MEDIATING ROLE OF EMOTIONAL DYSREGULATION IN CHILDHOOD TRAUMA AND SELF-HARM AMONG INDIVIDUALS WITH DRUG DEPENDENCE

TAYYABA KHATOON[1], DR. SYEDA RAZIA BUKHARI[2], FATIMA FAYYAZ[3], LIABA GULL[4], NAVEERA ABDUL RAUF[5], ADEENA AHMED[6]

[1]MS Scholar Clinical Psychology Faculty of Education and Social Sciences, ShaheedZulfikar Ali Bhutto Institute of Science and Technology

[2]Assistant Professor & Student Counselor Faculty of Education and Social Sciences, ShaheedZulfikar Ali Bhutto Institute of Science and Technology

[3]MS Scholar Clinical Psychology Faculty of Education and Social Sciences, ShaheedZulfikar Ali Bhutto Institute of Science and Technology

[4]MS Scholar Clinical Psychology Faculty of Education and Social Sciences, ShaheedZulfikar Ali Bhutto Institute of Science and Technology

[5]MS Scholar Clinical Psychology Faculty of Education and Social Sciences, ShaheedZulfikar Ali Bhutto Institute of Science and Technology

[6]MS Scholar Clinical Psychology' Faculty of Education and Social Sciences, Ripha International University Islamabad

Abstract

The study aimed to explore the impacts of Childhood Trauma and Emotional Dysregulation on Self-Harm behaviors among individuals with drug dependence.The study used a correlational research design to determine how closely the study variables are connected; sample was 100 participants from the clinical setting. CTQ-SF (Childhood Trauma Questionnaire-Short Form) with 28 items (Bernstein et al., 2003), Difficulties in emotion regulation scale (Gratz& Roemer, 2004), Inventory of Statement about Self-Injury (ISAS) were instruments for present study. Childhood Trauma positively associated with Emotional Dysregulation and self-harm i.e., .44 and .25*. Mediation analysis shows that emotional Dysregulation significantly mediates childhood experiences and self-harm i.e., p= .001***.*

Keywords: *Childhood trauma, emotional dysregulation, Self-Harm and individuals with drug dependence*

INTRODUCTION

According to the United Nations Office on Drugs and Crime, drug abuse is a serious problem among Pakistan's young people, who make up 28% of the nation's overall population. (Niaz et al., 2009). In 2013, 6.45 million people in Pakistan used drugs every year, with cannabis being the most prevalent substance, according to research by UNODC and the Pakistan Bureau of Statistics (UNODC, 2013).

Childhood is the sensitive period of one's life. Childhood events can have long-lasting physical, social, and emotional impacts. While positive experiences and situations can set a young child on a better path for life, traumatic events or environments during those formative years can have a permanent, detrimental impact. The history of traumatic childhood experiences is the main topic of the current study. Numerous studies have shown that childhood trauma has an impact on neuronal structure and function, which increases a person's risk for cognitive impairments and mental disorders such as schizophrenia, severe depression, bipolar disorder, posttraumatic stress disorder (PTSD), and drug dependence in later life (Mills et al., 2006). Strong evidence links exposure to trauma with drug dependence in particularFor instance, The National Survey of Adolescents found that adolescents in America who had experienced physical, sexual, or harassment were three times more likely to admit to doing drugs than those who had not. (Kilpatrick DG et al.,2003). The population which is on borderline to experience such incidents is the young adults.

Childhood and adolescent trauma exposure are especially harmful because there are various characteristics involves in development of emotional social and cognitive, as well as mental health

and educational outcomes (Koenen et al., 2003). Examples include the unexpected loss of a loved one, severe accidents, (mass) brutality, and natural calamities. Children who have experienced trauma are relatively common. Studies on the general population during times of peace found that exposure rates to any traumatic event ranged from 14% (Alisic et al., 2008) to more than 65% (Copeland et al., 2007; Elklit, 2002).

Self-Harm is characterized as deliberate self-harm without a clear intention to end one's life (Briere& Gil, 1998, Favazza, 1998). It is difficult to characterize Self-harm because the disease has not been well studied, and Self-harm acts vary significantly and depend on the self-creativity. Mutilator's Despite the fact that Self-Harm is the most widely used term, academics and counseling experts cannot agree on a single label for self-inflicted harm. This activity may also be referred to as intentional self-harm (Klonsky et al., 2003).When someone intentionally engages in a behavior (like cutting themselves) or consumes something toxic with the objective of harming themselves, this is referred to as a non-fatal act of self-harm. (Madge et al., 2008) According to the Lancet (2005) it is a global health issue and one of the strong indicators of successful suicide (cooper et al., 2005). Self-harm behaviors require medical intention due to injuries and it also can put individuals on high risk of suicide (Muehlenkamp& Gutierrez, 2007).

Emotion dysregulation can mediate the relationship between childhood trauma and Self Harm. This study will study the role of emotion dysregulation as a mediator in the relationship of childhood trauma and Self-Harm. The capacity to monitor and assess emotional experiences, adjust to their intensity and length, and control emotional reactions to suit situational demands are all areas where emotion dysregulation is perceived as difficulty (Gratz& Roemer, 2004). It might also be described as having trouble controlling the quick swings of solid emotions (Marwaha et al., 2014). Trauma-related abnormalities in emotion regulation have been associated with a wide range of mental diseases (Sheppes et al., 2015). For instance, mood disorders are linked to higher mental morbidity and emotional dysregulation,However, emotional dysregulation is a presenting symptom of both major depressive and bipolar illnesses, which might be seen as a characteristic of mood disorders (Eskander et al., 2020; Kim et al., 2018).

Answer to the following questions were focused in the present study

- What is the relationship between childhood trauma and Self-harm among individuals with drug dependence?
- What is the relationship between childhood trauma and emotional dysregulation among individuals with drug dependence?
- What is the relationship between Self-harm and emotional dysregulation among individuals with drug dependence?
- What is the mediating role of emotional dysregulation in childhood trauma and Self-harm among individuals with drug dependence?

MATERIAL AND METHODS

Study Design

The study was quantitative in nature and the research adopted a cross sectional research design for finding the correlation among variables.

The study used a correlational research design because it will to examine two or more variables and determine how closely they are connected. Additionally, it will explore the strength and direction of the relationship between variables that enable researchers to make forecasts based on their found correlations.

Participants and Procedures

The study population will be persons with drug dependence; purposive sampling was used to collect data. Sample size will be 100 male adults with drug dependence from clinical settings. Purposive sampling strategy was used, and the data collection mode was in-person.

Ethical Principles

In order to conduct this research, some ethical considerations were kept in mind.

Approval was taken from the Department of Psychology and Human Research and Ethics Committee ZABIST. The informed consent was taken from each participant by explaining the nature of the study before administering the questionnaires. They were giving potential research participants the information they needed to make an informed decision about participating in the study is referred to as informed consent. The participant was also informed by the researcher that they had the right to discontinue at any time.

Data Collection Tools

Childhood trauma in participants was assessed with the Versions of the CTQ-SF (Childhood Trauma Questionnaire-Short Form) with 28 items (Bernstein et al., 2003). Difficulties in emotion regulation scale (DERS) (Gratz& Roemer, 2004): DERS was used to evaluate participants' emotional dysregulation. The inventory of Statement about self-injury (ISAS) was used to assess self-harm behaviors.

Demographic Form

Demographic form was used consist of age, education, family system, birth order, marital status and drug categories.

Child Trauma Questionnaire (CTQ)

Childhood trauma in participants was assessed with the Versions of the CTQ-SF (Childhood Trauma Questionnaire-Short Form) with 28 items (Bernstein et al., 2003). The 28-item survey comprises three validity items, 25 clinical items, and five dimensions: physical violence, physical neglect, psychological abuse, and sexual assault. Each survey item was scored using a 5- point Likert scale (with a range of 1–5).

Difficulty in Emotional Regulation Scale (DERS)

Difficulties in emotion regulation scale (DERS) (Gratz& Roemer, 2004): DERS was used to evaluate participants' emotional dysregulation. An instrument called the Difficulties in Emotion
Regulation Scale (DERS) In order to generate scores on the subscales, the 36-item self-report scale asked participants how they connect to their emotions. Six subscales make up the DERS.

Inventory of Statement about Self-Injury (ISAS)

The inventory of Statement about self-injury (ISAS) was used to assess self-harm behaviors. The ISAS, which has two sections, measures the prevalence and characteristics of Self harm. In the first, 12 Self-harm behaviors that are carried out "intentionally (i.e., on purpose) and without suicidal intent" are evaluated for lifetime frequency. Second part has 39 questions on based on 13 subscales.

Data Analysis

SPSS was used for analysis of current study's result. Descriptive analysis was used for demographics mean: standard deviation frequency: Percentage to check the relationships among study variables Inferential analysiscorrelational analysis multiple regression analysis.

Results

Descriptive analysis is used to describe the characteristic of the sample. Frequency and Percentage are used to analyze the participants' demographic data because all the demographics are categorical.

Table 1 *Correlation Between Childhood Trauma and Emotional Dysregulation (N=100)*

S#	Variable	1	2	3	4	5	6	7	8	9	10	11	12
1	**CTQ- Physical abuse**		.46**	.53**	.14	.81**	.20*	.04	.24*	.17	.12	.52**	.43**
2	**CTQ- Sexual abuse**			.47**	.18	.76**	.25*	.08	.22*	.32**	.04	.48**	.45**
3	**CTQ- Physical neglect**				.15	.72**	.06	-.07	-.03	.26**	-.17	.46**	.17
4	**CTQ- Emotional**					.41**	-.13	-.20*	-.09	.34**	-.02	.27**	.07

	neglect																		
5	**CTQT**								.21*	-.01	.17	.29**	.02	.66**	.44**				
6	**DERS- Non acceptance**									.34**	.35**	-.24*	.21*	.13	.59**				
7	**DERS- goals**										.48**	-.41**	.30**	-.13	.46**				
8	**DERS- impulse**											-.12	.43**	.05	.67**				
9	**DERS- awareness**												-.04	.26**	.17				
10	**DERS- strategies**													.07	.65**				
11	**DERS- clarity**														.47**				
12	**DERST**																		

**. correlation is significant at the 0.05 level (2-tailed). **. correlation is significant at the 0.01 level (2-tailed). Note. CTQ= childhood trauma questionnaire, DERS= difficulty in emotion regulation scale.*

Table 2 shows the results of the correlation analysis between childhood trauma and emotional dysregulation. Analysis shows a positive correlation between the subscales of childhood trauma and difficulties in emotion regulation. The subscales of physical abuse and sexual abuse are in positive relation with difficulties of emotional regulation, i.e., .43**and .45**. The total of childhood trauma is also positively related to difficulties in emotion regulation, i.e., .44**, non-acceptance of emotional responses, lack of emotional responses, and lack of emotional clarity, have a positive relationship with childhood trauma, i.e., .21*, .29*, and .66.

Table 2 *Correlation between Childhood Trauma and Self-Harm (N=100)*

S#	Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1	**CTQ- Physical abuse**		.46**	.53**	.14	.81**	-.05	.12	-.05	-.17	.20*	.07	.23*	.13	.12	-.10	-.01	-.06	-.14	.04
2	**CTQ- Sexual abuse**			.47**	.18	.76**	-.31**	.22*	.13	.02	.08	.06	.12	.01	.11	-.11	-.03	-.01	-.11	.03
3	**CTQ- Physical neglect**				.15	.72**	-.04	.17	-.04	.05	.11	.12	.09	-.15	.02	-.11	-.07	.01	-.09	.02
4	**CTQ- Emotional neglect**					.41**	.04	.33**	-.16	-.06	-.01	-.03	.18	-.02	-.02	-.05	-.02	.26*	-.19	.01
5	**CTQT**						-.14	.25*	-.04	-.09	.13	.01	.18	-.01	.08	-.17	-.07	.09	-.15	-.01
6	**ISAS- affect regulation**							.12	.13	.13	.13	.00	.04	.14	.30**	.12	.25*	.12	.13	.41**
7	**ISAS- IB**								.18	.21*	.18	.02	.15	.12	.24*	.21*	.11	-.06	.08	.43**
8	**ISAS- self punishment**									.23*	.13	.34**	-.05	-.02	.32**	.34**	.05	.18	.12	.42**
9	**ISAS- self care**										.41**	.29**	.19	.06	.31**	.37**	.24*	.04	.21*	.57**
10	**ISAS- feeling generation**											.38**	.38**	.29**	.30**	.18	.47**	.21*	.19	.64**

11	**ISAS- anti suicide**	.12	.01	.27**	.39**	.17	.18	.16	.50**
12	**ISAS- sensation seeking**		.36**	.17	.19	.23*	-.01	-.21*	.41**
13	**ISAS- peer bonding**			.26**	.16	.41**	.17	.05	.44**
14	**ISAS- II**				.41**	.33**	.15	.24*	.64**
15	**ISAS- toughness**					.24*	.24*	.25*	.62**
16	**ISAS- marking distress**						.40**	.31**	.62**
17	**ISAS- revenge**							.17	.39**
18	**ISAS- autonomy**								.42**
19	**ISAST**								

**. correlation is significant at the 0.05 level (2-tailed). **. correlation is significant at the 0.01 level (2-tailed). Note. CTQ= childhood trauma questionnaire, ISAS= inventory of statements about self-injury, IB= interpersonal boundaries, II= interpersonal influence.*

Table 3 shows the correlation between childhood trauma and self-harm. Analysis shows that the scales of childhood trauma and Self Harm are not significantly related, but some of their subscales are associated. The subscale of childhood trauma, physical abuse, and sexual abuse are positively associated with the subscales of self-harm that are feeling generation and anti-suicide, i.e., .20* and .23*. Sexual abuse and emotional neglect are positively related to interpersonal influence, i.e., .22* and .33**. Emotional neglect is also negatively related to revenge, i.e., -.26**. The sum of childhood trauma is also positively related to interpersonal difficulty, i.e., .25*.

Table 3 *Mediation Analysis of Emotional DysregulationBetween Childhood Trauma and Self-Harm (N=100)*

Mediation Analysis

	Consequent							
Antecedent	**M (DER)**				**Y(SH)**			
		B	SE	P		B	SE	P
CT (X)	A	.36	.07	.001***	c'	-.02	.05	.001***
DER (M)		---	---	---	B	.07	.07	.29
Constant	i	.76.48	5.43	.000***	i	33.89	7.17	.000**
	R^2= .19				R^2= .01			
	F= 23.96, p= .000***				F= 1.11, p= .000***			

*Note. **. Significant at alpha level 0.05 (2-tailed). ***. Significant at alpha level 0.01 (2-tailed). CT= Childhood trauma, DER= difficulty in emotion regulation, SH= self-harm.*

The above table 4 shows that the mediator "emotional dysregulation" is playing a significant role between childhood trauma and self-harm. The direct effect of the mediator which is emotional dysregulation is significant at p=.0000 so the relationship is accepted whereas the indirect relationship with mediator is also significant at p=.0000 and the relationship is accepted, furthermore this shows that emotional dysregulation mediates the relationship between childhood trauma and self-harm.

DISCUSSION

The first question of this study was that there would be a significant positive relationship between childhood trauma and emotional dysregulation among individuals with drug dependence. Regarding Table 2, a direct relationship is there between the subscales of childhood trauma and difficulties in emotion regulation. The subscales of physical abuse and sexual abuse are in positive relation with difficulties of emotional regulation, i.e., .43**and .45**. The total of childhood trauma is also positively related to difficulties in emotion regulation, i.e., .44**. The subscales of difficulties in emotional regulation, which are non-acceptance of emotional responses, lack of emotional responses, and lack of emotional clarity, have a positive relationship with childhood trauma, i.e., .21*, .29*, and .66. The study's findings are consistent with the findings of previous studies, as Berfield et al. (2021) found that people who had experienced six or nine different forms of trauma had considerably more significant rates of adverse and favorable emotion dysregulation than those who had not. Trauma directly affects the brain, it impacts the limbic system's ability to adapt, which supports several mental processes, including emotional life (van der Kolk, 2014). Therefore, adults who experience trauma as children have impaired abilities to control their emotions and moods, including the ability to recognize their own and others' emotions and to understand them (Schutte et al., 2011). There are several causes of emotional control problems, including genetics and early trauma. Childhood emotional abuse is linked to issues with emotion regulation, the desire to employ contradictory emotion control techniques (such as alcohol and drug usage), and a breakdown in emotions (Zysberg&Rubanov, 2010). As shown in Table 3, the subscale of childhood trauma, physical abuse, and sexual abuse are positively associated with the subscales of self-harm that are feeling generation and anti-suicide, i.e., .20* and .23*. Sexual abuse and emotional neglect are positively related to interpersonal influence, i.e., .22* and .33**. Emotional neglect is also negatively related to revenge, i.e., -.26**. The sum of childhood trauma is also positively related to interpersonal difficulty, i.e., .25*. It is interpreted from the analysis that if an individual exposes to childhood trauma, they will also experience self-harm due to feeling generation, anti-suicide, and interpersonal problems. The current study's results align with those of earlier ones. According to research by Bardeen et al. (2013), a severe traumatic event increases impulsivity, which lowers the brain's ability for reaction inhibition and manage negative emotions, and raises the likelihood of self-harming behaviors. The co-occurrence of trauma and self-harm has been shown to have highly detrimental effects. An increased prevalence of all mental illnesses, including mood disorders, anxiety disorders, psychotic symptoms, and personality disorders, as well as self-harm and harmful patterns of drug misuse comorbidity, are all significantly correlated with childhood trauma (Brucker, 2007). Childhood maltreatment leads to maladaptive coping and behavioral patterns that result in self-harm. Different types of childhood maltreatment result in problems such as physical abuse associated with aggressive behavior, emotional abuse with emotion dysregulation, and sexual abuse associated with hazardous sexual behaviors in adulthood (Banducci et al., 2014). Some studies' findings are contrary to the present study. In their meta-analysis research, Klonsky and Moyer (2008) contend that the origin and persistence of these behaviors are not primarily caused by childhood sexual abuse. Furthermore, some studies that did not find a relationship between sexual abuse during childhood and self-mutilation are reported (Akyuz et al., 2005). Theoretical literature suggests that experiences in a family system and relationships with caregiver(s), rather than only childhood sexual abuse, significantly impact self-mutilation (Tantam& Whittaker, 1992).

Table 4stated that emotional dysregulation would mediate the relationship between childhood trauma and self-harm among individuals with drug dependence. Concerning Table 6, analysis shows that the mediated path is significant (P=.001***), which shows that emotion regulation mediates between childhood trauma and self-harm. The findings of earlier studies are supported by the current research, which demonstrates a beneficial relationship between childhood trauma and self-harming behaviors via the mediation of emotional dysregulation (Cloitre et al., 2005). The current study's findings are also validated by Peh et al. (2017), which explored that a higher frequency of self-harm correlated with emotional dysregulation and depressive symptoms.

Additionally, the results of the path analysis demonstrated that emotion dysregulation significantly moderated the link between the frequency of self-harm and the degree of maltreatment exposure.

Limitations

The current study has the following limitations.

- The use of self-report instruments was one of the study's primary shortcomings. It's possible that most teenagers won't want to answer inquiries regarding upsetting events and self-harm. The participants' varied socioeconomic, cultural, and demographic backgrounds and the population's makeup posed another restriction that may have impacted the findings.
- The study is conducted in Islamabad and Rawalpindi, so the findings cannot be generalized to the individuals of other cities.

CONCLUSION

It is concluded that childhood trauma experiences made some people more prone to self-harm because they harmed how well they could control their emotions. Self-harm is a reaction to abuse and neglect experienced throughout childhood. People who experienced mistreatment during childhood can turn to self-harming behaviors to express feelings they cannot express in any other manner. The nature of self-harming behaviors is comparable to paradoxical self-medicating, which may be an emotionally freeing experience for abused individuals. This study can therefore be interpreted as showing that alcohol/substance addicts who grew up in an environment that devalued their emotions choose impulsive and non-adaptive methods of regulating their emotions because they cannot deal with their negative emotional experiences adaptively.

REFERENCES

[1] *Alisic, E., van der Schoot, T. A., van Ginkel, J. R., &Kleber, R. J. (2008). Looking beyond posttraumatic stress disorder in children: Posttraumatic stress reactions, posttraumatic growth, and quality of life in a general population sample. The Journal of clinical psychiatry, 69(9), 10827.https://www.psychiatrist.com/jcp/trauma/child/looking-beyondposttraumatic-stress-disorder-children/*

[2] *Akyuz, G., Sar, V., Kugu, N., &Doğan, O. (2005). Reported childhood trauma, attempted suicide and self-mutilative behavior among women in the general population. European Psychiatry, 20(3), 268-273. http://doi.org/10.1016/j.eurpsy.2005.01.002*

[3] *Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., Stokes, J., Handelsman, L., Medrano, M., Desmond, D., &Zule, W. (2003).Development and validation of a brief screening version of the Childhood Trauma Questionnaire. Child abuse & neglect, 27(2), 169-190.https://doi.org/10.1016/s0145-2134(02)00541-0*

[4] *Banducci, A. N., Hoffman, E. M., Lejuez, C. W., &Koenen, K. C. (2014). The impact of childhood abuse on inpatient substance users: Specific links with risky sex, aggression, and emotion dysregulation. Child abuse & neglect, 38(5), 928-938.https://doi.org/10.1016/j.chiabu.2013.12.007*

[5] *Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions. American journal of Orthopsychiatry, 68(4), 609-620. https://doi.org/10.1037/h0080369*

[6] *Berfield, J. B., Goncharenko, S., Forkus, S. R., Contractor, A. A., & Weiss, N. H. (2021). The differential relation of trauma types with negative and positive emotion dysregulation. Anxiety, Stress, & Coping, 35(4), 425-439. https://doi.org/10.1080/10615806.2021.1964072*

[7] *Bardeen, J. R., Kumpula, M. J., &Orcutt, H. K. (2013). Emotion regulation difficulties as a prospective predictor of posttraumatic stress symptoms following a mass shooting. Journal of anxiety disorders, 27(2), 188-196.https://doi.org/10.1016/j.janxdis.2013.01.003*

[8] *Banducci, A. N., Hoffman, E. M., Lejuez, C. W., &Koenen, K. C. (2014). The impact of childhood abuse on inpatient substance users: Specific links with risky sex, aggression, and emotion dysregulation. Child abuse & neglect, 38(5), 928-938.https://doi.org/10.1016/j.chiabu.2013.12.007*

[9] *Cloitre, M., Miranda, R., Stovall-McClough, K. C., & Han, H. (2005). Beyond PTSD: Emotion regulation and interpersonal problems as predictors of functional impairment in survivors of childhood abuse. Behavior therapy, 36(2), 119-124.https://doi.org/10.1016/S0005-7894(05)80060-7*

[10] Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007).Traumatic events and posttraumatic stress in childhood.Archives of general psychiatry, 64(5), 577-584.https://jamanetwork.com/journals/jamapsychiatry/article-abstract/482289

[11] Cooper, J., Kapur, N., Webb, R., Lawlor, M., Guthrie, E., Mackway-Jones, K., & Appleby, L. (2005). Suicide after deliberate self-harm: a 4-year cohort study. American Journal of Psychiatry, 162(2), 297-303.https://doi.org/10.1176/appi.ajp.162.2.297

[12] Elklit, A. (2002). Victimization and PTSD in a Danish national youth probability sample. Journal of the American Academy of Child & Adolescent Psychiatry, 41(2), 174-181.https://doi.org/10.1097/00004583-200202000-00011

[13] Eskander, N., Chakrapani, S., &Ghani, M. R. (2020).The risk of substance use among adolescents and adults with eating disorders.Cureus, 12(9). doi:10.7759/cureus.10309

[14] Favazza, A. R. (1992). Repetitive self-mutilation.Psychiatric Annals, 22(2), 60-63. https://doi.org/10.3928/0048-5713-19920201-06

[15] Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. Journal of psychopathology and behavioral assessment, 26(1), 41-54.https://link.springer.com/article/10.1023/b:joba.0000007455.08539.94

[16] Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: results from the National Survey of Adolescents. Journal of consulting and clinical psychology, 71(4), 692-700.https://doi.org/10.1037/0022-006X.71.4.692

[17] Klonsky, E. D., & Moyer, A. (2008). Childhood sexual abuse and non-suicidal self-injury: meta analysis. The British Journal of Psychiatry, 192(3), 166-170. http://doi.org/10.1192/bjp.bp.106.030650.

[18] Kim, M. K., Kim, J. S., Park, H. I., Choi, S. W., Oh, W. J., &Seok, J. H. (2018).Early life stress, resilience and emotional dysregulation in major depressive disorder with comorbid borderline personality disorder.Journal of Affective Disorders, 236, 113-119. https://doi.org/10.1016/j.jad.2018.04.119

[19] Klonsky, E. D., & Moyer, A. (2008). Childhood sexual abuse and non-suicidal self-injury: meta analysis. The British Journal of Psychiatry, 192(3), 166-170. http://doi.org/10.1192/bjp.bp.106.030650.

[20] Madge, N., Hewitt, A., Hawton, K., Wilde, E. J. D., Corcoran, P., Fekete, S., ...&Ystgaard, M. (2008). Deliberate self-harm within an international community sample of young people: comparative findings from the Child & Adolescent Self-harm in Europe (CASE) Study. Journal of child Psychology and Psychiatry, 49(6), 667-677.https://doi.org/10.1111/j.1469-7610.2008.01879.x Lancet (2005)

[21] Mills, K. L., Teesson, M., Ross, J., & Peters, L. (2006). Trauma, PTSD, and substance use disorders: findings from the Australian National Survey of Mental Health and Well- Being.American Journal of Psychiatry, 163(4), 652-658. https://ajp.psychiatryonline.org/doi/full/10.1176/ajp.2006.163.4.652

[22] Marwaha, S., He, Z., Broome, M., Singh, S. P., Scott, J., Eyden, J., &Wolke, D. (2014). How is affective instability defined and measured? A systematic review.Psychological medicine, 44(9), 1793-1808. https://www.cambridge.org/core/journals/psychologicalmedicine/

[23] Muehlenkamp, J. J., & Gutierrez, P. M. (2007).Risk for suicide attempts among adolescents who engage in non-suicidal self-injury.Archives of suicide research, 11(1), 69-82. http://dx.doi.org/10.1080/13811110600992902

[24] Niazi MRUK, Zaman K, Ikram W. Is Poverty to be blamed for narcotic abuse? Int J Basic Appl Sci. 2009;9:96-101

[25] Peh, C. X., Shahwan, S., Fauziana, R., Mahesh, M. V., Sambasivam, R., Zhang, Y., ...&Subramaniam, M. (2017). Emotion dysregulation as a mechanism linking child maltreatment exposure and self-harm behaviors in adolescents.Child abuse & neglect, 67, 383-390.https://doi.org/10.1016/j.chiabu.2017.03.013

[26] Schutte, N. S., Malouff, J. M., & Hine, D. W. (2011). The association of ability and trait emotional intelligence with alcohol problems. Addiction Research and Theory, 19(3), 260-265. doi: https://doi.org/10.3109/16066359.2010.512108

[27] Skegg, K. (2005). Self-harm. The Lancet, 366(9495), 1471-1483.https://doi.org/10.1016/S0140-6736(05)67600-3

[28] Sheppes, G., Suri, G., & Gross, J. J. (2015).Emotion regulation and psychopathology.Annual review of clinical psychology, 11, 379 405.https://www.annualreviews.org/doi/abs/10.1146/annurev-clinpsy-032814-112739

[29] Tantam, D., & Whittaker, J. (1992).Personality disorder and self-wounding. The British Journal of Psychiatry, 161(4), 451-464.http://dx.doi.org/10.1192/bjp.161.4.451

[30] Van der Kolk, B. A., Perry, J. C., & Herman, J. L. (1991).Childhood origins of self-destructive behavior.American journal of Psychiatry, 148(12), 1665-1671. http://eqi.org/p1/abuse/vanderkolk_childhood_origins_of_self_destructive_behavior_199 1.pdf

[31] Zysberg, L., &Rubanov, A. (2010). Emotional intelligence and emotional eating patterns: a new insight into the antecedents of eating disorders. Journal of nutrition education and behavior, 42(5), 345-348.https://doi.org/10.1016/j.jneb.2009.08.009