impacted by father love absence (Xiang et al., 2024).

According to past studies adolescents who experience harsh parenting have been linked to self-harm behaviour. A moderated mediation model was developed to examine "how" and "when" harsh parenting is connected to adolescent self-harm behaviour. It was based on the integrated theoretical model of the development of self-harm behaviour and the cognitive-emotional model of self-harm behaviour. A total of 1638 Chinese teenagers, aged 12 to 19, of which 54.7% were girls as sample in a study. Path analyses revealed that alienation acted as a mediating factor between harsh parenting and self-harm behaviour, which was positively predicted. Cognitive reappraisal mitigated the effects of both the direct and indirect consequences of severe parenting on self-harm behaviour, resulting from estrangement. In particular, the relationships between harsh parenting and self-harm behaviour were lessened by cognitive reappraisal skills (Cheng et al., 2023). Not every young person who experiences harsh parenting participates in self-harm behaviour, despite the fact that it is closely linked to the incidence of self-harm behaviour (Liu et al., 2021). We claim that the adolescent's tactics for regulating their emotions determine the direction and degree of this connection. Emotion regulation is important because severe parenting practices can make teenagers feel intensely unpleasant emotions (Brody et al., 2014; Sim et al., 2009), and self-harm behaviour is most frequently used to treat negative emotions (Taylor et al., 2017).

2.6 Theoretical Framework

The current study is based on the Integrated theoretical model of the development & Maintenance of self-injury, defined by Nock (2009).

Over the years, various theories have been proposed to explain why people intentionally self-harm, such as control over sex or death, defining self-and-other boundaries, ending dissociative episodes, or protecting others from anger. However, most theoretical accounts lack empirical support. Empirical studies have identified risk factors for self-harm, such as childhood abuse, mental disorders, poor verbal skills, and subculture identification, but their causes remain unclear. Theoretical model that integrates these findings to explain the development and maintenance of self-harm behaviour.

2.7 Integrated theoretical model of the development & Maintenance of self-injury

The integrated theoretical model developed by Nock in 2009 provides a thorough framework for comprehending the onset and perpetuation of self-harm behaviour or nonsuicidal self-injury. Although the model is a particular framework, it advances the theoretical knowledge of self-harming behaviour. Nock's work may therefore be viewed as both a model and a theoretical contribution, with the model offering a systematic explanation that contributes to the overall theoretical framework of self-harm behaviour or nonsuicidal self-injury research. This model combines empirical data to explain why people self-harm and how the behaviour endures over time. Nock's approach suggests that self-harm behaviour is preserved because it successfully controls social circumstances and emotional experiences. The action is a coping strategy that influences interpersonal dynamics or offers instant respite from unpleasant feelings. The following elements are identified by the model as contributing to the onset and duration of self-harm behaviour or nonsuicidal self-injury.

2.7.1. Distal Risk Factors

The following background variables raise a person's susceptibility to self-harm behavior or nonsuicidal self-injury. Vulnerability to self-harm behaviour might be increased by experiences like abuse, neglect, or being subjected to animosity and criticism from family members. People may be more prone to self-harm behaviour if they have an inherent propensity for increased emotional or cognitive reactivity.

2.7.2. Proximal Risk Factors

Interpersonal disagreements or unreasonable social obligations are examples of immediate stresses that might set off self-harm behaviour or nonsuicidal self-injury episodes.

2.7.3. Intrapersonal Vulnerability Factors

People may have disturbing thoughts or strong negative emotions (such as grief or rage), which makes them turn to self-harm behaviour or nonsuicidal self-injury as a way to cope with these inner states. People may turn to self-harm behaviour as a hasty way to escape or lessen their misery if they are less able to handle emotional discomfort.

2.7.4. Interpersonal Vulnerability Factors

People who have trouble navigating social situations may turn to self-harm behaviour or nonsuicidal self-injury to express their pain or get help from others. Self-harm behaviour or nonsuicidal self-injury may be exacerbated by an increased need for approval or assurance from others, particularly if people believe that traditional methods are not meeting their requirements.

According to Nock's concept, people who are vulnerable to these kinds of situations could experience stressful situations that they find difficult to cope with on an emotional or social level. As a coping strategy to control their inner sensations or affect their social surroundings, people could respond by participating in self-harm behaviour or nonsuicidal

self-injury. Because of the instant alleviation or change brought about by self-harm behaviour or nonsuicidal self-injury, the behavior is reinforced, making it more likely to occur in similar circumstances in the future.

This model highlights the significance of intrapersonal and interpersonal vulnerabilities, as well as distal and proximal variables, in understanding the reasons behind self-harm behaviour or nonsuicidal self-injury. Self-harm behaviour or nonsuicidal self-injury reinforcing character is also highlighted, implying that the behaviour is sustained because it successfully meets certain emotional and social requirements.

The model highlights the various roles that nonsuicidal self-injury plays for each person, namely in controlling emotional experiences and handling social circumstances. These functions are classified along two dimensions: interpersonal (other-directed) and intrapersonal (self-directed), which are further subdivided into processes of positive and negative reinforcement. Four unique functional categories are produced by the model's identification of two main dimensions, intrapersonal and interpersonal, each of which has procedures for both positive and negative reinforcement.

2.7.5. Intrapersonal Positive Reinforcement

Self-injury or self-harm behaviour is used to create or enhance desirable internal emotions or sensations. The idea of intrapersonal positive reinforcement is crucial to comprehending nonsuicidal self-injury. People who engage in self-harming behaviours do so in order to produce or intensify desired interior moods or emotions. To create a physical sensation that counteracts feelings of numbness or emptiness, for example, some people may self-harm in an attempt to regain a sense of reality or aliveness.

2.7.6. Intrapersonal Negative Reinforcement

Self-injury or self-harm behaviour is used to lessen or avoid undesirable internal experiences, such as strong negative feelings or upsetting thoughts. To cope with

overwhelming emotions of despair, worry, or rage, a person may harm themselves. By diverting their attention from their inner turmoil, self-harm, for example, might offer instant comfort to someone who is experiencing severe emotional anguish.

2.7.7. Interpersonal Positive Reinforcement

Using self-injury or self-harm behaviour to get the desired results from other people. When verbal communication is difficult, a person may self-harm to convey their distress or to get support, care, or attention from friends or family. Self-harm, for instance, can be a visual warning to others that someone is in need of support or assistance when they are unable to communicate their emotional suffering.

2.7.8 Interpersonal Negative Reinforcement

Self-injury or self-harm behaviour is used as a means of evasion or avoidance of unwanted external circumstances or encounters. To escape perceived interpersonal constraints, evade social expectations, or disengage from disputes, a person may self-harm. For example, someone may utilize nonsuicidal self-injury or self-harm behaviour to avoid social duties or to settle a dispute, which would remove them from tense social situations.

Self-harm is more likely to occur in people who commit nonsuicidal self-injury because they frequently have particular vulnerabilities. Additionally, the model identifies certain weaknesses that raise the likelihood of participating in nonsuicidal self-injury. Self-harming people frequently have low distress tolerance, elevated negative thinking, and physiological hyper arousal as a coping mechanism for unpleasant mental or emotional events. Because of these vulnerabilities, people may find it difficult to control strong emotions, which may cause them to turn to nonsuicidal self-harm as a maladaptive coping strategy. Furthermore, those who self-harm as a form of self-expression or as a way to deal with social issues might not have good communication or problem-solving abilities, which makes navigating interpersonal relationships challenging and increases their need on

nonsuicidal self-injury to cope with social pressures. These correlations are supported by research, which shows that self-harmers frequently exhibit heightened emotional and physiological responses to stress and trouble managing discomfort.

According to this theoretical model of nonsuicidal self-injury or self-harm creation and maintenance (Nock, 2009), nonsuicidal self-injury arises and persists because some behaviours can quickly moderate uncontrollably intense emotional and negative experiences. A number of proximal and distal risk factors, such as high aversive emotions and poor distress tolerance (intrapersonal need) and poor verbal and social communication skills (interpersonal need), as well as self-harm or nonsuicidal self-injury-specific factors, such as high self-hatred or the fact that nonsuicidal self-injury is a relatively immediate process for dealing with an affective regulation, can increase chance of self-harming behaviour as an indicator of non-affective coping strategy (Nock, 2010).

Chapter 3

3. RESEARCH METHODOLOGY

3.1 Introduction

The goal of the current study was to investigate the impact of childhood traumatic experience on self-harm behavior among emerging adults and to study the moderating role of parental attachment and distress tolerance as mediator.

3.2 Research Design

A cross-sectional correlation research strategy was used to achieve the study's goals. To study relationship between childhood traumatic experiences, self-harm behavior, parental attachment and distress tolerance.

3.2.1 Phase-I: Pilot study

The pilot study, which was carried out to create further psychometric features of the study scales (such as reliability coefficients and item-total correlations) and explore the link between the study variables, was part of the initial phase of the research.

3.2.2 Phase -II: Main study

The main study, which was mainly concerned with testing the study's hypotheses, was a part of the second phase of the research.

3.3 Data Analysis

The data was analysed by SPSS 22 version. After the data entry into the data editor, data cleaning was done to locate the missing values and outliers. Some missing values were found which were replaced with the mean value. No outliers were found in the data. Different analysis was done on the data after data entered. Analysis were reliability

analysis, inter scale correlation, item total correlation, regression, t-test, anova, moderation and mediation. After the analysis the results were reported and discussed.

3.4 Research Ethics

At the initial stage of data collection, informed consent were given to the participants to ensure their willingness in the research. Researcher provided a brief explanation of the nature and objective of the study and provided assurances on all aspects of research ethics while gathering information from adults. In exchange for their consent to participate in the study, they were assured the right to privacy and confidentiality as well as the right to stop at any time.

Phase I: Pilot Study

The following objective was formulated for the pilot study phase:

Objectives

1. To determine psychometric properties of the study scales i.e., child trauma questionnaire (CTQ), The risk-taking and self-harm inventory for adolescents, The adult scale of parental attachment and distress tolerance scale (DTS).
2. To study the pattern of relationship between study variables i.e., childhood traumatic experiences, self-harm behavior, parental attachment and distress tolerance.

3.5 Instruments

The following instrument were employed to fulfil the pilot study objectives.

1.Demographic Sheet.

Along with the informed consent contract, a demographic sheet was attached to the questionnaire to collect information on the sample's personal characteristics. Demographic

information included gender, age, family system, education, family Income, marital status, current household status, previous medical or psychiatric history and hospitalization.

2.Childhood Traumatic Questionnaire.

Childhood Trauma Questionnaire (CTQ) short form scale developed by Bernstein and Fink (1998) was used to assess childhood traumatic experience. It comprises of the following six sub- scales emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, and idealized upbringing. According to Bernstein and Fink's formulation of the childhood trauma questionnaire scale, a cut-off score of around 35 or above on the whole scale score is typically seen as suggestive of a considerable history of childhood trauma. Higher score on the scale and each of its five subscales indicates higher traumatic experience. The childhood trauma questionnaire is a self-report tool consisting of 28 items that is used to assess abuse experiences up until the age of 15. A 5-point Likert scale is used to classify it, with 1 denoting never, 2 a few times, 3 occasionally, 4 frequently, or 5 constantly. The childhood trauma questionnaire had a high level of total scale internal consistency (Cronbach alpha α=0.80-0.89).

3.The Risk-Taking and Self-Harm Inventory

The RTSHIA, Risk-Taking and Self-Harm Inventory was created by Vrouva and colleagues (2010) was used to assess self-harm behaviour, which includes two subscales: risk-taking and self-harming behaviour. Whereas a higher score by a person on each subscale indicates risk-taking and self-harming behaviour in them. The questionnaire comprises 26 items divided into two factors, risk-taking and self-harm. For the research study variable, only the self-harm subscale was used to assess self-harm behaviour in emerging adults. The self-harm subscale, which has 19 items, looks at a variety of self-harming activities, such as drug misuse, cuts, burns, bites, bruises, and hair ripping. Respondents must indicate how frequently the behaviours they have described using a 4-

point Likert scale (1=never, 2=once, 3=more than once, and 4=many times). Significant evidence was found to support the measure's convergent, concurrent, and divergent validity, and both components' inter-item and test-retest reliabilities were high (Cronbach's α = .93).

4.Adult Scale of Parental Attachment.

The Adult Scale of Parental Attachment was developed by Snow et al. (2005) was used to assess parental attachment among emerging adults. The adult scale of parental attachment is a self-report tool used to evaluate how people perceive patterns of relationship based on their early interactions with both father and mother figures. The overall scale measures two types of parental attachment style i.e. secure and insecure for both mother and father respectively. 40 items on a 5-point Likert scale (never = 1, seldom = 2, sometimes = 3, frequently = 4, and always = 5) make up each of the two subscales. Mother and father secure attachment subscale Cronbach's alpha values are α = 0.94 and α = 0.94, whereas for mother and father insecure attachment subscale Cronbach's alpha values are α = 0.87 and α = 0.88. A higher score on each subscale indicates that the adults have a certain attachment style.

5.Distress Tolerance Scale.

Simons and Gaher (2005) created the Distress Tolerance Scale (DTS), which was used to assess distress tolerance among emerging adults, which is a person's capacity to endure and experience uncomfortable emotional states. People's perceptions, experiences, and coping mechanisms with distressing emotions are measured by the distress tolerance scale. Fifteen items make up the distress tolerance scale, which is scored on a five-point Likert scale (1 being "strongly disagree" and 5 being "strongly agree"). The distress tolerance alpha coefficients range between Cronbach's α = 0.82–0.85, indicating a good level of internal consistency. After reverse-coding item 6, the scores of all 15 things are

added together to Determine the overall distress tolerance scale score. A greater degree of Distress tolerance is indicated by a lower score.

3.6 Sample

A sample of 50 university students (*n* = 23 male students and 27 female students) ranging in age from 18 to 29 years (*M* = 23.15, *SD* = 2.44) from various universities in Rawalpindi, Islamabad, and Dera Ismail Khan participated in the pilot study. Through convenient based sampling technique, the sample was collected for study purpose. The sample age group that has been targeted for this current study was emerging adults. Data was analysed statistically through *SPSS*-22.

3.7 Procedure

Convenient sampling was used to collect the data, and each respondent gave their informed consent. The goal of the study was explained to them. After that, a demographic sheet and the questionnaires were given to the participants. They were given instructions on how to fill out the surveys, with a focus on the fact that there are no right or wrong answers. They received guarantees that their data would be kept private, allowing them to complete the surveys with confidence and without hiding any information. They were also informed that the data would only be used for research.

Results of Pilot Testing

In order to assess the reliability and validity of the scales and their subscales, psychometric qualities were examined using descriptive statistics. Below are the results.

Table 1

Frequencies and Percentages of Demographic Characteristics of the Sample (N=50).

Variable	*f*	%
Gender		
Males	23	46%
Females	27	54%
Age		
18-23 Emerging Adults	22	44%
24-29 Established Adults	28	56%
Education		
BS	35	70%
MS	9	18%
Other	6	12%
Family system		
Joint	18	36%
Nuclear	32	64%
Family Income		
lower income group	6 (≤75000)	12%
Middle income group	35 (76000-15000)	70%
High income group	9 (≥151000)	18%
Marital Status		
Single	43	86%
Married	7	14%
Parental Status		
Single Parent	7	14%
Two Parent	32	64%
Others	11	22%

f = Frequency, %= percentage

Table 1 shows the demographics of the entire sample (N = 50), which is made up of 46% male students and 54% female students. These demographics include gender, age, education, family system, family income, marital status, and parental status.

Table 2

Descriptive Statistics and Alpha coefficients of the key study variables (N=50)

Scales	No. of Items	α	*M*	*SD*	Range		Skewness	Kurtosis
					Actual	Potential		
CT								
CTE	25	.83	52.11	14.49	26-87	5-125	0.23	0.13
IU	3	.74	9.89	3.69	3-15	5-15	-.25	-1.05
SH	19	.93	29.93	11.50	19-58	4-76	0.99	-0.06
PA								
SecM	12	.92	42.09	12.13	12- 60	5-60	-0.16	-0.90
InsecM	8	.79	21.35	7.55	8-40	5-40	0.32	0.01
SecF	12	.93	36.20	13.35	12-60	5-60	-0.13	-0.77
InsecF	8	.81	20.11	7.82	8-40	5-40	0.41	-0.30
DT	15	.87	35.89	11.20	15-60	5-75	-.10	-.95

Note: CT= Childho0d Trauma; CTE= Childhood traumatic Experience; IU= Idealizing Upbringing; SH= Self Harm; PA: Parental Attachment; SecM= Mother Secure Parental Attachment; InsecM= Mother Insecure Parental Attachment; SecF= Father Secure Parental Attachment; InsecF = Father Insecure Parental Attachment; DTS= Distress Tolerance.

Descriptive data (i.e., means, standard deviations, range, skewness, and kurtosis) for each of the research variables are displayed in Table 2. Results show that skewness (±2) and kurtosis (±2) fall within acceptable limits, indicating that the data is normally distributed (Gravetter & Wallnow, 2012). Additionally, all of the scales' alpha coefficients fall between.74 and.93, indicating excellent to good reliability indices. Therefore, it was concluded that the scales were appropriate for use with the indigenous Pakistani sample.

Table 3

Correlation between the study variables (N=50)

	1	2	3	4	5	6	7	8
1. CTE	-	-.50**	.52**	-.51**	.25**	-.28**	.25**	.10
2. IU	-	-	-.46**	.53**	-.16**	.50**	-.15*	-.07**
3. SH	-	-	-	-.37**	.29**	-.13**	.45**	.13
4. SecM	-	-	-	-	.29**	.49**	.20**	-.17**
5. InsecM	-	-	-	-	-	-.12*	.49**	-.21**
6. SecF	-	-	-	-	-	-	.12**	-.08**
7. InsecF	-	-	-	-	-	-	-	-.04
8. DT	-	-	-	-	-	-	-	-

Note: CTE= Childhood traumatic Experience; IU= Idealizing Upbringing; SH= Self Harm; SecM= Mother Secure Parental Attachment; InsecM= Mother Insecure Parental Attachment; SecF= Father Secure Parental Attachment; InsecF = Father Insecure Parental Attachment; DT= Distress Tolerance.

Table 3 shows the results of bivariate correlations between the study's variables. Values indicate significant (**p<.01) positive correlation of childhood traumatic experience with self-harm behaviour, insecure parental attachment with mother, and insecure parental attachment with father whereas childhood traumatic experience negatively correlate with idealizing upbringing, secure parental attachment with mother and secure parental attachment with father. Values indicate non-significant positive correlation between childhood traumatic experiences and distress tolerance. Idealizing upbringing showed significant negative correlation with self-harm behaviour, distress tolerance and insecure parental attachment with mother and father. whereas idealizing upbringing showed positively significant association with secure parental attachment with mother and secure parental attachment with father. Values indicate significant (*p<0.1) negative correlation between insecure parental attachment with mother and secure parental attachment with father. Values indicate idealizing upbringing non-significant relate with insecure parental

attachment with father. These results show how the research variables relate to one another. Additionally, it offers a starting point for testing the main study's objectives and hypotheses.

Table 4

Item Total Correlation and Corrected Item Total Correlation of Childhood traumatic questionnaire scale (N=50)

Item	Item-Total-Correlation	Corrected Item Total-Correlation	Item	Item-Total-Correlation	Corrected Item-Total-Correlation
Childhood Traumatic Experience					
1	.42**	.41	14	.56**	.50
2	.34*	.39	15	.48**	.44
3	.39**	.23	16	.70**	.64
4	.37*	.30	17	.36**	.26
5	.30*	.28	18	.42**	.34
6	.44**	.20	19	.42**	.29
7	.34*	.38	20	.43**	.38
8	.56**	.24	21	.57**	.53
9	.32*	.24	22	.61**	.54
10	.50**	.44	23	.36**	.26
11	.56**	.50	24	.56**	.51
12	.57**	.50	25	.54**	.44
13	.70**	.65			
Idealizing Upbringing					
1	.83**	.56	3	.80**	.57
2	.82**	.60			

***p < .000*

For the Childhood Traumatic Questionnaire Scale (i.e., Childhood Traumatic Questionnaire and Idealizing Upbringing), Table 4 displays the item-total correlation and corrected item-total correlation values. Values in the table indicate that all the items have significant positive correlations ($p<.001$) with the sum of each sub-scale reflecting high internal consistency and reliability of the scale.

Table 5

Item Total Correlation and Corrected Item Total Correlation of the Self-Harm Inventory for Adolescents scale (N=50)

Item	Item-Total-Correlation	Corrected Item Total-Correlation	Item	Item-Total-Correlation	Corrected Item-Total-Correlation
		Self-Harm			
1	.35*	.32	11	.82**	.78
2	.82**	.78	12	.51**	.45
3	.75**	.72	13	.76**	.71
4	.73**	.70	14	.81**	.76
5	.64**	.58	15	.63**	.58
6	.58**	.52	16	.83**	.80
7	.80**	.77	17	.72**	.67
8	.56**	.54	18	.64**	.62
9	.71**	.67	19	.58**	.65
10	.54**	.47			

***p < .001*

For the Self-Harm Inventory for Adolescents scale, Table 5 displays the item-total correlation and corrected item-total correlation values. Values in the table indicate that all the items have significant positive correlations ($p<.001$) with the sum of scale reflecting high internal consistency and reliability of the scale.

Table 6

Item Total Correlation and Corrected Item Total Correlation of Adult Scale of Parental Attachment (N=50)

Item	Item-Total-Correlation	Corrected Item-Total-Correlation	Item	Item-Total-Correlation	Corrected Item-Total-Correlation
Secure Parental Attachment with Mother					
1	.74**	.68	7	.79**	.73
2	.84**	.80	8	.77**	.72
3	.82**	.78	9	.55**	.49
4	.84**	.80	10	.62**	.57
5	.69**	.63	11	.68**	.61
6	.89**	.86	12	.63**	.56
Insecure Parental Attachment with Mother					
1	.63**	.68	5	.66**	.63
2	.55**	.80	6	.67**	.86
3	.65**	.78	7	.70**	.73
4	.68**	.80	8	.63**	.76
Secure Parental Attachment with Father					
1	.83**	.79	7	.72**	.66
2	.82**	.77	8	.82**	.78
3	.76**	.71	9	.67**	.60
4	.61**	.53	10	.63**	.56
5	.80**	.75	11	.72**	.66
6	.83**	.79	12	.79**	.74
Insecure Parental Attachment with Father					
1	.64**	.51	5	.60**	.45
2	.70**	.58	6	.75**	.63
3	.71**	.60	7	.48**	.33
4	.67**	.53	8	.72**	.61

***p < .001*

For the Adult Scale of Parental Attachment subscales (secure parental attachment with mother, insecure parental attachment with mother, secure parental attachment with father, and insecure parental attachment with father), the item-total and corrected item correlation values are shown in Table 6. Table displays the item-total correlation, which

ranged from .48 to.89 (p<.001), as well as the equivalent corrected item-total correlation, which runs from.33 to.86. The scale's internal consistency suggests that it is reliable for testing hypotheses that will be used in the main study.

Table 7

Item Total Correlation and Corrected Item Total Correlation of Distress Tolerance scale (N=50)

Item	Item-Total-Correlation	Corrected Item-Total-Correlation	Item	Item-Total-Correlation	Corrected Item-Total-Correlation
		Distress Tolerance			
1	.67**	.64	9	.54**	.44
2	.52**	.34	10	.72**	.68
3	.66**	.63	11	.43**	.36
4	.75**	.70	12	.71**	.66
5	.56**	.53	13	.49**	.38
6	.41**	.50	14	.55**	.46
7	.57**	.44	15	.55**	.65
8	.60**	.52			

***p < .001*

To assess the internal consistency of each scale, item-total correlations were calculated. Table 7 displays the item-total correlation for the distress tolerance scale, which ranged from.41 to.75 (p<.001), as well as the equivalent corrected item-total correlation, which runs from.34 to.68. The scale's internal consistency suggests that it is reliable for testing hypotheses that will be used in the main study.

Phase-II: Main Study

The main study objective of phase II research was to investigate the relationship between childhood traumatic experiences and self-harm behaviour in emerging adults. It also looked at the mediating role of distress tolerance and the moderating role of parental

attachment, specifically secure and insecure parental attachment. The primary focus of the study was on the following goals.

3.8 Objectives

The following objectives of main study are:

1. To investigate the relationship of childhood traumatic experience, self-harm behaviour, parental attachment and distress tolerance among emerging adults.
2. To examine the impact of childhood traumatic experiences on self-harm behavior among emerging adults.
3. To study the moderating role of parental attachment (i.e. secure and insecure parental attachment style) between Childhood traumatic experience and self-harm behavior among emerging adults.
4. To study the mediating role of distress tolerance between Childhood traumatic experience and self-harm behavior among emerging adults.
5. To study a demographic based group differences on the studied variables.

Study Design

A cross-sectional correlational study methodology was employed to investigate the relationship between childhood traumatic experiences, self-harm behavior, parental attachment and distress tolerance among emerging adults.

Sample

This study focused on undergraduate and graduate students from several public and private universities in Dera Ismail Khan, Rawalpindi, and Islamabad. Participants in this primary study comprised N = 332 (n = 143 male students; n = 189 female students) with age groups classified as emerging adults (M = 1.57, SD = 0.50). Those that participate range in age from 18 to 29. The general population was sampled using a convenient sampling strategy that involved visiting several urban institutions.

Chapter 4

ANALYSES AND INTERPRETATION OF THE DATA

The objective of main study was to investigate the impact of childhood traumatic experience on self-harm behavior among emerging adults and further investigate this path through a moderating effect of parental attachment and mediating link of distress tolerance.

Table 8

Frequencies and Percentages of Demographic Characteristics of the Sample (N=332).

Variable	*f*	*%*
Gender		
Male Students	143	43.1%
Female Students	189	56.9%
Age		
18-23 Emerging Adults	175	52.7%
24-29 Established Adults	157	47.3%
Education		
BS	197	59.3%
MS	63	19.0%
Other	72	21.7%
Family system		
Joint	93	28.0%
Nuclear	239	72.0%
Family Income		
lower income group	92 (≤75000)	27.7%
Middle income group	136 (76000-15000)	41.0%
High income group	104 (≥151000)	31.3%
Marital Status		
Single	293	88.3%
Married	39	11.7%
Parental Status		
Single Parent	51	15.4%
Two Parent	228	68.7%
Others	53	16.0%

f = Frequency, %= percentage

Table 8 shows frequencies of demographic characteristics which included gender, age, education, family system, family Income, marital status and parental status.

Table 9

Descriptive statistics and alpha coefficients of the study variables (N=332)

Scales	No. of Items	α	*M*	*SD*	Range		Skewness	Kurtosis
					Actual	Potential		
CT								
CTE	24	.89	43.72	16.13	24-95	5-125	1.26	1.67
IU	3	.70	9.72	3.49	3-15	5-15	-.01	-1.18
SH	19	.93	28.50	10.33	19-58	4-76	1.32	.89
PA								
SecM	12	.92	42.01	11.23	12-60	5- 60	.05	-1.44
InsecM	8	.75	21.38	6.90	8-40	5-40	.44	.38
SecF	12	.92	35.83	12.34	12-60	5-60	.19	-.70
InsecF	8	.83	21.61	7.90	8-40	5-40	.38	-.38
DT	15	.84	34.80	10.65	14-56	5-75	-.19	-.91

Note: CT= Childhood trauma; CTE= Childhood traumatic Experiences; IU= Idealizing Upbringing; SH= Self Harm; PA= Parental attachment; SecM= Mother Secure Parental Attachment; InsecM= Mother Insecure Parental Attachment; SecF= Father Secure Parental Attachment; InsecF= Father Insecure Parental Attachment; DT= Distress Tolerance

Descriptive data (i.e., means, standard deviations, range, skewness, and kurtosis) for each of the research variables are displayed in Table 9. Results show that skewness (±2) and kurtosis (±2) fall within acceptable limits, indicating that the data is normally distributed (Gravetter & Wallnow, 2012). Additionally, all of the scales' alpha coefficients fall between.70 and.93, indicating excellent to good reliability indices. Consequently, it was determined that the scales were suitable for usage with the native Pakistani population. Since item number four had a negative correlation with the total and was therefore not relevant or culturally suitable, it was removed from the questionnaire on childhood

traumatic experiences.

Table 10

Correlation between the study variables (N=332).

		1	2	3	4	5	6	7	8
1	CTE	-	-.61**	.79**	-.48**	.21**	-.42**	.20**	-.04
2	IU	-	-	-.55**	.47**	-.14**	.43**	-.13*	-.15**
3	SH	-	-	-	-.36**	.24**	-.24**	.37**	.01
4	SecM	-	-	-	-	.27**	.60**	.35**	-.31**
5	InsecM	-	-	-	-	-	-.12*	.49**	.26**
6	SecF	-	-	-	-	-	-	.23**	-.31**
7	InsecF	-	-	-	-	-	-	-	.11
8	DT	-	-	-	-	-	-	-	-

** $p < .01$

Note: CTE= Childhood traumatic Experiences; IU= Idealizing Upbringing; SH= Self Harm; SecM= Mother Secure Parental Attachment; InsecM= Mother Insecure Parental Attachment; SecF= Father Secure Parental Attachment; InsecF= Father Insecure Parental Attachment; DT= Distress Tolerance.

Table 10 shows the results of bivariate correlations. Values indicate significant (**p<.01) positive correlation of childhood traumatic experience with self-harm behavior, insecure parental attachment with mother and insecure parental attachment with father, whereas significant negative association of childhood traumatic experience with idealizing upbringing, secure parental attachment with mother and secure parental attachment with father. Values indicate significant (*p<0.1) negative correlation of self-harm behavior with secure parental attachment with mother and secure parental attachment with father, whereas significant (**p<.01) positive correlation with insecure parental attachment with mother and insecure parental attachment with father. Values indicate significant (*p<0.1) negative correlation between insecure parental attachment with mother and secure parental attachment with father. Values indicate non-significant negative correlation between

childhood traumatic experience and distress tolerance. Values indicate significant (*p<0.1) negative correlation of distress tolerance with idealizing upbringing, secure parental attachment with mother and secure parental attachment with father. Values indicate non-significant positive correlation of distress tolerance with self-harm behavior, insecure parental attachment with mother and insecure parental attachment with father. These results show how the study variables relate to one another.

Table 11

Simple linear Regression Analysis on Self-harm behavior by Childhood Traumatic Experience and Idealizing Upbringing (N=332).

Self-harm Behavior					
				95% CI	
Variables	*B*	*SE B*	*β*	*LL*	*UL*
Childhood Traumatic Experience	.50	.02	.79***	.45	.54
R = .77, R^2= .59, ΔR^2=.59, (F = 476.11 ***)					
Self-harm Behavior					
Idealizing Upbringing	-1.64	.17	-.55***	-1.91	-1.37
R = .55, R^2= .31, ΔR^2=.31, (F = 145.410***)					

***p < .001*
Note. CTE= childhood traumatic experience; IU= idealizing upbringing.

Impact of childhood traumatic experience and idealizing upbringing on self-harm behavior of emerging adults has been shown in Table 11. Findings indicate that childhood traumatic experience is a strong significant positive predictor of self-harm behavior (ΔR^2 = .59, β =.77, F =476.11, p < .001) by contributing 59% of variability in self-harm behavior. Findings indicate that idealizing upbringing is a strong significant negative predictor of self-harm behavior (ΔR^2 =.306, β =-.55, F =145.410, p < .001) by contributing 31% of variability in self-harm behavior.

Table 12

Simple linear Regression Analysis on Distress Tolerance by Idealizing Upbringing (N=332).

	Distress Tolerance				95% CI	
Variable	*B*	*SE B*	*β*	*t*	*LL*	*UL*
Constant	39.21	1.72		22.83	35.83	42.59
IU	-.45	.17	-.15**	-2.73	-.78	-.13
R =.15 , R^2= .02, ΔR^2=.02, (F = 7.45**)						

**p < .001
Note. IU= idealizing upbringing.

Impact of idealizing upbringing on distress tolerance of emerging adults has been shown in Table 12. Findings indicate that idealizing upbringing is a significant negative predictor of distress tolerance (ΔR^2 =.02, β =-.15, F =7.45, p < .001) by contributing 2% of variability in distress tolerance.

Table 13

Means, SDs and t values of Study Variables based on Gender (N=332)

	Males (n = 143)		Females (n = 189)					95%CI		
Variables	*M*	*SD*	*M*	*SD*	*t*	*df*	*p*	*LL*	*UL*	Cohen's *d*
CT										
CTE	46.03	15.98	45.21	16.00	.46	330	.65	-2.67	4.30	-
IU	9.90	3.18	9.59	3.70	.80	330	.43	-.45	1.07	-
SH	28.20	10.64	28.72	10.11	-.46	330	.65	-2.78	1.73	-
PA										
SecM	42.02	10.78	42.01	11.59	.01	330	.99	-2.44	2.47	-
InsecM	21.52	7.01	21.28	6.83	.32	330	.75	-1.26	1.75	-
SecF	35.24	12.84	36.28	11.95	-.76	330	.45	-3.73	1.65	-
InsecF	22.10	7.63	21.23	8.10	1.00	330	.32	-.85	2.60	-
DT	36.10	10.88	33.81	10.39	1.94	330	.05	-.03	4.60	-

***p < .001, ** p<.01*
Note: CI=Confidence Interval, UL=Upper Limit, LL= Lower Limit. CT= Childhood trauma; CTE= Childhood traumatic Experiences; IU= Idealizing Upbringing; SH= Self Harm; PA= Parental attachment; SecM= Mother Secure Parental Attachment; InseM= Mother Insecure Parental Attachment; SecF= Father Secure Parental Attachment; InseF= Father Insecure Parental Attachment; DT= Distress Tolerance.

Table 13 shows the mean differences based on gender. Values in the table reveal that no significant ($p > .05$) mean differences across gender were observed on any of the variables, i.e., childhood traumatic experience, idealizing upbringing, self-harm behavior, mother-secure parental attachment, mother-insecure parental attachment, father-secure parental attachment, father-insecure parental attachment, and distress tolerance.

Table 14

Means, SDs and t values of Study Variables based on Family system (N=332)

	Joint (n = 93)		Nuclear (n = 239)					95%CI		
Variables	*M*	*SD*	*M*	*SD*	*t*	*df*	*p*	*LL*	*UL*	Cohen's *d*
CT										
CTE	47.88	15.33	44.66	16.16	1.65	330	.09	-.61	7.05	-
IU	10.90	2.81	9.26	3.62	3.94	330	.000	.82	2.46	0.51
SH	27.27	12.88	28.98	9.14	-1.36	330	.17	-4.19	.77	-
PA										
SecM	39.77	12.30	42.88	42.88	-2.28	330	.023	-5.79	-.43	-0.10
InsecM	20.78	9.43	21.61	5.62	-.98	330	.33	-2.48	.83	-
SecF	35.67	11.85	35.89	12.54	-.15	330	.88	-3.20	2.75	-
InsecF	17.69	6.54	23.13	7.87	-5.92	330	.000	-7.25	-3.63	-0.75
DT	33.52	10.10	35.30	10.83	-1.37	330	.17	-4.34	.78	-

****p < .001, ** p<.01*

Note: *CI*=Confidence Interval, *UL*=Upper Limit, *LL*= Lower Limit. CT= Childhood trauma; CTE= Childhood traumatic Experiences; IU= Idealizing Upbringing; SH= Self Harm; PA= Parental attachment; SecM= Mother Secure Parental Attachment; InseM= Mother Insecure Parental Attachment; SecF= Father Secure Parental Attachment; InseF= Father Insecure Parental Attachment; DT= Distress Tolerance.

Table 14 shows the mean differences based on the family system. Values in the table reveal that no significant (p > .05) mean differences were observed between nuclear and joint family systems on childhood traumatic experience, self-harm behavior, secure parental attachment with mother, secure parental attachment with father, insecure parental attachment with mother, insecure parental attachment with father and distress tolerance

across family system. However, emerging adults from joint family system scored significantly higher (p<.001) on idealized upbringing as compared to their counterparts. Whereas, emerging adults from nuclear family system scored significantly higher (p<.05) on mother's secure attachment and father's insecure attachment (p<.001) as compared to emerging adults from joint family system.

Table 15

Means, SDs and t values of Study Variables based on Marital status (N=332)

	Single (*n* = 293)		Married (*n* = 39)					95%CI		
Variables	*M*	*SD*	*M*	*SD*	*t*	*df*	*p*	*LL*	*UL*	Cohen's *d*
CT										
CTE	47.00	16.06	34.79	10.25	4.62	330	.000	7.00	17.40	0.91
IU	9.49	3.49	11.41	2.99	-3.27	330	.001	-3.07	-.76	-0.59
SH	29.16	10.59	23.51	6.24	3.26	330	.001	2.24	9.07	0.65
PA										
SecM	40.88	11.18	50.49	7.38	-5.21	330	.000	-13.2	-5.98	-1.01
InsecM	20.66	5.91	26.77	10.61	-5.41	330	.000	-8.33	-3.89	-0.71
SecF	35.93	12.69	35.08	9.31	.40	330	.69	-3.29	4.99	-
InsecF	21.95	8.29	19.05	2.96	2.16	330	.031	.26	5.53	0.47
DT	35.65	10.73	28.44	7.44	4.06	330	.000	3.72	10.70	0.78

****p < .001, ** p < .01*

Note: CT= Childhood trauma; *CI*=Confidence Interval, *UL*=Upper Limit, *LL*= Lower Limit. CT= Childhood trauma; CTE= Childhood traumatic Experiences; IU= Idealizing Upbringing; SH= Self Harm; PA= Parental attachment; SecM= Mother Secure Parental Attachment; InseM= Mother Insecure Parental Attachment; SecF= Father Secure Parental Attachment; InseF= Father Insecure Parental Attachment; DT= Distress Tolerance.

Table 15 shows the mean differences based on marital status. Values in the table reveal that no significant (p > .05) mean differences were observed between single and married emerging adults on secure parental attachment with father. However, emerging adults from single status scored significantly higher (p<.001) on childhood traumatic experience, self-harm behavior, insecure parental attachment with father and distress

tolerance as compared to their counterparts. Whereas, emerging adults from married status scored significantly higher (p<.05) on idealizing upbringing and mother's secure attachment as compared to emerging adults from single status.

Table 16

Means, SDs and t values of Study Variables based on age-group (N =332)

	Emerging Adults 18-23 (*n* = 175)		Established Adults 24-29 (*n* = 157)					95%CI		
Variables	*M*	*SD*	*M*	*SD*	*t*	*df*	*p*	*LL*	*UL*	Cohen's *d*
CT										
CTE	44.58	10.21	46.66	20.56	-1.18	330	.24	-5.53	1.38	-
IU	10.02	3.52	9.39	3.43	1.65	330	.10	-.12	1.38	-
SH	25.49	7.27	31.86	12.08	-5.89	330	.000	-8.50	-4.25	-0.64
PA										
SecM	41.29	11.29	42.82	11.15	-1.25	330	.21	-3.96	.89	-
InsecM	19.53	6.05	23.45	7.21	-5.39	330	.000	-5.35	-2.49	-0.59
SecF	37.69	13.56	33.76	10.47	2.93	330	.004	1.29	6.57	0.32
InsecF	21.32	8.28	21.92	7.46	-.70	330	.49	-2.31	1.11	-
DT	36.55	9.96	32.84	11.07	3.22	330	.001	1.44	5.98	0.35

****p < .001, ** p < .01*

Note: *CI*=Confidence Interval, *UL*=Upper Limit, *LL*= Lower Limit. CT= Childhood trauma; CTE= Childhood traumatic Experiences; IU= Idealizing Upbringing; SH= Self Harm; Pa= Parental attachment; SecM= Mother Secure Parental Attachment; InseM= Mother Insecure Parental Attachment; SecF= Father Secure Parental Attachment; InseF= Father Insecure Parental Attachment; DT= Distress Tolerance.

Table 16 shows the mean differences based on age range groups. Values in the table reveal that no significant (p > .05) mean differences were observed between 18-23 age range and 24-29 age range on childhood traumatic experience, idealizing upbringing, secure parental attachment with mother, and insecure parental attachment with father. However, emerging adults from 18-23 age range scored significantly higher (p<.001) on secure parental attachment with father and distress tolerance as compared to their

counterparts. Whereas, emerging adults from 24-29 age range scored significantly higher (p<.05) on self-harm behavior and mother's insecure attachment (p<.001) as compared to emerging adults from 18-23 age range.

Table 17

Means, SDs and t values of Study Variables based on Education Wise group (N = 332)

	Bachelor		Master							
	(*n* = 197)		(*n* = 135)					95%CI		
Variables	*M*	*SD*	*M*	*SD*	*t*	*df*	*p*	*LL*	*UL*	Cohen's *d*
CT										
CTE	46.06	16.28	44.84	15.54	.68	330	.16	-2.30	4.73	-
IU	10.15	3.86	9.09	2.75	2.76	330	.000	.31	1.82	0.32
SH	28.38	10.32	28.68	10.38	-.27	330	.34	-2.58	1.97	-
PA										
SecM	42.99	11.89	40.59	10.08	1.92	330	.001	.05	4.86	0.22
InsecM	23.14	7.62	18.81	4.62	5.91	330	.000	2.89	5.78	0.69
SecF	35.53	13.85	36.26	9.74	-.53	330	.000	-3.44	-1.99	0.06
InsecF	22.00	8.22	21.03	7.41	1.10	330	.000	.77	2.71	0.12
DT	32.22	12.31	38.56	5.87	-5.57	330	.000	-8.59	-4.10	0.66

****p <.001, ** p < .01*

Note: *CI*=Confidence Interval, *UL*=Upper Limit, *LL*= Lower Limit. CT= Childhood trauma; CTE= Childhood traumatic Experiences; IU= Idealizing Upbringing; SH= Self Harm; PA= Parental attachment; SecM= Mother Secure Parental Attachment; InseM= Mother Insecure Parental Attachment; SecF= Father Secure Parental Attachment; InseF= Father Insecure Parental Attachment; DT= Distress Tolerance.

Table 17 shows the mean differences based on education wise groups. Values in the table reveal that no significant (p > .05) mean differences were observed between bachelor and master students on childhood traumatic experience and self-harm behavior. However, emerging adults from bachelor scored significantly higher (p<.001) on idealized upbringing, secure parental attachment with mother, insecure parental attachment with mother and insecure parental attachment with father as compared to their counterparts.

Whereas, emerging adults from master scored significantly higher (p<.05) on father's secure parental attachment (p<.001) and distress tolerance as compared to emerging adults from bachelor.

Table 18

Income-wise Comparison on Childhood Traumatic Experience, Self-Harm Behavior, Parental Attachment and Distress Tolerance among emerging adults (N = 332).

	Lower Income Group (≤75000) (*n*=92)		Middle Income Group (76000-150000) (*n*=136)		High Income Group (≥151000) (*n*=104)				
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*P*	*η2*
CT									
CTE	40.58	8.23	50.99	20.33	42.88	12.24	14.98	.000	.083
IU	9.83	3.47	9.93	3.14	9.35	3.91	.90	.41	-
SH	25.35	6.92	30.81	12.93	28.27	8.10	8.04	.000	.047
PA									
SecM	40.15	12.58	42.62	9.99	42.87	11.43	1.77	.172	-
InsecM	22.65	8.54	22.31	6.48	19.04	5.03	9.23	.000	.053
SecF	35.98	11.35	35.60	13.32	36.00	11.94	.04	.96	-
InsecF	16.48	4.29	23.88	7.98	23.16	8.26	32.13	.000	.163
DT	32.29	12.11	34.43	10.93	37.50	8.07	6.16	.002	.036

df =2, 329

Note: η^2 =Partial eta squared values are suggestive of significant effect size. Cohen (1969) classified effect of 0.2 as small, 0.5 as medium, and 0.8 or higher as large. CT= Childhood trauma; CTE= Childhood traumatic Experiences; IU= Idealizing Upbringing; SH= Self Harm; PA= Parental attachment; SecM= Mother Secure Parental Attachment; InsecM= Mother Insecure Parental Attachment; SecF= Father Secure Parental Attachment; InsecF= Father Insecure Parental Attachment; DT= Distress Tolerance.

According to the participants' income-wise, Table 18 displays the variations in

research variables among lower, middle, and higher income groups. Results of univariate analysis to find out mean differences on childhood traumatic experience, self-harm behavior, insecure parental attachment with mother, insecure parental attachment with father, and distress tolerance have been found out to be highly significant. Mean values show that significant group differences are seen in childhood traumatic experience (F = 14.98, $p < .001$), self-harm behavior (F = 8.04, p < .001), insecure parental attachment with mother (F = 9.23, $p < .001$) and insecure parental attachment with father (F = 32.13, $p <$ .001) among income groups. Mean values show that significant group differences are seen on distress tolerance (F = 6.16, $p < .001$) among income groups. Whereas values in the table reveal that non-significant (p >.05) mean differences were observed among lower, middle and higher income group on idealizing upbringing, secure parental attachment with mother, and secure parental attachment with father.

Table 19

Post hoc analysis of group difference on the family income-wise domain (N=332)

Variables	*(I)* Income groups	*(J)* Income groups	Mean Difference *(I-J)*	*(i-j)*	*S.E*	*95% CI*	
						LL	*UL*
CTE	Lower	Middle	LIG< MIG	-10.4***	2.07	-14.5	-6.34
	Lower	High	LIG< HIG	-2.30	2.20	-6.62	2.02
	Middle	High	MIG>HIG	8.12***	2.00	4.19	12.05
SH	Lower	Middle	LIG< MIG	-5.46***	1.37	-8.15	-2.77
	Lower	High	LIG< HIG	-2.92*	1.45	-5.77	-.07
	Middle	High	MIG>HIG	2.54	1.32	-.05	5.13
InsecM	Lower	Middle	LIG>MIG	.34	.91	-1.44	2.13
	Lower	High	LIG>HIG	3.61***	.96	1.72	5.51
	Middle	High	MIG>HIG	3.27***	.88	1.55	5.00
InsecF	Lower	Middle	LIG< MIG	-7.40***	.98	-9.33	-5.48
	Lower	High	LIG< HIG	-6.69***	1.04	-8.73	-4.64
	Middle	High	MIG>HIG	.72	.94	-1.14	2.58
DT	Lower	Middle	LIG< MIG	-2.13	1.42	-4.92	.65
	Lower	High	LIG< HIG	-5.21***	1.50	-8.16	-2.25
	Middle	High	MIG<HIG	-3.07*	1.37	-5.76	-.39

*$p < .05$, **$p < .01$, ***$p < .001$, NS=Non signifiant
Note: LIG= Lower income group, MIG=Middle income group, HIG= High income group. CTE= Childhood traumatic Experiences; SH= Self Harm; InsecM= Mother Insecure Parental Attachment; InsecF= Father Insecure Parental Attachment; DT= Distress Tolerance.

To determine within-group differences, a post-hoc analysis was further calculated in Table 19. The results showed that, in comparison to the lower and higher income groups, the middle-income group had a considerably greater degree of childhood traumatic

experience (p<.001). While there was a significant difference (p<.001) between the middle and higher income categories, no significant differences were found between the lower and higher groups. To investigate within-group differences, a post-hoc analysis was further computed. The results showed that, although there are no significant differences in the impact of self-harm between the middle and higher income groups, the middle income group demonstrated a significantly higher level of the impact of self-harming behaviour compared to the lower and middle income groups (p<.001). To determine within-group differences, a post-hoc analysis was further performed. The results showed that the lower-income group had a significantly higher level of insecure parental attachment with their mother (p<.001) than both the middle and higher-income groups, while there were no significant differences between the lower and middle-income groups and a significant difference (p<.001) between the lower and higher-income groups. The middle-income group had a greater degree of insecure parental connection with their father, according to a post-hoc study. Additionally, insecure parental connection with the father is not significantly different between middle- and high-income groups (p >.05), but it is extremely significant (p <.001) between the two groups lower and middle income. Additionally, a highly significant difference between the lower and higher income groups is revealed (p <.001). In the latter, the findings show that there is no significant difference (p >.05) in the distress tolerance of the middle-class and low-income groups. There is a significant difference (p <.05) between the middle- and high-income groups, and a highly significant difference (p <.001) between the low- and high-income groups. A post-hoc analysis reveals that the level of distress tolerance is higher in the higher income group.

4.1 Moderation Analyses

The moderating effects of parental attachment (secure and insecure parental attachment between the mother and father) were investigated in order to shed light on the

relationship between the traumatic childhood experience and self-harm behavior among emerging adults. The possibility of these factors being modulated was ascertained by applying the macro process analysis proposed by Hayes (2013). In essence, process is a methodical technique to assessing route models like moderation, mediation, and their mixtures. Additionally, it provides many of the Sobel test and interaction term features in a single command (Preacher & Hayes, 2004). In addition to calculating the OLS regression coefficient, it also produces conditional effects in moderation models.

Table 20

Moderating effect of Secure Parental Attachment with Mother in the relationship between Childhood Traumatic Experience and Self-Harm Behavior among emerging adults (N = 332)

Variable	*B*	*SE B*	*t*	Self-Harm Behavior	
				p	*95% CI*
Constant	16.88	4.40	-3.84	.000	[-25.53, -8.23]
CTE	1.04	.09	11.35	.000	[.86, 1.22]
SecM	-.62	.11	5.74	.000	[.41, .84]
CTE x SecM	-.02	.00	-6.17	.000	[-.02, -.01]
R^2	.63				
F	188.85***				

*p > .05= non-significant, ***p* < .001
Note: B= Unstandardized coefficients; LL = Lower limit; UL = Upper Limit; CTE = Childhood Traumatic Experience; SecM = Secure Parental Attachment with Mother

Moderating Effect of Secure Parental Attachment with Mother

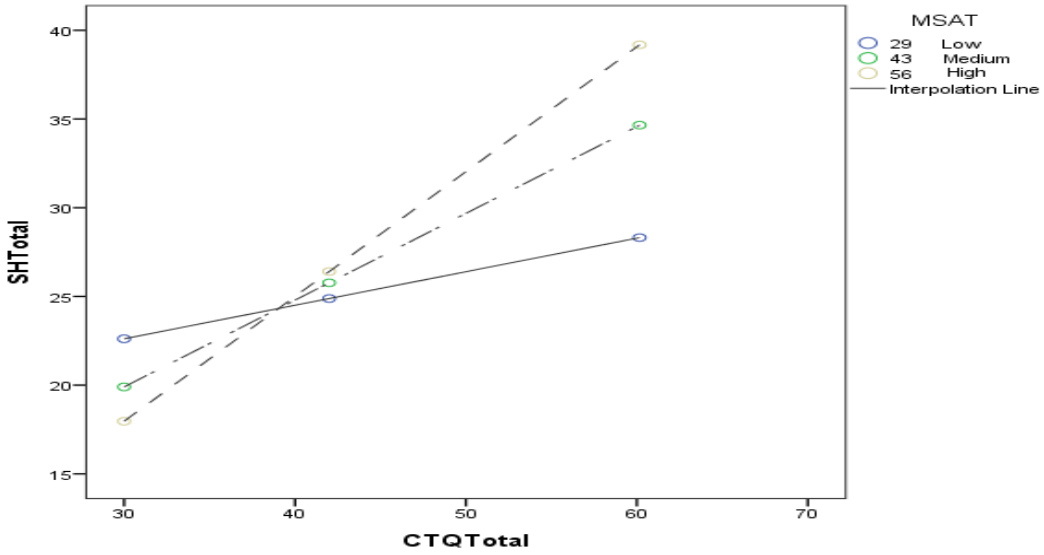

Figure 2. Moderating effect of Secure Parental Attachment with Mother in the relationship between Childhood Traumatic Experience and Self-Harm Behavior among emerging adults.

The findings concerning the moderating effects of secure parental attachment with mother in the relationship between childhood traumatic experience and self-harm behavior among emerging adults are shown in table 20. Demonstrating how secure parental attachment with mother acts as a moderator. In explaining self-harm behavior, table 20 shows a substantial interaction effect between childhood traumatic experience and secure parental attachment with mother. The interaction effect between secure parental attachment with mother and childhood traumatic experience was statistically significant negative, accounting for 63% of the variance in self-harm behavior among emerging adults (B =-.02, $R2$ = .63, F =188.85, p =.000). Secure parental attachment to the mother served as a protective factor by reducing the detrimental impact of traumatic experiences throughout childhood on self-harm behavior. The mod graph describes this effect further by showing that high levels of secure parental attachment with mother diminished the impact of childhood traumatic experience on self-harm behavior whereas medium and low levels of

secure parental attachment with mother increased the impact of childhood traumatic experience on self-harm behavior.

Table 21

Moderating effect of Insecure Parental Attachment with Mother in the relationship between Childhood Traumatic Experience and Self-Harm Behavior among emerging adults (N = 332)

				Self-Harm	
Variable	*B*	*SE B*	*t*	*p*	*95% CI*
Constant	42.05	3.85	10.92	.000	[34.47, 49.62]
CTE	.45	.09	-4.85	.000	[-.64, -.27]
InsecM	1.67	.18	-9.45	.000	[-2.02, -1.33]
CTE x InsecM	.04	.00	10.31	.000	[.03, .05]
R^2	.69				
F	247.10***				

*p > .05= non-significant, ***p < .001*

Note: B= Unstandardized coefficients; LL = Lower limit; UL = Upper Limit; CTE = Childhood Traumatic Experience, InsecM = Insecure Parental Attachment with Mother

Moderating Effect of Insecure Parental Attachment with Mother

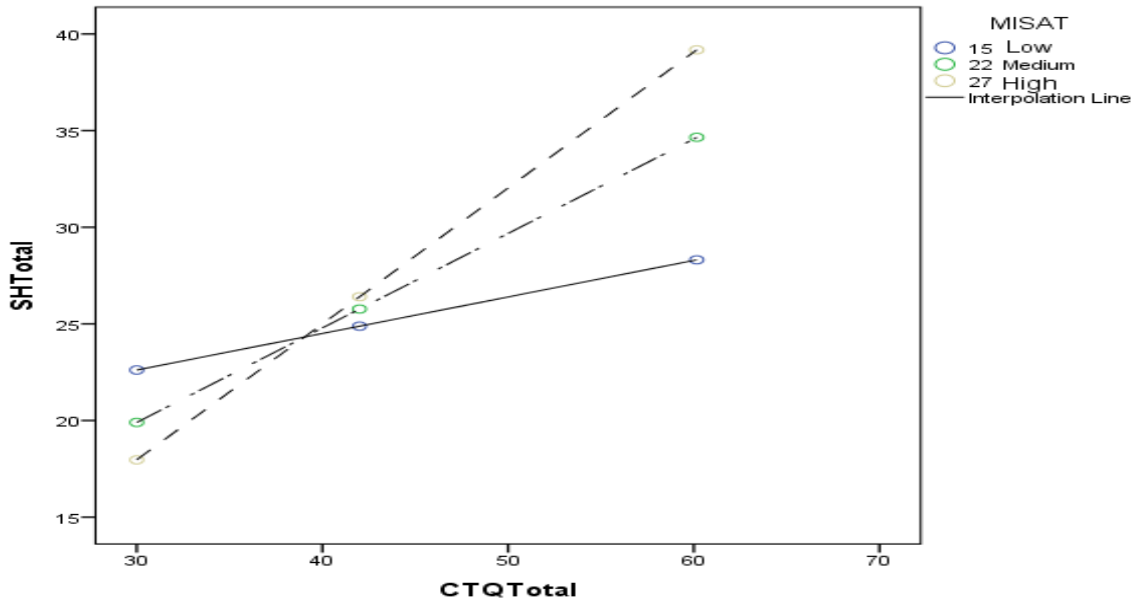

Figure 3. Moderating effect of Insecure Parental Attachment with Mother in the relationship between Childhood Traumatic Experience and Self-Harm Behavior among emerging adults.

The findings concerning the moderating effects of insecure parental attachment with mother in the relationship between childhood traumatic experience and self-harm among emerging adults are shown in table 21. Demonstrating how insecure parental attachment with mother acts as a moderator. The interaction effect between insecure parental attachment with mother and childhood traumatic experience was statistically significant positive, accounting for 69% of the variance in self-harm behaviour among emerging adults (*B* =.04, *R2* = .69, *F* =247.10, *p* =.000). Insecure parental attachment with mother increase the negative effects of childhood traumatic experience on self-harm behavior. The mod graph describes this effect further by showing that high levels of insecure parental attachment with mother amplify the impact of childhood traumatic experience on self-harm behavior whereas medium and low levels of insecure parental attachment with mother decrease the impact of childhood traumatic experience on self-harm behavior.

Table 22

Moderating effect of Secure Parental Attachment with Father in the relationship between Childhood Traumatic Experience and Self-Harm Behavior among emerging adults (N = 332)

Variable	*B*	*SE B*	*t*	Self-Harm	
				p	*95% CI*
Constant	1.52	3.69	.41	.68	[-5.74, 8.78]
CTE	.54	.07	7.88	.000	[.40, .67]
SecF	-.10	.10	.97	.33	[-.10, .30]
CTE x SecF	.00	.00	-.33	.74	[.00, .00]
R^2	.60				
F	161.32***				

*p > .05= non-significant, ***p < .001*

Note: B= Unstandardized coefficients; LL = Lower limit; UL = Upper Limit; CTE = Childhood Traumatic Experience, SecF = Secure Parental Attachment with Father

The results of father secure parental attachment moderation effect are shown in table 22. The model's results show that secure parental attachment with father non-significantly moderated the relationship between childhood traumatic experience and self-harm behavior among emerging adults, accounting for 60% of the variation (*B* =.00, *R2* =.60, *F* = 161.32, *p* =.74) in self-harm behavior in among emerging adults.

Table 23

Moderating effect of Insecure Parental Attachment with Father in the relationship between Childhood Traumatic Experience and Self-harm behavior among emerging adults (N = 332)

				Self-Harm	
Variable	*B*	*SE B*	*t*	*p*	*95% CI*
Constant	37.96	4.80	7.91***	.000	[28.53,47.40]
CTE	.39	.11	-3.51***	.000	[-.60, -.17]
InsecF	1.38	.21	-6.46***	.000	[-1.81, -.96]
CTE x InsecF	.04	.00	7.89***	.000	[.03, .05]
R^2	.69				
F	245.06***				

*p > .05= non-significant, ***p < .001*
Note: CTQ = Childhood Traumatic Questionnaire, InsecF = Insecure Parental Attachment with Father

Moderating Effect of Insecure Parental Attachment with Father

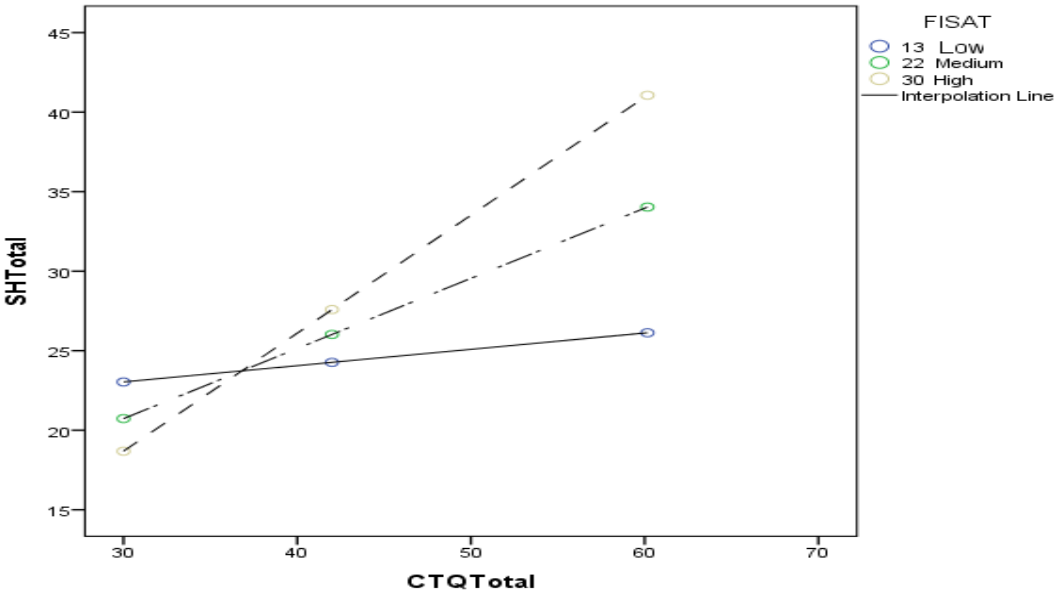

Figure 4. Moderating effect of Insecure Parental Attachment with Father in the relationship between Childhood Traumatic Experience and Self-harm behavior among emerging adults.

The findings concerning the moderating effects of insecure parental attachment with father in the relationship between childhood traumatic experience and self-harm behavior among emerging adults are shown in table 23. Demonstrating how insecure parental attachment with father acts as a moderator. The interaction effect between insecure parental attachment with father and childhood traumatic experience was statistically significant, accounting for 69% of the variance in self-harm behavior among emerging adults (B =.04, $R2$ = .69, F =245.06, p =.000). Insecure parental attachment with father increase the negative effects of childhood traumatic experience on self-harm behavior. The mod graph describes this effect further by showing that high levels of insecure parental attachment with father amplify the impact of childhood traumatic experience on self-harm behavior whereas medium and low levels of insecure parental attachment with father decrease the impact of childhood traumatic experience on self-harm behavior.

4.2 Mediation Analyses.

In order to explain the relationship between childhood traumatic experience and self-harm behavior among emerging adults, the mediating role of distress tolerance was examined. Process Macro was used to conduct mediation analyses of these variables (Hayes, 2013). Process, which offers many of the features of the Sobel test and interaction term in a single command (Preacher & Hayes, 2008), is basically a computational approach for evaluating path models like moderation, mediation, and their combinations (Preacher & Hayes, 2004).

The mediating role of distress tolerance in the association between childhood traumatic experiences and self-harm conduct in emerging adults was examined using a mediation analysis. Findings show that the association between self-harm behavior and traumatic childhood experiences is not mediated by distress tolerance. A substantial direct effect of the model was found (b =.50, CI [.46,.55], p<.001). It was determined that the indirect effect of the model was not significant (b = -.003, CI [-.01,.003], p>.05). Afterwards, distress tolerance was also tested as moderator in the relationship between childhood traumatic experiences and self-harm behavior to check its role otherwise. However, results did not reveal any significant moderating effect B =-.0048, $R2$ =.38, F = 66.19, (p>.05) of distress tolerance in this path of relationship either.

Chapter 5

SUMMARY, FINDINGS, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1. Summary

The purpose of the present study was to examine the effect of childhood traumatic experience on self-harm behavior in emerging adults, as well as the effect of adult parental attachment (i.e., secure parental attachment and insecure parental attachment with father and mother). Additionally, the study examined how parental attachment (i.e., secure parental attachment and insecure parental attachment) moderates the association between childhood traumatic experience and self-harm behavior among emerging adults. Additionally, another objective of the study was to find out the mediating effect of distress tolerance in the association between childhood traumatic experience and self-harm behavior among emerging adults. Comparing groups based on all study variables, including gender, age, education, family system, family income, marital status and parental status. Different scales were used in the present study, i.e., the childhood traumatic questionnaire, the self-harm inventory of adolescence, the adult scale of parental attachment, and the distress tolerance scale along with a detailed demographic sheet. The data was collected from under-graduate and graduate university students of different universities in Islamabad and Rawalpindi with a convenient sampling technique

5.2. Findings

The findings of the present study showed that there is a positive relationship between childhood traumatic experience and self-harm behavior. As in the literature, the present study found that parental attachment plays a moderating role in the relationship between childhood traumatic experience and self-harm behavior. Secure parental

attachment with mother decreases the impact of childhood traumatic experience on self-harm behavior, whereas insecure parental attachment with mother increases the impact. Secure parental attachment with father as moderator has no impact on the relationship between childhood traumatic experience and self-harm behavior; on the other hand, insecure parental attachment with father increases the effect of childhood traumatic experience on self-harm behavior. Further results indicate that distress tolerance does not mediate the association between childhood traumatic experience and self-harm behavior.

5.3. Discussion

Adolescents and young adults in Pakistan have lately shown an increased prevalence of self-harm behaviour. According to studies conducted in Pakistan, adolescents and young adults are the age group most at risk for self-harm behavior (Khan, et al., 2002; Khan et al., 1996; Shekhani et al., 2018; Salman et al., 2014; Shahid & Hyder, 2008; Syed & Khan, 2008;). Youth who have had traumatic childhood experiences, such as abuse and broken attachments, are more likely to experience high emotionality or dissociative states. As a result, they may resort to extreme behaviours like self-harm behaviour or other behaviours to express or control their emotions (Gonzales & Bergstrom, 2013). An authoritarian parenting style, characterized by high levels of control and demands and low levels of warmth and affection, can increase a child's chance of developing self-harm behaviour (Baetens et al., 2014).

5.3.1. Relationship between Study Variables.

The findings of the study (Table 10) supported this assumption and accepted this first hypothesis by providing evidence that childhood traumatic experiences are significantly positive correlated with self-harm behavior among adults. Table 10 shows the results of bivariate correlations. Values indicate significant (**p<.01) positive correlation of childhood traumatic experience with self-harm behavior, insecure parental attachment

with mother and insecure parental attachment with father, whereas significant negative association of childhood traumatic experience with idealizing upbringing, secure parental attachment with mother and secure parental attachment with father. Values indicate significant (*p<0.1) negative correlation of self-harm behavior with secure parental attachment with mother and secure parental attachment with father, whereas significant (**p<.01) positive correlation with insecure parental attachment with mother and insecure parental attachment with father. Values indicate significant (*p<0.1) negative correlation between insecure parental attachment with mother and secure parental attachment with father. Values indicate non-significant negative correlation between childhood traumatic experience and distress tolerance. Values indicate significant (*p<0.1) negative correlation of distress tolerance with idealizing upbringing, secure parental attachment with mother and secure parental attachment with father. Values indicate non-significant positive correlation of distress tolerance with self-harm behavior, insecure parental attachment with mother and insecure parental attachment with father. These results show how the study variables relate to one another.

5.3.2 Predictive Role of the Study Variables.

Linear regression analyses were used to evaluate the study's premise and investigate the impact of childhood traumatic experiences on self-harm in emerging adults. Results of the study (Table 11) predicted that childhood traumatic experience was the strong positive predictor of self-harm and indicated that by increase in childhood traumatic experience, self-harm behavior will be increased too. Results of the study (Table 11) predicted that idealizing upbringing was negative predictor of self-harm behavior and indicated that by increase in idealizing upbringing, self-harm behavior will be decrease too. Impact of idealizing upbringing on distress tolerance of emerging adults has been shown in Table 12. Findings indicate that idealizing upbringing is a significant negative predictor of distress

tolerance The study aims to explore the association between childhood sexual abuse (CSA) and self-harm behavior in a sample of undergraduate students, and the mediating role of self-blame. This is a correlational study in which data were collected from a total of 2,926 students across 8 districts in Pakistan, including Faisalabad, Sialkot, Bahawalpur, Rahim Yar Khan, Karachi, Multan, Mirpur, and Quetta. Participants (who were aged between 16 to 24) were selected from a range of universities and postgraduate colleges, to encourage self-reporting more accurately. Analyses showed a strong correlation between CTQ and CSA, as well as between the frequency and existence of self-harm behavior. (Naeem et al.,2024).

Findings of this current study have supported Hypothesis 1 that states; childhood traumatic experiences have positive relationship with self-harm behavior and insecure parental attachment with mother and father respectively. These results are consistent with the body of previous research for the available data. As per previous studies literature, a research study was conducted in Pakistan (2023), to examine the relationship between self-harm behavior and childhood trauma. Childhood traumatic experiences was discovered to be a risk factor for self-harm behaviour in a comprehensive evaluation of research done in various age groups (Ford & Gómez, 2015). Additionally, a longitudinal research found that among teenage pupils, self-harm behaviour was linked to a higher history of childhood traumatic experiences (Garisch & Wilson, 2015). Research consist of 267 young individuals in the sample, ranging in age from 18 to 35. The study's findings show that self-harm behaviour was strongly predicted by childhood trauma (Fatima & Azam, 2023). The study aims to explore the association between childhood sexual abuse and self-harm in a sample of undergraduate students, and the mediating role of self-blame. This is a correlational study in which data were collected from a total of 2,926 students across 8 districts in Pakistan, including Faisalabad, Sialkot, Bahawalpur, Rahim Yar Khan,

Karachi, Multan, Mirpur, and Quetta. Analyses showed a strong correlation between childhood traumatic experience and existence of self-harm (Naeem et al.,2024). According to another study report strong correlations were found between emotional and sexual abuse with self- harm behavior (Glassman et al., 2007). This conclusion confirms the positive relationship between childhood traumatic experience and self-harm behavior among emerging adults. Another tenacity of this current study is to examine some of the communal predictors of self-harm behavior among emerging adults. Research has demonstrated that childhood traumatic experiences, when parents or other adults neglect to provide a kid with the required emotional or physical care, can result in feelings of worthlessness, emptiness, and self-blame in the child. They see self-harm behavior as a helpful coping strategy for these emotions, but it is not suicidal (Zheng et al., 2023). According to a longitudinal study found that adolescents who experienced parental abuse had far lower levels of parental attachment than adolescents who did not experience abuse or even those who merely saw physical abuse between their parents (Julian et al.,2017). A thorough search of internet databases turned several studies looking at the connection between parents' adult attachment and the likelihood of child abuse or maltreatment.16 studies in all (N = 1,830) were chosen. Insecure parental attachment and child abuse are significantly positively correlated, according to a meta-analysis using random-effects models (Lo et al., 2019). Moreover, a research was conducted in 2023 included 3142 Spanish adolescence participants between 12 to 18 age range to find significant association between childhood traumas and insecure parental attachment (Navas & Cano, 2023). Results of previous study shows that the relationship between self-harm and childhood maltreatment might be partially explained by insecure attachment and defective mentalizing (Stagaki et al., 2022). Prior research has also demonstrated a link between higher degrees of negative childhood experiences and insecure attachment patterns and a higher incidence of sickness (Felitti. et

at.,2002; Maunder. et al.,2001). According to a research study, those who had experienced abuse may have had more insecure attachment patterns than individuals who had not (Unger & De Luca,2014). Insecure parental attachment and child abuse are significantly positively correlated, according to a meta-analysis using random-effects models (Lo, et al., 2019).

Whereas finding of current study results does not supported the positive relationship between childhood traumatic experience and poor distress tolerance. Meanwhile, a research study finding revealed that Lower distress tolerance was substantially linked with child trauma exposure (Russo et al., 2023). The results of the research analyses showed a strong positive relationship between the number of complex trauma experiences and distress tolerance, as well as a substantial positive relationship between the number of complex trauma experiences and difficulty regulating emotions. The findings also showed that emotional control and distress tolerance in later, young-adult functioning were significantly predicted by complicated trauma events throughout childhood (Lombardo, 2020). These results did not support the current study's finding. According to the research finding results established that high levels of parental rejection and overprotection were related to lower distress tolerance and higher levels of psychological distress (Sadia et al., 2021).

In the present study Hypothesis 2 has been supported that states; childhood traumatic experiences have negative relationship with secure parental attachment among emerging adults. Whereas finding of current study results does not supported the negative relationship between childhood traumatic experience and distress tolerance. In the past studies results generated as in adolescents, secure attachment moderates the relation between child sexual abuse and trauma symptoms (Jardin et al., 2017). Meanwhile, a research study finding revealed that Lower distress tolerance was substantially linked with childhood traumatic experiences and participant’s details were 385 numbers, aged range

between 18 and 48 (Russo et al., 2023). This is in line with a growing body of studies that shows a critical link between childhood abuse and adult mental health issues is a decreased distress tolerance (Robinson et al., 2021). Research evidence suggested direct negative correlations between childhood trauma and secure parental attachment patterns (Ejaz et al., 2025). The results of the analyses showed a strong positive relationship between the number of complex trauma experiences and distress tolerance, as well as a substantial positive relationship between the number of complex trauma experiences and difficulty regulating emotions (Lombardo, 2020).

Similarly, in a sample of urban teenagers, cumulative exposure to violence (including family and community violence) was linked to a reduced threshold for distress tolerance (Heleniak et al., 2021). A research was conducted in Tehran on 2021 which predicted negative correlation between childhood trauma and distress tolerance consisted of 326 Iranian male and females selected by convenient sampling technique through online platform and results state that distress tolerance has been shown negative correlation to childhood trauma (Farahani, Azadfallah & Watson, et al,2022). Many psychosocial problems, such as depression and trauma, are associated with distress tolerance (Ellis et al., 2012; Berenz et al., 2018).Meanwhile, a research study finding revealed that Lower distress tolerance was substantially linked with child trauma exposure(Russo & Oliveros, 2023).According to the research finding results established that high levels of parental rejection and overprotection were related to lower distress tolerance and higher levels of psychological distress (Sadia et al.,, 2021).

5.3.3 Moderating Role of Parental attachment.

Process Macro was used to conduct moderation analyses (Hayes, 2013) in order to investigate the role of parental attachment (i.e. secure parental attachment with mother and father and insecure parental attachment with mother and father) in the relationship between

childhood traumatic experience and self-harm behavior among emerging adults.

Hence, the findings of the study (Table 20) were in favor of Hypothesis 4 that states "secure parental attachment with mother decreases the effect of childhood traumatic experiences on self-harm behavior among emerging adults". Whereas finding of present study results (Table 22) reported that secure parental attachment with father have no effect on the relationship between childhood traumatic experience and self-harm behaviour. Previous literature also supports this hypothesis. A research study used mother and paternal attachment security as moderating factors to examine the significance of childhood traumas as a risk factor for self-harm in a sample of Central American migrant high school students. It was discovered that the relationship between childhood trauma and self-harm was mitigated by maternal attachment security but not by paternal attachment security (Walker, et al.,2023). The self- harm risk was successfully reduced by family harmony and positive parenting practices, such as parental support and emotional warmth and understanding (Cheng et al., 2022, Fong et al., 2022, Victor et al., 2019). Self-harm with visible tissue damage was directly impacted by adverse childhood experiences. Negative childhood experiences and self-harm with visible tissue damage were mediated by parental attachment (Lichvárová et al., 2025). According to a research study results suggest that secure attachment with the mother may be protective for both the autonomic and social functions of the self-harm behaviour (Bahali, et al. 2024). In central China, 1795 teenagers were included in this research. Results of this study generated as self-harm behaviour is directly impacted by father love absence (Xiang et al., 2024).

According to published research, insecure parental attachment is a risk factor for self-harm behavior (Cassels et al., 2019), and there is evidence that attachment issues are a major contributing factor to self-harm (Molaie et al., 2019). According to the interpersonal/systemic model of self-harm, people's negative social or familial

environments may unintentionally encourage self-destructive behaviours (Prinstein et al., 2009). That is, although bad parent-child connections may exacerbate self-harm behavior or injury, positive relationships may avoid it. Furthermore, research has shown that parenting practices and family functioning are predictive of and strongly associated with self-harm behavior (Baetens et al., 2015; Ren et al., 2018). In another research study that included 662 junior high school student's participant and the research title was about to study "The Impact of Parent–Child Attachment on Self-Injury Behavior: Negative Emotion and Emotional Coping Style as Serial Mediators ". The research investigated that negative emotion mediates between self-harm behavior and both father-child and mother-child parental attachment, while emotional coping style only works between father-child attachment and self-harm behavior (Tao et al., 2020). This goes in favor of Hypothesis 5 of the current study table 21 and table 23 that states "Insecure parental attachment (i.e., avoidant and anxious) exacerbate the effect of childhood traumatic experiences on self-harm behavior among emerging adults". According to present study results this hypothesis is accepted significantly.

5.3.4 Mediating Role of distress tolerance.

To examine the role of distress tolerance in the association between childhood traumatic experiences and self-harm behavior among emerging adults, mediation analyses were performed using Process Macro (Hayes, 2013). This is the third goal of the research.

Third hypotheses states that distress tolerance mediates the relationship between childhood traumatic experiences and self-harm behavior among emerging adults. The findings of this present study does not supported this hypothesis and results as generated distress tolerance does not mediate the relationship between childhood traumatic experiences and self-harm behavior among emerging adults. Whereas from previous literature results were in favor of hypothesis such as the indirect effect of emotional neglect

on self-harm behavior was mediated by low distress tolerance, low self-compassion, high self-disgust, and resulting high emotion regulation difficulty (Yasemin & Mujgan, 2023). Furthermore, a research was conducted to study mediating role of distress tolerance in association between childhood traumatic experience and self-harm behavior, sample included 397 college students, aged 18 to 30 and results stated that Low distress tolerance acted as a mediating factor in the emotional neglect's indirect impact on self-harm behaviour (Erol & Inozu, 2023). Research among Chinese teenagers reveals that distress intolerance mediates the association between child maltreatment and self-harm. This underlines the necessity for interventions that promote distress tolerance to minimize self-harm behaviors (Kang et al., 2018).

5.3.5. Differences on Demographic Variables.

The final goal of the study was to compare the mean differences among the emerging adults in the current study by gender, age, education, family system, family income, marital status, parental status, and ethnicity. Table 8 shows frequencies of demographic characteristics which included gender, age, education, family system, family Income, marital status, and parental status. By using t-test analysis on gender, Age, education, family system, family income, marital status and parental status all the study variables were examined. T-test was used to analyze group differences across all study variables based gender male and female. Results (table 13) indicated that influence of childhood trauma, idealizing upbringing, father insecure and secure parental attachment, mother insecure and secure parental attachment and distress tolerance non- significantly higher among males as compared to females. Results indicated that influence of self-harm and father secure parental attachment tolerance non- significantly higher among female students as compared to male students. Regarding the gender disparity, it has been shown that teenage females are more likely than boys to self-harm (Nawaz et al., 2024). According

to a study results the pooled prevalence of self-harm behavior by sex (38 studies, 266 491 participants) was higher for female adolescent's participants then for male adolescents (Moloney et al., 2024). According to research results despite the fact that males are more likely than women to suffer traumatic experiences in general, research indicates that women are two to three times more likely than men to acquire post-traumatic stress disorder (PTSD) following a traumatic event: around 10% to 12% for women and 5% to 6% for men (Kessler et al.,2017; Yazawa et al., 2022).Research study stated that self-harm was more common among girls, with the mean age at which self-harm began being 13 years old, 47% reporting only one or two episodes, and cutting being the most prevalent type (Gillies et al,. 2018). Self-harm behavior is generally described as more common in female than male teenagers (Steinhoff et al., 2021) while some research finds no sex difference (Swannell et al., 2014). In their search for gender differences, Kenny and Donaldson (1991) found that, compared to college males, college women reported feeling noticeably closer to their parents. Compared to women, men reported far greater levels of discomfort tolerance (Simons & Gaher, 2005).

Another t-test was used to analyze difference among nuclear and joint family system on study variables was also explored. Results (table 14) indicated that influence of father insecure parental attachment and mother secure parental attachment significantly higher in nuclear then joint family system. Results (table 14) indicated that influence of idealizing upbringing significantly higher in joint family system then nuclear family system. Non-significantly differences were also found in childhood traumatic experience where joint family system scored higher than nuclear family system. Non-significantly differences were also found in father secure parental attachment, mother insecure parental attachment, self-harm behavior and distress tolerance where joint family system scored lower than nuclear family system. A research study conducted in Pakistan stated that

females in our sample were more likely to self-harm, and they were also more likely to be young, unmarried, and part of a joint family. (Karamat,2023). According to research in this area, students from joint families typically lack self-control and are less tolerant of stress than students from nuclear families (Azhar et al., 2020; Tull et al., 2007).

Another t-test was used to analyze difference among single and married on study variables was also explored. Results (table 15) indicated that influence of childhood traumatic experience, self-harm behavior, father insecure parental attachment and distress tolerance significantly higher in single then married. Significantly differences were also found in idealizing upbringing, mother secure and insecure parental attachment where married status students scored higher than single status. Non-significantly differences were also found in father secure parental attachment, where married status students scored lower than single status. Marital status has been shown to have a substantial impact on the prevalence of self-harm behaviours. Self-harm is generally more common among those who are single, divorced, or separated than among those who are married. Self-harm was shown to be substantially correlated with being unmarried or separated in a study of people with drug use disorders. This implies that the lack of a supportive marriage may make this demographic more susceptible to self-harm (Gupta et al., 2019).

Another t-test was used to analyze difference among age group as range between 18-23 and 24-19 on study variables was also explored. Results (table 16) indicated that self-harm behaviour and mother insecure parental attachment significantly higher in 24-29 age range then 18-23 age range emerging adults. Significantly differences were also found in father secure parental attachment and distress tolerance where 24-29 age emerging adults scored higher than 18-23 age emerging adults. Non-significantly differences were also found in idealizing upbringing and distress tolerance where 18-23 age range emerging adults scored higher than 24-29 age range emerging adults. Non-significantly differences

were also found in childhood trauma, mother secure parental attachment and father insecure parental attachment, where 18-23 age range emerging adults scored lower than 24-29 age range emerging adults. The effects of childhood traumatic experiences may become more noticeable in the 18-23 age range emerging adults, which is at a crucial developmental period. Increased psychological anguish may result from the discovery of unaddressed difficulties during the transition to independence. Adverse childhood experiences (ACEs) are associated with more mental health issues in emerging adulthood, according to studies (Howell, 2024).

Table 17 shows the mean differences based on education wise groups. Values in the table reveal that a significant ($p<.001$) mean differences observed on idealizing upbringing, secure parental attachment with mother and insecure parental attachment with mother, where master students scored lower than bachelor. Insecure parental attachment with father reveal a significant difference in the mean score, where bachelor students score higher than married students, whereas secure parental attachment with father and distress tolerance reveal a significant difference in the mean score, where master students score higher than bachelor students.

According to the participants' income-wise, Table 18 displays the variations in research variables among lower, middle, and higher income groups. Results of univariate analysis to find out mean differences on childhood traumatic experience, self-harm behavior, insecure parental attachment with mother, insecure parental attachment with father, and distress tolerance have been found out to be highly significant. Mean values show that significant group differences are seen on childhood traumatic experience among income groups. Mean values show that significant group differences are seen on self-harm behavior among income groups. Mean values show that significant group differences are seen on insecure parental attachment with mother and insecure parental attachment with

father among income groups. Mean values show that significant group differences are seen on distress tolerance among income groups. Whereas results of univariate analysis to find out mean differences on idealizing upbringing, secure parental attachment with mother, and secure parental attachment with father have been found out to be non-significant. Idealizing upbringing is non-significantly higher in the middle-income group, the impact of secure parental attachment with mother is higher in the higher-income group, the mean difference on the income group is non-significant, and the lost mean differences are high in the higher-income group on secure parental attachment with father.

Limited research has been done on how emerging adults from different ethnic groups in Pakistan differ in terms of their self-harming behaviour, parental connection, distress tolerance, and childhood traumatic experiences. Exposure to childhood trauma is widespread and linked to worse mental health outcomes for young boys and girls, according to research done in rural Pakistan. The study emphasizes the incidence of trauma among Pakistani children even though it does not specifically target any ethnic group (Khan & Munshi, 2024).

5.4. Conclusion

The present study found that experience of childhood traumatic experience leads to level of self-harm behavior and parental attachment play moderating role in relationship between childhood trauma and self-harm behavior among emerging adults whereas distress tolerance does not mediate the relationship. As proposed, mother secure parental attachment buffer the effect of childhood traumatic experience that lead toward self-harm behavior among emerging adults. Secure maternal connection is often a protective element in child development. It gives a sense of safety, emotional control, and resilience. Reactive, sensitive, and emotionally supporting carers are frequently seen in children with stable attachments, which promotes emotional stability and trust. Whereas mother and father

insecure parental attachment exacerbate the effect. As for distress tolerance as mediator doesn’t shows significant relationship between childhood trauma experience and self-harm behaviour among emerging adults. Although secure parental attachment usually protects against the impacts of childhood trauma, in some situations, particularly coupled with unresolved trauma and attachment issues, it might make self-harm worse. Targeted therapy interventions and supportive settings are necessary to address the attachment dynamics as well as the trauma for effective recovery. Childhood trauma, particularly when unprocessed or unresolved, can have long-lasting repercussions on an individual's mental health and behavior. Self-harm is one such expression, frequently coupled with coping techniques for overwhelming emotions, emotional dysregulation, or unresolved trauma. A person's ability to cope with trauma and its consequences, such as their propensity to harm themselves, is greatly influenced by their secure parental attachment.

5.5. Limitations and suggestions

Following are the limitations of the present study:

- Data for the present study is taken from Dera Ismail Khan, Islamabad and Rawalpindi universities, so it is suggested for generalizability of results, the data should be included from other cities too.
- Cross-sectional study method was used for present the study which results can’t be used or apply in long term. For this reason, longitudinal is preferable to apply in research studies. Cross-sectional designs are used in this research on trauma, self-harm, distress tolerance, and parental attachment, which makes it more difficult to prove causation. To comprehend the directionality and temporal correlations between these factors, longitudinal studies are required.
- The study's statistical power may be limited by small sample numbers, making it more difficult to identify meaningful connections or interactions. Cultural, ethnic,

and socioeconomic variety are frequently ignored in research, despite the fact that they may have an influence on coping strategies, attachment patterns, and distress tolerance.

- Distress tolerance as a mediator and parental connection as a moderator may oversimplify the complex and reciprocal interactions between these factors. Other possible mediators (such emotional dysregulation, coping mechanisms) or moderators (like peer support, cultural norms) might not have received enough attention.

Research on parental attachment, self-harm, traumatic events, and distress tolerance is instructive, but it needs more study due to methodological, sampling, measuring, and application flaws. By filling up these gaps, we may better understand these intricate interactions and develop solutions for populations that are at risk.

5.6. Implications

The present study's findings have important implications for developmental psychology research, especially in figuring out how parental attachment, distress tolerance, and traumatic experiences throughout childhood influence self-harm behavior. An elaborate description of the study implications may be found below:

- Understanding how early experiences influence emotional, cognitive, and behavioral development is the goal of developmental psychology. By analyzing the degree of parental attachment, this study adds to the expanding body of research on attachment theory and highlights how important it is for resilience and emotional control. Distress tolerance is presented in the study as a non-pathological component that affects how people handle trauma from childhood. It moves the research's emphasis to comprehending how emotional resilience varies among individuals.

- Self-harm is among the maladaptive behaviours that are significantly predicted by childhood trauma. It clarifies the long-term effects of trauma, especially how it affects coping strategies through interactions with attachment and distress tolerance. These results can be used by researchers to create frameworks that incorporate distress tolerance training and connection restoration into trauma treatment.
- This study provides clinical psychologists with useful information. To lessen self-harming behaviours, clinicians can create therapeutic procedures that emphasize mending attachment relationships and increasing distress tolerance. By identifying early markers of self-harm risk, such as unstable attachment or poor distress tolerance, research motivated by these results might facilitate prompt treatments. The study advises doctors to use a strengths-based approach by focussing on non-pathological variables, which helps clients develop resilience and deal with hardship.
- The findings support the use of attachment-based interventions in family therapy to restore or strengthen parent-child bonds, especially in traumatized families. The study emphasizes the critical role of parental attachment in emotional development, which can direct family-focused research and practices. By designing evidence-based parenting programs, researchers can help carers understand the significance of secure attachment and teach them strategies to foster emotional regulation in children.
- The study emphasizes how important family relationships are to developmental results. Researchers can create studies to assess the efficacy of parenting education programs that educate parents how to assist their children's development of distress tolerance and secure attachment. Future research can look into how attachment

styles and family dynamics affect how coping mechanisms are developed in traumatized youngsters.

- This study provides a number of paths for further inquiry. Understanding of how cultural variations in attachment and parenting practices affect self-harming behaviours and distress tolerance. Examining how attachment and distress tolerance change over time and how they affect trauma survivors' long-term results. Investigating how biological, psychological, and social elements interact dynamically to influence self-harming behaviours.
- The implications also apply to research and practices in education. Researchers can investigate the effects of educational initiatives that promote emotional control and distress tolerance, especially for students who have experienced trauma. How teachers might be educated to identify attachment-related problems and provide nurturing situations that foster resilience can be evaluated in future studies.

There are broad ramifications for developmental psychology, therapeutic practice, family research, and educational environments from the results of this study. The foundation for a better understanding of resilience and adaptive behaviours is laid by this study, which highlights the significance of parental attachment and distress tolerance in relation to childhood trauma and self-harm. It pushes researchers and clinicians to focus on developing protective variables that enable people to recover from traumatic life experiences rather than just pathology.

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APPENDIX A

Informed Consent

I am a student of MPhil Applied Psychology, National University of Modern Languages, Islamabad & I am conducting this research on behaviour and emotional dimensions of university students. To explore the relationship, this research requires your information.

Your participation in this study is Voluntary. The information you provide will be kept confidential and will only be used for research purposes. If you feel hesitant, emotionally uncomfortable, or bored during the activity, you can quit at any time.

Thank you for your cooperation

Participant Signature

Demographics Details

Tick the option which is relevant or write additional detail yourself if required.

1. Gender : Male / Female / Other
2. Age : _____
3. Family Income : _____
4. Family System : Joint / Nuclear
5. Education : BS / BA / Masters: (Semester specified: _____)
6. Marital Status : Single / Married / Widow
7. Previous Medical History: _____
8. Hospitalization (if any) : _____
9. Previous psychiatric History: _____
10. Hospitalization (if any Time and Duration):_____

APPENDIX B

Childhood Traumatic Questionnaire (CTQ) – SHORT FORM

These questions ask about some of your experiences growing up as a child and a teenager. For each question, circle (or select in any other way if completing online) the number that best describes how you feel. Although some of these questions are of a personal nature,

Q	QUESTION	NEVER TRUE	RARELY TRUE	SOMETIMES TRUE	OFTEN TRUE	VERY OFTEN TRUE
When I was growing up						
1	I didn't have enough to eat.	1	2	3	4	5
2	I knew that there was someone to take care of me and protect me.	1	2	3	4	5
3	People in my family called me things like "stupid", "lazy", or "ugly".	1	2	3	4	5
4	My parents were too drunk or high to take care of the family.	1	2	3	4	5
5	There was someone in my family who helped me feel important or special	1	2	3	4	5
When I was growing up						
6	I had to wear dirty clothes	1	2	3	4	5
7	I felt loved.	1	2	3	4	5
8	I thought that my parents wished I had never been born	1	2	3	4	5
9	I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	1	2	3	4	5
10	There was nothing I wanted to change about my family.	1	2	3	4	5
When I was growing up						
11	People in my family hit me so hard that it left me with bruises (injure) or marks.	1	2	3	4	5

12	I was punished with a belt, a board, a cord (or some other hard object).	1	2	3	4	5
13	People in my family looked out (be careful) for each other.	1	2	3	4	5
14	People in my family said hurtful or insulting things to me.	1	2	3	4	5
15	I believe that I was physically abused.	1	2	3	4	5
When I was growing up						
16	I had the perfect childhood.	1	2	3	4	5
17	I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor.	1	2	3	4	5
18	Someone in my family hated me.	1	2	3	4	5
19	People in my family felt close to each other.	1	2	3	4	5
20	Someone tried to touch me in a sexual way or tried to make me touch them.	1	2	3	4	5
When I was growing up						
21	Someone threatened to hurt me or tell lies about me unless I did something sexual with them.	1	2	3	4	5
22	I had the best family in the world.	1	2	3	4	5
23	Someone tried to make me do sexual things or watch sexual things.	1	2	3	4	5
24	Someone molested me (took advantage of me sexually).	1	2	3	4	5
25	I believe that I was emotionally abused.	1	2	3	4	5
When I was growing up						
26	There was someone to take me to the doctor if I needed it	1	2	3	4	5
27	I believe that I was sexually abused.	1	2	3	4	5
28	My family was a source of strength and support.	1	2	3	4	5

APPENDIX C

Self-Harm Questionnaire

Instructions

This questionnaire asks about a number of different things that young people sometimes do. Please do not be concerned if some statements seem unusual. They are included to provide us with greater understanding and knowledge about these behaviors and the best way to help young people.

- Please complete this questionnaire on your own.
- If a statement is not applicable to you, please circle Never.
- Please try to answer as truthfully as possible.
- All your answers are kept strictly confidential.

1	Have you ever been suspended (i.e., punished with exclusion) or dropped out of school?	Never	Once	More than once	Many times

2	Have you ever intentionally cut your skin?	Never	Once	More than once	Many times
3	Have you ever intentionally burned yourself with a hot object (such as a cigarette)?	Never	Once	More than once	Many times
4	Have you ever intentionally bitten yourself, to the extent that you broke the skin?	Never	Once	More than once	Many times
5	Have you ever intentionally banged your head against something or hit or punched yourself, to the extent that you caused a bruise to appear?	Never	Once	More than once	Many times
6	Have you ever intentionally prevented wounds from healing or picked at areas of your body to the point of drawing blood?	Never	Once	More than once	Many times
7	Have you ever intentionally scraped, scrubbed, or scratched your skin to the point of breaking your skin or drawing blood?	Never	Once	More than once	Many times

8	Have you ever intentionally rubbed a sharp object (such as sandpaper) or dripped anything toxic (such as acid) onto your skin?	Never	Once	More than once	Many times
Please say yes to the following questions only if you did the behavior intentionally, or on purpose, to hurt yourself. Circle Never if you did something only accidentally (e.g., you tripped and banged your head on accident).					
9	Have you ever exercised an injured part of your body intending to hurt yourself?	Never	Once	More than once	Many times
10	Have you ever intentionally pulled your hair out?	Never	Once	More than once	Many times
11	Have you ever starved yourself to hurt or punish yourself?	Never	Once	More than once	Many times
12	Have you ever forced yourself to eat too much to hurt or punish yourself?	Never	Once	More than once	Many times
13	Have you ever stayed in a friendship or a relationship with somebody who repeatedly hurt your feelings on purpose?	Never	Once	More than once	Many times
14	Have you ever tried to make yourself suffer by thinking horrible things about yourself?	Never	Once	More than once	Many times
15	Have you ever taken an overdose? (i.e., taken an excessive amount of medication without having been prescribed this dosage)	Never	Once	More than once	Many times
16	Have you ever seriously thought about harming a part of your body?	Never	Once	More than once	Many times
17	Have you ever seriously thought about killing yourself?	Never	Once	More than once	Many times

18	Have you ever tried to kill yourself?	Never	Once	More than once	Many times
19	Have you ever intentionally hurt yourself in any of the abovementioned ways so that it led to hospitalization or injury severe enough to require medical treatment?	Never	Once	More than once	Many times

APPENDIX D

The Adult Scale of Parental Attachment Short Form 40 item

Directions: Please answer all of the following questions on the behavior of the person who you most identified as a mother figure while you were a child. This person may have been a step-parent, a grandmother, an aunt, or a woman who was unrelated but a primary caregiver. Choose the person you spent the most time with before age fourteen. Should you feel there was not a person in your life who you considered a mother figure, do not complete this section, but move on to the next section. Answer each question individually and as accurately as possible. Do not worry about consistency across answers; we expect contradictions will exist in some cases. ASPA-SF (20 item pertaining to Mother caregiver.)

Survey Item	**Scale**				
	Never	**Seldom**	**Sometimes**	**Frequently**	**Constantly**
1. I had my mother with me when I was upset.	1	2	3	4	5
2. I resented my mother spending time away from me.	1	2	3	4	5
3. I was helpless without my mother.	1	2	3	4	5
4. I felt there was something wrong with me because I was distant from my mother.	1	2	3	4	5
5. I put my mother's needs before my own.	1	2	3	4	5
6. I felt abandoned when my mother was away for a few days.	1	2	3	4	5
7. I turned to my mother for many things including comfort and reassurance.	1	2	3	4	5
8. I wish there was less anger in my relationship with my mother.	1	2	3	4	5
9. I enjoyed taking care of my mother.	1	2	3	4	5
10. I got frustrated when my mother left me alone.	1	2	3	4	5
11. I was never certain about what I should do until I talked to my mother.	1	2	3	4	5
12. I often felt angry with my mother without knowing why.	1	2	3	4	5
13. I talked things over with my mother.	1	2	3	4	5
14. It was hard for me to get on with my work if my mother had a problem.	1	2	3	4	5
15. I felt it was best to depend on my mother.	1	2	3	4	5
16. I had a terrible fear that my relationship with my mother would end.	1	2	3	4	5
17. It made me feel important to be able to do things for my mother.	1	2	3	4	5
18. I needed my mother to take care of me.	1	2	3	4	5
19. I wanted to get close to my mother, but I kept pulling back.	1	2	3	4	5
20. I usually discussed my problems and concerns with my mother.	1	2	3	4	5

Directions: Please answer all of the following questions on the behavior of the person who you most identified as a father figure while you were a child. This person may have been a step-parent, a grandfather, an uncle, or a man who was unrelated but a primary caregiver. Choose the person you spent the most time with before age fourteen. Should you feel there was not a person in your life who you considered a father figure, do not complete this section. Answer each question individually and as accurately as possible. Do not worry about consistency across answers; we expect contradictions will exist in some cases.

Survey Item	**Scale**				
	Never	**Seldom**	**Sometimes**	**Frequently**	**Constantly**
21. I turned to my father for many things including comfort and reassurance.	1	2	3	4	5
22. I felt abandoned when my father was away for a few days.	1	2	3	4	5
23. I put my father's needs before my own.	1	2	3	4	5
24. I worried my father would let me down.	1	2	3	4	5
25. I often felt too dependent on my father.	1	2	3	4	5
26. I resented my father spending time away from me.	1	2	3	4	5
27. It was easy for me to be affectionate with my father.	1	2	3	4	5
28. I wish there was less anger in my relationship with my father.	1	2	3	4	5
29. I sacrificed my own needs for the benefit of my father.	1	2	3	4	5
30. I felt it was best to depend on my father.	1	2	3	4	5
31. I got frustrated when my father left me alone.	1	2	3	4	5
32. It was hard for me to get on with my work if my father had a problem.	1	2	3	4	5
33. I talked things over with my father.	1	2	3	4	5
34. I often felt angry with my father without knowing why.	1	2	3	4	5
35. I needed my father to take care of me.	1	2	3	4	5
36. I had a terrible fear that my relationship with my father would end.	1	2	3	4	5
37. I usually discussed my problems and concerns with my father.	1	2	3	4	5
38. I enjoyed taking care of my father.	1	2	3	4	5
39. I felt there was something wrong with me because I was distant from my father.	1	2	3	4	5
40. I was never certain about what I should do until I talked to my father.	1	2	3	4	5

APPENDIX E

Distress Tolerance Scale (DTS)

Think of times that you feel distressed or upset. Circle the item that best describes your beliefs about feeling distressed or upset. Please answer regarding your feelings of distress 'in general', that is, on the average.

Strongly	**Strongly Disagree**	**Mildly Disagree**	**Agree and Disagree Equally**	**Mildly Agree**	**Agree**
1. Feeling distressed or upset is unbearable to me.	1	2	3	4	5
2. When I feel distressed or upset, all I can think about is how bad I feel.	1	2	3	4	5
3. I can't handle feeling distressed or upset	1	2	3	4	5
4. My feelings of distress are so intense that they completely take over.	1	2	3	4	5
5. There's nothing worse than feeling distressed or upset.	1	2	3	4	5
6. I can tolerate being distressed or upset as well as most people.	1	2	3	4	5

7. My feelings of distress or being upset are not acceptable	1	2	3	4	5
8. I'll do anything to avoid feeling distressed or upset.	1	2	3	4	5
9. Other people seem to be able to tolerate feeling distressed or upset better than I can.	1	2	3	4	5
10. Being distressed or upset is always a major ordeal for me.	1	2	3	4	5
11. I am ashamed of myself when I feel distressed or upset.	1	2	3	4	5
12. My feelings of distress or being upset scare me.	1	2	3	4	5
13. I'll do anything to stop feeling distressed or upset.	1	2	3	4	5
14. When I feel distressed or upset, I must do something about it immediately.	1	2	3	4	5
15.When I feel distressed or upset, I cannot help but concentrate on how bad the distress actually feels.	1	2	3	4	5

APPENDIX F

Social Desirability Scale

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide how it pertains to you.
Please respond either TRUE (**T**) or FALSE (**F**) to each item. Indicate your response by circling the appropriate letter next to the item. Be sure to answer all items.

1). It is sometimes hard for me to go on with my work if I am not encouraged (give support, confidence, or hope to (someone).	True	False
2). I sometimes feel resentful (irritated) when I don't get my way.	True	False
3). On a few occasions, I have given up (stop trying) doing something because I thought too little of my ability.	True	False
4). There have been times when I felt like rebelling (refuse to obey) against people in authority even though I knew they were right.	True	False
5). No matter who I'm talking to, I'm always a good listener.	True	False
6). There have been occasions when I took advantage of someone.	True	False
7). I'm always willing to admit to it when I make a mistake.	True	False
8). I sometimes try to get even (inflict trouble or harm on someone) rather than forgive and forget.	True	False
9). I am always courteous (Respectful), even to people who are disagreeable.	True	False
10). I have never been irked (irritate) when people expressed ideas very different from my own.	True	False
11). There have been times when I was quite jealous of the good Fortune(luck) of others.	True	False
12). I am sometimes irritated by people who ask favors (approval, support, or liking for someone) of me.	True	False
13). I have never deliberately said something that hurt someone's feelings.	True	False