AN INVESTIGATION OF THE NON-SUICIDAL SELF-INJURY IN THE CONTEXT OF PSYCHOLOGICAL PAIN, MENTALIZATION, AND FALSE SELF

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ABSTRACT

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Master's Program in Clinical Psychology

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This study aimed to investigate the frequency, characteristics, and functions of non-suicidal self-injury in a sample of Turkish people. Furthermore, the relationship of self-injury between psychological pain, false self, hypomentalization, and hypermentalization was examined. The difference between self-injurers and non-injurers in terms of these concepts was also discussed. For this purpose, a total of 422 participants, 143 self-injurers and 279 non-injurers, between the ages of 18-65, participated in the study. Personal Information Questionnaire, Inventory of Statements About Self Injury (ISAS), The Psychache Scale (PS), The Reflective Functioning Questionnaire (RFQ-54), and Perception of The False Self Scale (POFSS) were conducted online via Google Forms. Spearman correlation analysis was performed to examine the relationship between the variables of the study. A significant positive relationship was found between self-injury and psychological pain, false self, and hypomentalization, while no relationship was observed between hypermentalization. In addition, an independent sample t-test was conducted to examine the difference

between self-injurers and non-injurers in terms of psychological pain, false self, hypomentalization, and hypermentalization. While self-injurers showed higher levels of psychological pain, false self, and hypomentalization from non-injurers, the two groups did not differ in terms of hypermentalization. Finally, binary logistic regression analysis was conducted, and the results revealed that psychological pain significantly predicted self-injury. While the results revealed the importance of evaluating the function of self-injury and its relationship with psychological pain, the importance of developing self-injury prevention programs for future studies was emphasized.

Keywords: Non-suicidal Self-injury, Psychological Pain, False Self, Hypermentalizaton, Hypomentalization

ÖZET

KENDİNE ZARAR VERME DAVRANIŞININ PSİKOLOJİK ACI, MENTALİZASYON VE SAHTE BENLİK BAĞLAMINDA İNCELENMESİ

Gülsün, Büşra

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Bu çalışmanın amacı, Türkiye örnekleminde, intihar amacı olmayan kendine zarar verme davranışını incelemek ve psikolojik acı, sahte benlik ve zihinselleştirme kapasitelerindeki (hipomentalizasyon ve hipermentalizasyon) bozukluklarla ilişkisini araştırmaktır. Bu amaçla 18-65 yaşları arasında 143'ü kendine zarar veren ve 279'u kendine zarar vermeyen olmak üzere toplam 422 katılımcı çalışmaya katılmıştır. Katılımcılara Kişisel Bilgi Formu, Kendine Zarar Verme Davranışı Değerlendirme Envanteri (KZVDDE), Psikolojik Acı Ölçeği (PA), Yansıtıcı İşleyiş Ölçeği (RFQ-54) ve Sahte Benlik Algısı Ölçeği Google Forms üzerinden çevrimiçi olarak uygulanmıştır. Araştırmanın değişkenleri arasındaki ilişkiyi incelemek için Spearman korelasyon analizi yapılmış ve kendine zarar verme ile psikolojik acı, sahte benlik ve hipomentalizasyon arasında pozitif bir ilişki bulunurken, hipermentalizasyon ile

arasında anlamlı bir ilişki bulunmamıştır. Ayrıca, kendine zarar verenler ile zarar vermeyenler arasında, psikolojik acı, sahte benlik, hipomentalizasyon ve hipermentalizasyon açısından farkı incelemek için bağımsız örneklem t-testi yapılmıştır. Kendine zarar verenler, vermeyenlere göre daha yüksek düzeyde psikolojik acı, sahte benlik ve hipomentalizasyon gösterirken, iki grup hipermentalizasyon açısından farklılık göstermemiştir. Son olarak ikili lojistik regresyon analizi uygulanmış ve psikolojik acının kendine zarar vermenin varlığını yordadığı ortaya konmuştur. Kendine zarar vermenin işlevlerinin ve kendine zarar verenlerin psikolojik acılarının değerlendirilmesinin klinik müdahaleye ışık tutacağı ortaya konmuştur. Ayrıca gelecekte yapılacak araştırmalar için kendine zarar vermeyi önleme programlarının geliştirilmesinin önemi vurgulanmıştır.

Anahtar Kelimeler: İntihar Amacı Olmayan Kendine Zarar Verme, Psikolojik Acı, Sahte Benlik, Hipermentalizasyon, Hipomentalizasyon

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LIST OF ABBREVIATIONS

APA: American Psychiatric Association

BPD: Borderline Personality Disorder

DSM-5: Diagnostic and Statistical Manual of Mental Disorders- 5

NSSI: Non-Suicidal Self-Injury

SIB: Self-injurious Behavior

CHAPTER 1: INTRODUCTION

"The marks on myself [are] a way to visualize my frustration." (Leaf and Schrock, 2011, p. 160).

In the current study, the concepts of self-injury, psychological pain, mentalization, and false self will be explained, respectively. This study is carried out to increase our understanding nature of self-injury. Another purpose is to examine self-injury with references to psychological pain, false self, and mentalization. Self-injury refers to the intentional harm of individuals to their bodies without the intention of suicide (Nock, 2010). Psychological suffering is thought to be related to self-injury, and the expectation of this study is that those who engage in self-injury suffer from psychological pain. Psychological pain is defined as hurt, anguish, aching, and soreness in mind (Shneidman, 1993). A small number of studies have shown the association between self-injury and psychological pain (Holden, Campos and Lambert, 2020; Nahaliel et al., 2014; Holden et al., 2021). While false self is explained as being compatible with others depending on their performance and expectations (Winnicott, 1960), mentalization is the ability to interpret one's own and others' inner mental processes (Fonagy et al., 2016). In this study, individuals who practice self-injury are expected to have false self perception and have impairment in mentalization capacity (hypomentalizaion and hypermentalization). In the next section, self-injury, and its definition, history, methods, classifications, associated psychological disorders, relationship with suicide, and functions will be discussed. Afterward, different authors' opinions about the concept of psychological pain will be evaluated. After mentioning the relationship between psychological pain and self-injury, the mentalization and false self concepts will be explained. Lastly, the relationship of these concepts with psychological pain and self-injury will be detailed.

1.1. Self-Injury

Innate drive for self-preservation is believed to be had in all animals. Moreover, it is one of the most crucial features of rational human behavior (Baumeister and Scher, 1988). While it is based on the organizing principle, peoples' behaviors like engaging in self-injury are seen to be often contrary or inconsistent with this principle (Nock, 2010).

1.1.1. Definition and Classification of Self-Injury

Throughout history, cases of self-injury have been documented; in fact, one of the earliest records of self-injury is contained in the Bible, which describes a man being captured by a demon who was "crying and cutting himself with stones" (Nock, 2010).

Self-injury is defined as not intended to be suicidal or approved socially while intentionally destroying the body tissues (Klonsky, 2007; Suyemoto, 1998; Nock, 2010). If the emerging body tissue is not the result of an intentional act seen in alcohol abuse or binging, it is not related to self-injurious behavior. Since body piercings and tattoos are socially approved behavior, they are not examined as self-injury. Exceptions of this will be seen in such socially approved behavior if they are applied with the intention of destroying body tissue (Klonsky, 2007). Self-injury is included in the literature with the terms parasuicide, self-mutilation, self-harm, deliberate self-injury, non-suicidal self-injury (NSSI), and self-destruction (Welch, 2001; Nock, 2010). In this study, the terms *non-suicidal self-injury* (NSSI) or *self-injury* will be used interchangeably. The term *self-injurious behaviors* (SIBs) will be used to refer to such behaviors. Moreover, while the term of *self-injurers* is used to refer to individuals who are engaging in SIBs, *non-injurers* is used to address individuals who do not practice self-injury.

A variety of behaviors are included under self-injury (Favazza, 1987). Favazza and Conterio (1988) state that comparably rare behaviors and extraordinarily destructive behaviors are commonly associated with a psychotic disorder. Notable examples of these behaviors are listed as castration, limb amputation, and eye enucleation. Despite this, other examples of self-injurious behaviors such as breaking a bone, pulling hair, and cutting skin, described as slightly less destructive and low on lethality, are more prevalent than comprehended.

Baumeister and Scher (1988) suggest three process models for SIBs and distinguish them by their degrees of intentionality. Firstly, *deliberate or primary self-destruction*, in which one engages self-injury deliberately. *The tradeoff* is the second model where the person makes a poor choice among the available two options, or the person tends to select the short-term benefits although there are long-term risks and costs. *Counterproductive strategies* or *unintentional self-destruction* is the last category in which the person neither desires nor predicts harm to self. The self-injury that will be implied and explored in this study is in the first category of Baumeister and Scher (1988).

Likewise, Nock (2010) suggests a similar distinction between direct and indirect forms of self-injury. In comparison, direct forms include cutting or burning oneself, well-known examples of indirect forms; like smoking tobacco, drinking alcohol, or eating high-fat foods, which are performed to achieve pleasure, not with self-injury. Despite this discrepancy, these behaviors share common elements in modifying affective or social experience, giving bodily harm, and being connected with other forms of mental disorders like depression or anxiety (Nock, 2010). On the other hand, Toprak et al. (2011) revealed that those who engage directly in self-injury are more prone to the practice of indirectly self-injurious behaviors as well. These authors also found that those with a self-injury history were more likely to smoke and abuse alcohol and substances.

Silverman et al. (2007) made a nomenclature about self-injurious behaviors and classified these under *Suicide-Related Behaviors*. In line with this classification, *Self-Harm Type I* is a type of SIB not resulting in an injury, whereas *Self-Harm Type II* is the SIB resulting in a non-fatal injury. Lastly, *Self-Inflicted Death* refers to SIBs resulting in death.

According to Menninger (1938), self-injury is depicted as the surrender or rejection of the masculine role. It embodies concepts classified as neurotic, religious, or psychotic which are culturally validated (Menninger, 1938). Firstly, self-injury is practiced by neurotic patients in both substituted and symbolic forms. Compulsive and repetitive behaviors like; nail-biting, attacks upon the skin (which the dermatologist calls neurotic excoriations), kicking or hitting oneself body parts, tearing out hairs could be the forms of *neurotic self-mutilation*. According to Menninger, self-injury may begin as a form of punishment for genital self-abuse. As the second

concept, *religious self-mutilation* could involve religious rituals like surgical mutilation of the genitals, self-castration, and self-immolation. These behaviors indicate the projection of the superego.

Finally, the psychotic patients engage in self-injury to reach an erotic goal while punishing themselves. A known example of *psychotic self-mutilating behavior* is amputating body parts such as the penis.

Self-cutting is the most prevalent type of self-injurious behavior (Favazza and Conterio, 1988; Nock et al., 2006). The existence of a self-cutting syndrome is still being debated (Suyemoto, 1994). Burning, obscuring wound healing, and scratching are the most applied types of self-injurious behaviors following self-cutting (Klonsky, 2007). Most individuals report using more than one type of self-injury (Glenn and Klonsky, 2013; Klonsky, 2011; Nock and Prinstein, 2004). On the other hand, hitting or biting oneself, picking, and pulling out one's hair are less often reported techniques of SIBs (Nock, 2010). Meanwhile, many self-injurers damage several parts of their bodies (Sornberger et al., 2012). Razor blades are the most selected appliance, and the most preferred body parts are wrists and forearms. Most self-injurers were found to report the absence of pain during engaging in self-injurious behaviors (Suyemoto, 1998).

Gender, race, or socioeconomic status does not relate to engaging in self-injurious behavior (Hilt et al., 2008). Moreover, the average age at which self-injury begins is 12 years (Glenn and Klonsky, 2013; Klonsky, 2011). Young adults and adolescents are the most threatened by the NSSI, a highly prevalent condition (Klonsky, Victor and Saffer, 2014). According to Nock (2009), since adults may reject engagement in self-injurious behaviors, adolescents may have a higher prevalence of self-injury. Moreover, a review of 119 studies suggested that the prevalence of NSSI was 17.2% in adolescents, 13.4% in young adults, and 5.5% in adults (Swannell et al., 2014). In Nock and Prinstein's (2004) study, it is found that adolescents reported 19 or more incidents in the last year. Self-injurious behaviors are seen to be performed hidden by most self-injurers (Tantam and Huband, 2009). Self-injurers have more trouble expressing their emotions than non-injurers. At the same time, they have difficulty with their awareness and experiences (Gratz, 2007).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes engaging in self-injurious behavior as a criterion for borderline personality disorder

[American Psychiatric Association (APA), 2013]. Moreover, it is among the disorders stated in the DSM-5's Conditions for Further Study section that requires investigation (APA, 2013). According to DSM-5, the Non-suicidal Self-injury criteria are as follows: Criterion A harms one's own body deliberately for five or more days in the last year. It can cause pain or bleeding, although it is not suicidal. Criterion B, the person engages in self-injury because the person has expectations of at least one of the following; avoiding a negative emotion or cognitive state, creating a positive mood, or solving an interpersonal problem. Criterion C, self-injury is related to at least one of the following; negative emotions that precede the behavior, thinking about the behavior, or intending to do something challenging to control. Criterion D includes social disapproval of self-injurious behavior (e.g., tattoo). Criterion E is that the behavior or its consequences affect the functionality of the person. Finally, criterion F consists of another mental disorder or medical condition that cannot better explain the behavior (APA, 2013). According to APA (2013), one of the functional consequences of self-injury is that it increases the likelihood of blood-borne disease if cutting is performed with standard tools.

Baumeister and Scher (1988) emphasized that people act intending to harm themselves, even if they are not conscious of them, according to the Freudian explanation. Moreover, according to psychodynamic theorists, NSSI is used to maintain control of urges towards sex or death (Nock, 2009). Kernberg (1988) stated on a psychoanalytic exploration that individuals who practice self-injurious behavior have characteristics of a lack of superego integration, absence of the capacity for experiencing guilt, and the general characteristics of borderline personality.

Altering and annihilating the surface of the body tissue provides two types of information: morbid behavior and self-help behavior. Favazza and Conterio (1988) state that self-help has been used to refer to situations in which self-injury may provide relief from debilitating symptoms. These symptoms may lead to provisional psychotic episodes and suicidal acts if they are not checked.

While Cross (1993) states that self-injury is displayed to show control over sex and death drives, Suyemoto (1998) says that it is displayed to define the boundary between self and others and protect others from one's own anger. According to Herpertz (1995), it functions as an end to dissociative episodes.

NSSI is a frequently applied and repetitive behavior. 36% of adolescents are found to engage in NSSI at least once a month (Hilt et al., 2008). Muehlenkamp et al. (2012), in their review study, examined 52 studies published in various parts of the world and reported that the mean lifetime prevalence of NSSI in adolescents was 18%.

Self-injurious adolescents recruited from the community to participate in a study reported having thoughts of self-injury approximately five times per week and participating in the behavior one to two times a week. Meanwhile, it was found that self-injury takes less than an hour when the individual currently has the thought of self-injury (Nock, Prinstein and Sterba, 2009).

Thoughts of self-injury usually arise in response to a stressful event when the individual is alone and having unpleasant thoughts or emotions (Nock, Prinstein and Sterba, 2009). Behavioral studies have shown decreased pain sensitivity (Bohus et al., 2000). According to this term, self-injurers feel less pain and have higher thresholds of pain than non-injurers. Moreover, self-injurers' beliefs about deserving the pain they experience, their habits for pain caused by injuries, or the release of endorphins while engaging SIBs have been suggested as other possible explanations (Nock et al., 2006). Moreover, self-injurers reported anger, guilt, and shame towards engaging in this behavior (Klonsky, 2009). Existing theoretical models explain that the behavior continues because the rewards outweigh the negative results it provides (Nock, 2010).

When examining the rate of engaging SIBs in the studies conducted in Turkey, while Zoroğlu et al. (2003) reported the engaging rate of SIBs as 21.4% in their study, Öksüz and Malhan (2005) found this rate as 8%. On the other hand, Toprak et al. (2011) reported a lifetime NSSI rate of 15.4%.

A large volume of published studies emphasizes that the gender difference between self-injurers is not significant (Klonsky, Oltmanns and Turkheimer, 2003; Klonsky, 2011; Nock and Prinstein, 2004; Nock et al., 2006; Zoroğlu et al., 2003).

However, a difference emerges when the genders are compared in terms of the applied method of SIBs. For example, Zoroğlu et al. (2003) found in their study that females practice hair pulling more than males. On the other hand, Bresin and Schoenleber (2015) found that women practice more cutting and biting than men.

Klonsky and Muehlenkamp (2007) stated that child abuse is a risk factor for SIBs. Noll et al. (2003) explained this situation by suggesting that individuals can

revive the abuse they were exposed to by harming themselves. Although child abuse appears to be an essential risk factor for engaging SIBs, Klonsky and Muehlenkamp (2007) underline that not every abused person harms himself, and not every self-injurer is abused.

1.1.2. Relationship with Suicide

Although the self-injurious behavior does not intend to include an attempt of suicide by its definition, the self-injurers are likely to ideate suicide more and attempt suicide more, separately from the act. This likelihood is observed more in people with self-injurers with borderline personality disorder in contrast to self-injurers without BPD (Herpertz, 1995).

NSSI is linked to depression, anxiety, impulsivity, and BDP, all known as risk factors. On the other hand, Klonsky, May and Glenn (2013) revealed a stronger connection between a history of suicide attempts and NSSI. Furthermore, there is a piece of increasing longitudinal evidence that NSSI is a powerful indicator of potential suicide attempts (Wilkinson et al., 2011). Crabtree (1967) states that chronic self-injurers are known for their intense sensitivity to rejection, frequent crises, and probability of incidental suicide acts. These pose an effective therapeutic process by revealing unpleasant feelings in therapists, including anger, pessimism, helplessness. On the other hand, Muehlenkamp (2005) and Walsh (2005) stated a difference between SIBs and suicidal behaviors. While the aim of the suicide attempt is death, self-injurers experience relief from negative emotions.

1.1.3. Comorbidity

While self-injury is seen in clinical samples, it is also seen in non-clinical and high-functioning populations (Klonsky, Oltmanns and Turkheimer, 2003; Whitlock, Eckenrode and Silverman, 2006). However, it is noteworthy that the prevalence of NSSI is higher in studies conducted with clinical samples compared to those with non-clinical samples (e.g., Glenn and Klonsky, 2013). Many studies in the literature demonstrate that those who engage in SIBs have different psychological disorders, which includes substance disorders, eating disorders, posttraumatic stress disorder, major depression, and anxiety disorders (Klonsky, Oltmanns and Turkheimer, 2003; Klonsky, 2007; Nock et al., 2006; Favazza, DeRosear and Conterio, 1989). Nock et al.

(2006) conducted a study with psychiatric adolescents to confirm these findings and found that 87.6% of self-injurers were diagnosed with DSM-IV Axis I.

A borderline personality disorder is a diagnosis that most often accompanies self-injury (Kernberg, 1988). Since the occurrence of self-injurious behavior would create a bias for diagnosing borderline personality disorder, the process of deciding for an accurate diagnosis may be complicated (Ghaziuddin et al.,1992). Glenn and Klonsky (2013) found that 52% of adolescents meet both NSSI and BPD criteria in their study. According to the APA (2013), people with borderline personality disorder can behave aggressively and hostile, while SIBs are more related to intimacy, cooperative behaviors, and positive relationships.

Klonsky, Oltmanns and Turkheimer (2003) revealed that participants with a history of SIBs have higher scores on borderline, schizotypal, dependent, and avoidant personality disorder measures than those who do not have a history of SIBs. At the same time, they found higher scores on depression and anxiety measures in the non-clinical adult sample.

Whitlock, Eckenrode and Silverman (2006) found a correlation between eating disorder symptoms and self-injury. Moreover, it has been found that individuals with a diagnosis of substance use disorder are prone to engage SIBs (Klonsky and Muehlenkamp 2007).

1.1.4. Functions of Self-Injury

One of the critical components of effective intervention is understanding why people engage in self-injury (Lewis and Arbuthnott, 2012). Acknowledging the nature of these functions would lead therapists to understand, assess and treat the patients who engage in self-injurious behaviors (Suyemoto, 1998). Many studies examine the functions of SIBs in the literature (Suyemoto, 1998; Klonsky, 2007; Nock and Prinstein; 2004). One of the reasons to engage in self-injurious behaviors is that it serves more than one function. While there are other functions as “revenge,” “toughness,” “marking distress,” or “self-care” (Klonsky, 2007), the main functions of the self-injury would be explained as follows:

a. Affect-regulation

"I did not even know it was called self-injuring. I just knew it made me feel better." (Leaf and Schrock, 2011, p. 156).

Klonsky and Muehlenkamp (2007) identified the most common function of self-injury as affect-regulation. It is suggested that self-injury alleviates negative affect (Gratz, 2003). In the study conducted by Nock and Prinstein (2004), it was revealed that the first purpose of adolescents who harm themselves in doing this is regulation of emotional or physiological experiences. Linehan (1993) theorized that these individuals might learn poor strategies for coping with emotional distress, become less able to manage their emotions, and develop a maladaptive affect regulation strategy by injuring themselves. Comparably, according to APA (2013), the most common function of self-injury is to reduce negative emotions such as tension or anxiety.

b. Self-punishment or Self-directed Anger

"I get rid of my anger for a while, until something else pissed me off." (Leaf and Schrock, 2011, p. 163).

Self-punishment or self-directed anger is defined as another motivation of self-injury. Studies are suggesting that self-punishment is the most common function of self-injury (Klonsky, 2007). The self-punishment function appears to be consistent with the relationship between self-injury and low self-esteem (Klonsky, Oltmanns and Turkheimer, 2003). Self-punishment is familiar to these individuals, so it has become a way of soothing themselves (Klonsky and Muehlenkamp, 2007).

c. Anti-dissociation

"I hate my body, and don' t feel as if it belongs to me." (Allen, 1995).

Self-injurers sometimes report feeling nothing or feeling unreal. Physical injury or seeing blood can prevent this experience; thus, they regain the sense of self. Feeling generation is another term for this function because by hurting

themselves, they can produce and feel at least pain (Klonsky and Muehlenkamp, 2007). Favazza and Conterio (1988) suggested that self-injury may ensure relief from episodes of depersonalization, feelings of loneliness, emptiness, albeit this relief are rapid and short-winded. On the other hand, Crabtree (1967) and Kafka (1969) view that studies of female patients stress the ability of blood provided by self-cutting to serve as a transitional healing object and end periods of depersonalization and the need for long-term therapy.

d. Interpersonal Influence & Peer Bonding

" I need to see blood, and for other people to see me bleed." (Allen, 1995).

Another function of self-injury has been identified as the desire to influence or manipulate others, arouse affection in loved ones, or bond with peers or other self-injurers (Klonsky and Muehlenkamp, 2007). Allen (1995) conceptualized self-injury as a cry for help, an attempt to be taken more seriously, or influencing people's behavior.

e. Interpersonal Boundaries and Autonomy

"Being in control, being the only person who can hurt me." (Allen, 1995).

Some self-injurers report affirming the boundaries of themselves by self-injury. These individuals feel different from others and become more independent and autonomous (Klonsky and Muehlenkamp, 2007).

f. Anti-Suicide

Some self-injurers report that they are engaging in self-injury because they resist their urges to attempt suicide (Klonsky and Muehlenkamp, 2007).

g. Sensation Seeking

Generating excitement is another function of self-injury. These people engage in self-injury to create exhilaration in a similar way to bungee jumping (Klonsky and Muehlenkamp, 2007).

1.2. Psychological Pain

Psychological pain is referred to in the literature regarding mental pain, psychic pain, emptiness, psychache, heartache, emotional pain, or social pain (Tossani, 2013; Meerwijk and Shattell, 2012).

Shneidman (1993) named psychological pain as psychache and defined it as hurt, anguish, aching, soreness in the psyche, in mind. The author also associated it with feelings of extreme shame, guilt, loneliness, fear, or anxiety. Shneidman (1993) emphasized that unbearable psychological pain leads to suicide. Shneidman (1999) developed a scale called The Psychological Pain Assessment Scale (PPAS) to investigate psychological pain and added the definition of psychache to this scale as follows;

"Psychological pain is the same as somatic or physical pain, it is how you feel as a person; how you feel in your mind or heart. It refers to how much you hurt as a human being. It is mental suffering, inner torment. Psychache refers to hurt or misery. It is a pain of shame, or guilt, or grief, or humiliation, or hopelessness, or loneliness, or sadness, or anguish, feel inside. It is an ache in the mind. "

In addition, Shneidman (1993) argued that psychological pain is linked to psychological needs. According to Murray (1938), some of these needs are a success, commitment, autonomy, order, play, shame-avoidance, and understanding. Preventing these psychological needs reveals psychological pain. Moreover, he stated that those who attempted and committed suicide suffer from psychache (Shneidman, 1993). On the other hand, Shneidman (1985) highlighted that those who suffer tolerable psychache attempt non-serious suicide. Those who suffer intense and excruciating psychache more severe suicide attempts (Orbach et al., 2003a). Most likely, every individual experiences psychological pain in some part of their life, such as an illness or the end of a romantic relationship (Meerwijk and Shattell, 2012).

"The pain has become excruciating, constant, and endless." (Institute of Medicine, 2002).

This quote, taken from a journalist's suicide note, is an example of the inability to endure the pain that leads to suicide. The other expression frequently seen in suicide notes or told to clinicians after a suicide attempt is "I cannot stand the pain any longer." (Institute of Medicine, 2002). This pain is not physically felt but psychologically experienced (Mee et al., 2006).

Bakan (1968) stated that psychological pain occurs when a person separates from significant other; psychological pain is related to the loss. Moreover, he noted that psychological pain is associated with one's awareness of a disruption in the tendency to maintain a sense of wholeness and social unity. On the other hand, Freud (1917) explained this concept in terms of mourning and longing experienced after the traumatic loss of the loved one.

Loeser (2000) stated that the pain is not in the body but in the mind, and it can occur due to situations such as fear, anxiety, depression, hunger, fatigue, or the loss of loved objects. He also emphasized that the events that cause pain are unique to the person, there are no tools to measure the pain, and the only way to understand and help the patient is to listen to the patient's narrative.

Explaining the central theme of existentialism, Frankl and Lasch (1992) state that living is suffering, that in order to survive, it is necessary to find meaning in that pain. Individuals' attitude towards inevitable pain is one of the factors that help them discover the purpose of life. The emptiness of a person who cannot find the meaning of his life is suffering. This pain can end off when meaning for life is found (Frankl and Lasch, 1992).

Individuals may have different thresholds in psychological pain as well as in physical pain. If individuals with a predisposition to psychological pain have a major depressive disorder, physical illness, or stress, they are at greater risk for suicide.

In their study, Kovacs, Beck and Weissman (1975a) reported that 56% of the participants who attempted suicide reported doing so to escape from life and found that this reason was associated with high levels of hopelessness and depression (mostly hopelessness). Likewise, in another study by Kovacs, Beck and Weissman (1975b), it was revealed that hopelessness is more related to suicide than depression. Mee et al. (2006) suggested that psychological pain is analogous with hopelessness and suggested that psychological pain should be evaluated as a symptom separate from

mood disorders. In connection with this, suicide seems to be the only escape route when the psychological pain is so intense (Mee et al., 2006).

Individuals who are faced with unbearable life events such as the loss of a child or spouse may experience psychological pain, and these individuals are at risk for depression and suicide (Mee et al., 2006).

Bolger (1999) suggested that psychological problems occur due to avoiding the pain and suffering resulting from life. Bolger (1999) defined emotional pain as the awareness of a feeling of brokenness. According to him, emotional pain occurs when a traumatic event suddenly fragments a connection with significant others or individuals' identities. The awareness of individuals to the threat of survival begins with the realization of disconnection from significant others, and the fear of annihilation, which is called the inevitable pain by Bakan (1968), emerges.

The study's findings conducted by Orbach et al. (2003a) revealed a positive relationship between psychological pain and suicidal tendency and a negative relationship between psychological pain and optimism, life regard. According to the findings of this study, the driving forces in individuals' attempts to end their suffering appear to be emptiness, loss of meaning, and not being future-directedness.

Herman (1992) and Janoff-Bulman (1992) suggested that psychological pain is a perception of an adverse change in the self and is triggered by trauma and loss.

Orbach et al. (2003b), as a result of their study, conceptualized mental pain as a 'perception of negative changes in the self and its function that is accompanied by strong negative feelings.'. In addition, they found that although mental pain, depression, and anxiety were found to be related, these conditions were distinguishable from each other.

Verrocchio et al. (2016), as a result of their systematic review of the literature, suggested that the level of psychological pain associated with the risk of suicide is independent of the level of the depressive state.

Orbach et al. (2003b) developed a scale to measure psychological pain and described nine factors of psychological pain: the experience of irreversibility, loss of control, narcissistic wounds, emotional flooding, freezing, estrangement, confusion, social distancing, and emptiness.

According to a study conducted by You et al. (2014) with the Chinese population, psychological pain is not inevitable for suicide, and the individual may not commit suicide due to protective factors such as life satisfaction.

Both adults and children (in situations such as child abuse or being bullied) can experience psychological pain. Disorders in which psychological pain is encountered as a symptom include depression, schizophrenia, bipolar disorder, or posttraumatic stress disorder. Psychological pain is intense in women diagnosed with borderline personality disorder. Moreover, it has been associated with childhood abuse (Meerwijk and Shattell, 2012).

1.3. Self-Injury and Psychological Pain

"scars show that my pain is that real and that bad." (Leaf and Schrock, 2011, p. 161).

There are few studies on the relationship between suffering psychological pain and engaging in self-injurious behavior. Holden, Campos and Lambert (2020) conducted a study to test the contribution of psychological pain to self-injurious behaviors. This study included psychiatric history and over-the-counter drug use as covariates because they were clinical variables associated with self-injury. In conclusion, they found that psychological pain was a significant predictor of engaging in SIBs, even when controlling for these critical covariates. In addition, according to the results of this study, psychological pain and frequency of SIBs (none, once or more than once) were significantly correlated.

Gratz (2003) argues that while some of the consequences of self-injury are negative reinforcement, others may increase emotional pain and isolation. Moreover, Gratz (2000) found in his study that participants who were self-injurers reported that its function was to reduce emotional pain.

Leibenluft, Gardner and Cowdry (1987), in their study, interviews with five borderline personality disorder patients who injured themselves, explained that individuals' self-injury is the need to stop excessive emotional pain. These individuals

transform intangible psychological pain into real physical pain. In addition, endorphins released as a result of self-injury cause this psychological pain to be relieved.

Nahaliel et al. (2014) tested their hypotheses that the presence of mental pain mediates the relationship between self-injury, the number of losses experienced in one's life, and suicidal tendency. Researchers found a high correlation between the presence of mental pain and self-injury.

Orbach (2009) argues that the primary source of mental pain is internally produced pain. This inner pain arises in connection with early traumatic experiences and early conflicts. Self-injurious tendencies are activated when pain is triggered internally. Orbach mentions that the suicidal body must be created to transform the unbearable psychological pain into self-injury. Dissociation, anhedonia, numbness, indifference to physical pain, and heightened senses are related to the suicidal body. These bodily states make it easier to attack the body aggressively. As a result, suicidal behavior may occur, which may result from both psychological pain and self-injury (Orbach, 2009).

According to the study results by Holden et al. (2021), those who self-injurers were depressed and in a great deal of mental pain.

1.4. Mentalization

The capacity to interpret in terms of inner mental states (such as feelings, wishes, goals, desires, and attitudes) of both oneself and others is the mentalization or reflective functioning (Fonagy et al., 2016). In other words, mentalization involves not only evaluating mental states to others but also to the person himself, thus distinguishing from empathy (Allen, Fonagy and Bateman 2008). People use mental states to understand and, more importantly, predict each other's actions (Fonagy and Target, 1998). The process of making sense of these internal states enables people to discover their subjective experiences, that is, a wide range of self-knowledge (Slade, 2005). Allen, Fonagy and Bateman (2008) summarized mentalization as being aware of oneself or others' mental states and being able to look at oneself from the outside and put themselves in the shoes of others. In addition, according to these authors, mentalization capacity functions in controlling one's strong desires and emotions and making them more bearable. Mentalization is like insight in psychoanalysis (Slade,

2005; Allen, Fonagy and Bateman, 2008). Moreover, it refers to the desire to make sense of emotions and inner experiences without being overwhelmed. According to Fonagy and Target (1995; 1996), reflective functioning, or mentalization, is an expression of this psychological capacity associated with the representation of the self.

Mentalization is referred to as the theory of mind in developmental psychology. It is an act in which children develop their understanding of the mental states of others. Children's experiences with others enable them to create multiple self-others experiences (Fonagy et al., 2002). As they discover the meaning of other people's actions, children will begin to find their psychological experiences meaningful. It will affect emotion control, affect-regulation, and self-monitoring capacities. People are born with the ability to develop mentalization capacity, and early childhood experiences play a role in the child's learning of mental states (Fonagy et al., 2002). With the capacity of the mother to hold the mental states of the child, the child learns his/her own mental states in the representation of the mother. The child develops his/her own mentalization capacity due to the mental states that the mother re-represents to the child first with gestures and actions and then in words and play (Slade, 2005). According to Fonagy et al. (2002), the inability to enter someone else's mental state is based on the failure of mirroring in infancy.

Bion (1962) proposed a theory on the origins of thinking. In this direction, Bion (1962) argues that thoughts emerged with an absence or loss. The baby perceives these thoughts as "bad" in nature. Bion distinguishes between thoughts and the apparatus which thinks the thoughts. The capacity to think thoughts is called the alpha function. The beta function is thoughts without an apparatus. Mentalization will be possible if the alpha function can convert beta elements into alpha elements; namely, the mother can contain the infant's thoughts. Bion (1962) also suggests that there is a conflict between these bad thoughts and the capacity to replace them with thoughts that might think and that the outcome of this conflict depends on the infant's capacity to tolerate frustration and the mother's (breast's) capacity to transform the infant's thoughts (beta to alpha) and project them to the infant.

Mentalization and introspection are different from each other. Introspection has an apparent influence on one's own experience and applying the theory of mind to one's own mental states. On the other hand, mentalization is an external awareness (Fonagy et al., 2002).

Winnicott (2005) suggested that mirroring the mother plays a role in the development of mentalization. The minds of babies develop from the inside and the outside, and they find their minds in the minds of their caregivers (Fonagy et al., 2002).

The more people envision mental states in themselves and others, the more likely they are to engage and remain in close and continuous relationships. They feel having an autonomous mind (Fonagy et al., 2002).

There may be some situations in which deviations occur in the responses of parents to infants. Children's experiences with their abusive parents' anger, hatred, fear, and malicious intentions disappear. The child then identifies with the aggressor and takes on the aggression and hatred of his/her parents (Fraiberg, 1981). For children exposed to abuse and trauma, taking their parents' minds can be scary and dangerous. Children with severe psychopathology in their parents experience their inner life as an unknown when they are entirely deprived of mirroring. It results in alienation, isolation, a fragmented and empty sense of self, and an inability to develop nurturing relationships with others. In addition, situations such as the mother's invasion of play in a way that distorts the imagination or pretense may negatively affect the development of mentalization capacity by emerging in the later stages where parental talk, play, and playfulness are essential for the child (Slade, 2005).

Holmes (2006) argued that the definition of mentalization has four related aspects and listed them as follows: The state of being "mind-minded" in the phrase of Meins et al. (1998); explicit or implicit hypotheses that a person uses to understand why s/he or someone else might have thought or done something; the implicit is the intentional stance of Dennett (1987), that is, the capacity to have desires or wishes, and finally, mentalization is a process, capacity or skill that is more or less present or absent in people.

Fonagy and Luyten (2009) suggested that mentalization can be organized on four poles. The first of these is implicit-automatic versus explicit-controlled mentalization. Explicit mentalization is a conscious, verbal, reflective process that requires awareness and effort, while implicit mentalization is unconscious, nonverbal, nonreflective, requiring little attention and effort. Mirroring is a process that explains this (Satpute and Lieberman, 2006). The second is mentalization based on internal versus external features of self and others. Focusing on the mental internals means directly considering thoughts, feelings, and experiences (Satpute and Lieberman,

2006), while focusing on external attributes means focusing on physical and visible characteristics or the actions of others or our own actions (Fonagy, Gergely and Target, 2007). The third is cognitive versus affective mentalization. Baron-Cohen et al. (2008) defined the theory of mind mechanism and the empathizing system as two independent processing to differentiate this category. The theory of mind mechanism is mediated by agent-attitude- proposition, while the empathizing system is mediated by self-affective state-proposition. Finally, there is mentalization concerning self versus others. The emphasis here is that neuroimaging studies envision someone else's mind, and identifying one's own thoughts and feelings is supported by the same brain systems. It is about knowing how someone else feels from the inside (Fonagy and Luyten, 2009).

Fonagy et al. (2002) stated that mentalization is a preconscious process and depends on the attachment relationship between mother and child and the reflection capacity of the mother. If the child is deprived of these, s/he will experience confusion about self occurs.

Lecours and Bouchard (1997) proposed a conceptual model of levels of mental elaboration. According to this model, mentalization consists of two independent dimensions. There is a gradually increasing mental elaboration in both dimensions. The first dimension is a drive-affect expression, and this dimension has different channels: somatic and motor activity, imagery, and verbalization. Somatic mode is the expression of affects by various internal physiological means and somatic lesions. Motor activity includes voluntary behavior and action. Imagery is the form of mental contents, images expressed in dreams, fantasies, or any mental material, and primary processes dominate. Finally, verbal expressions are lexical representations dominated by secondary processes. There are five levels of containment or degrees for each of these channels. The first is disruptive impulsion, that is, an uncontrolled form of direct expression. Affect cannot be owned here. Primitive forms of projective identifications are typical for this level. Beta elements (Bion, 1962) or primary symbols (Luquet, 1987) activate without alpha function or preconscious ego activity. The sense of this level of drive-affect impulse may be unconscious. This level has four sublayers. The first of these is unmentalised-unrepresented. It is the lowest layer and includes non-mental libidinal stimuli without mental representation. At this level, there are somatizations, the death instinct, or self-injury, violent behaviors. The second level is

represented-unsymbolised. At this level, delirium and hallucinations are present. The third level is symbolized-repressed. At this level, the repressed unconscious actualizes the 'return of the repressed.'. This transformation takes place through symptoms or acting out, meaning. The last level is highly symbolized, repressed. At this level, there are higher symbolized forms. Common examples of the drive-affect impulse are a sudden headache or nausea during a session, engaging in self-injurious behaviors, verbal expression, or inappropriate crying. After the drive affect impulse, the next level is modulated impulsion. Examples of this level are physical symptoms during an anxiety attack or swearing, joking, insulting, or criticism. Any modulated expression is performed by the unconscious while relying on higher levels of mentalization. The next level is externalization. An example of this level is attributing the state of irritability to the provocation of another. Attribution of causes to external events (projections) allows drive-affect experiences to be externalized. The fourth stage is appropriation. At this level, the individual easily recognizes the existence of his/her own mental processes and observes him/herself. Finally, the last stage is abstracting-reflexive. The subject can make sense of what s/he encounters and produce a meta-discourse about it so that his/her mental experience is filled with depth and meaning. As a result of all the stages, Lecours and Bouchard (1997) suggested that healthy mental functioning balances between 'modulated impulse' and 'appropriation.'.

Mentalization refers to a context-dependent, dynamic process, not a feature. Quick and automatic mentalization is often biased. Therefore, effective mentalization is related to the balance established between the different poles of mentalization. On the other hand, psychopathologies are explained by the imbalance in mentalization dimensions (Luyten et al., 2020).

Fonagy et al. (2016) described two types of impairments for mentalization as follows:

1.4.1. Hypomentalization

The first is called hypomentalizing and refers to the inability to think about models of one's own mind and/or the minds of others. Hypomentalizating has been associated with vulnerability to depression (Luyten and Fonagy, 2014), eating disorders (Skårderud, 2007), and borderline personality disorder (Fonagy and Luyten, 2016). Although these individuals are aware of their limitations, they have average

scores in empathy as a component of the Reflective Functioning Questionnaire. As a result, hypomentalization carries a risk of responding correctly to scales.

Moreover, it is seen that the disorders associated with hypomentalization (substance abuse or self-injury) are related to the regulation of stress and arousal involved in unmentalized self-states (Fonagy et al., 2016). It can be understood that these individuals have a tendency to externalize unmentalized experiences (Luyten et al., 2020).

1.4.2. Hypermentalization

Hypermentalizing, excessive mentalizing, or pseudomentalizing expresses an opposite tendency. In this case, there may be a bias in the self-reports of individuals. This situation can be observed in the person's long and detailed statements that have nothing to do with reality. Although there is no evidence of mental models, there is the production of mental representations. These individuals describe themselves as good mentalizers (e.g., "Of course I always know why I do what I do").

While hypomentalization for borderline personality disorder presents itself as being relatively rigid and defensive, these patients also have a tendency to hypermentalize. These patients may show severe imbalances in mentalization (Fonagy and Luyten, 2016).

On the contrary, genuine mentalization is expressed as a person's recognition of the opacity of mental states and being humility about knowing one's mental states and knowing the mental states of others (Fonagy et al., 2002; Fonagy et al., 2016).

1.5.Self-Injury, Psychological Pain and Mentalization

According to the dimensions of mentalization of Lecours and Bouchard (1997), self-injurious behavior corresponds to 'unmentalized-unrepresented,' which is located at the bottom layer of disruptive impulsion at the bottom layer of elaboration. At the bottom layer of disruptive impulsion are unmentalized sensory experiences and libidinal stimuli without mental representation.

Through reflective functioning or mentalization capacity, infants develop their ability to understand, label, and regulate emotions during the first five months of their life (Fonagy and Target, 1997). Reactions from caregivers (such as not responding to

the infant's feelings, misinterpreting the infant's feelings, projecting excessive emotions onto the infant (see Fonagy et al., 2002) and mentalization capacity led to the emergence of different coping strategies in infants. The avoidant infant suppresses emotional expression, while the resistant infant heightens emotional expression, or the disorganized infant may freeze in the face of perceived threats (Cassidy, 1994). On the other hand, one of the leading functions of self-injury is the capacity of emotion regulation (Klonsky, 2007). Through this function, self-injurers can change their unwanted and unpleasant feelings (Victor and Klonsky, 2014).

Moreover, Bushman, Baumeister and Phillips (2001) revealed that aggressive behaviors might serve an emotion-regulation function. Tatnell, Hasking and Newman (2018) conducted a study suggesting that each attachment pattern may increase self-injury risk through different emotion regulation difficulties. In addition, while the authors emphasize the need for long-term studies, as Fonagy et al. (2002) mentioned, they argue that mentalization treatment for self-injurers will improve individuals' understanding of their own and others' mental states in order to improve their emotional regulation abilities.

Another relationship between self-injury and mentalization capacity is borderline personality disorder. While individuals with a borderline personality disorder may engage in self-injury (Kernberg, 1988; Glenn and Klonsky, 2013; Klonsky, Oltmanns and Turkheimer, 2003), on the other hand, they have low mentalization capacity (Luyten and Fonagy, 2014).

In the literature, there are studies in which there are indirect relationships between difficulties in emotion regulation and depression (Joormann and Stanton, 2016; Boden and Thompson, 2015; Joormann, 2010). Moreover, it has been revealed that individuals who have suffered psychological pain are at risk for depression (Mee et al., 2006).

1.6.False Self

"I felt, like, not really real. I just felt so fake. And I was just really upset and I just wanted to do something that would change it." (Leaf and Schrock, 2011, p. 160).

According to Harter (2002), false self behavior is an experience of being phony far from being authentic. The fact that the person does not say what s/he thinks or believes or does not express the person's actual opinion refers to false self behaviors (Harter, Waters and Whitesell, 1997). Moreover, Harter et al. (1996) defined it as acting in a way that does not reflect one's true self.

Winnicott introduced the concepts of true self and false self to psychoanalysis in 1960. While false self defines as being compatible based on the performance and expectations of others, the true self is grounded in the most profound sense. In addition, Winnicott believed that creativity was only in the true self (Winnicott, 1960). True self feels real, but it should never be affected by external reality and should never comply. When the false self emerges and is treated as if it is real, a great feeling of futility and despair occurs in the individual. In a particular case of the false self, the intellectual process becomes the center of the false self (Winnicott, 1965). In addition, Winnicott (1965) argues that only the true self can be analysed and the analysis of the false self can lead to disappointment.

The false self develops in the early stage of the infant-mother relationship, and this is the process that the infant's observation to the mother (Winnicott, 1960). The infant is in a state of complete dependence on the mother in the earliest period of his/her life, and with the help of the 'primary maternal preoccupation,' the mother experiences a kind of relatedness where she can perceive her infant's needs as her own without the need for verbal or concrete signs. The 'primary maternal occupation' begins during the mother's pregnancy and reaches its peak at the end of the pregnancy. In this way, the mother can meet all the omnipotence of the infant. While this function of the mother depends on her own mental health, it is also affected by the environment. This essential function enables the mother to understand the expectations and needs of the infant (Winnicott, 1960; 1965).

The infant's illusion of omnipotence and controlling experiences emerges as the mother good enough adapts to the infant's behaviors and needs. The good-enough mother repeatedly meets the infant's omnipotence, thereby strengthening the infant's weak ego. With this identification, the mother knows how to hold her infant. Then the infant gradually leaves omnipotence and acquires true self spontaneity and merges with events in the external world. As a result, the infant does not just react; s/he begins to exist. What this special relationship emerges is 'devotion' (Winnicott, 1960).

If the mother cannot be a good enough mother, if she cannot feel the infant's needs, she cannot meet the infant's gesture. Instead, she substitutes her own gesture, which will have a sense of the infant's compliance. This compliance is the earliest stage of the false self. The infant's compliance with false self responds to environmental demands. When the mother's adaptation is not good enough, there is no cathexis of external objects, and the infant remains isolated due to which the infant lives falsely. False existence may appear in the early stages, then disappear, but then manifest more severely in the later stage. The infant with false self complies and accepts environmental responses. In this case, the infant's relationships are also false (Winnicott, 1960).

Winnicott (1960) stated that the false self is a defensive function to hide and protect the true self. In addition, Winnicott (1960) suggested that there are five levels of false self organizations. These levels can be listed as follows:

(a) Extreme: it is the establishment and appearance of the false self as if it were real. However, in social relationships, false self betrays itself. At this level, the true self is completely hidden.

(b) Less extreme: at this level where the false self defenses the true self, the potentially true self is accepted but still hidden.

(c) More towards health: at this level, the false self waits for favorable conditions for the true self to occur. However, if the conditions are not found, the new defense will be suicide. Thus, the whole self is destroyed to avoid the destruction of the true self.

(d) Still further towards health: it is the construction of the false self into identities.

(e) In health: the false self is in a benign state, necessary for socialization.

According to the study of Weir and Jose (2010), false self behavior involves hiding one's true feelings. The reason why these feelings are hidden is that they are negative. Harter et al. (1996) suggested that especially adolescents' hiding their true selves and displaying false self behavior are associated with depressive and anxious moods. However, Weir and Jose (2010) revealed that false self behavior is not associated with depression but only with anxiety.

1.7. Self-Injury, Psychological Pain and False Self

Winnicott (1960) suggested that one of the consequences of having a false self could be suicide as a defense. It is a defense because the false self cannot hide the true self and thus destroys the whole self. On the other hand, self-injurious behavior has the function of anti-suicide, which means individuals prevent suicide by engaging in self-injury (Klonsky, 2007). Moreover, psychological pain leads to suicide (Shneidman, 1999).

In addition, suffering psychological pain accompanies the experience of hopelessness (Shneidman, 1999), while false self causes individuals to experience despair in their adulthood (Winnicott, 1960).

Another common aspect of self-injury, psychological pain, and having a false self is experiencing negative emotions and depression. Weir and Jose (2010) stated that the reason for hiding the false self in the true self is that the true self is full of negative emotions. On the other hand, psychological pain is caused by negative emotions (Shneidman, 1999).

One of the functions of engaging in self-injury is relieving negative emotions (Klonsky, 2007). Besides, engaging in self-injury (Klonsky, Oltmanns and Turkheimer, 2003), suffering psychological pain (Meerwijk and Shattell, 2012; Mee et al., 2006), and having a false self (Harter et al., 1996) have been suggested to be associated with depression.

1.8. Aim of the Study

The study aims to improve our understanding of self-injurious behavior. More specifically, we intent on examining firstly the relationship between self-injury, psychological pain, and secondly the relationship between self-injury and hypomentalization, hypermentalization and perception of the false self in a Turkish sample. Furthermore, the difference between self-injurers and non-injurers was examined in terms of study variables. While few studies in the literature investigate the relationship between these concepts, there is no study examining this relationship in Turkey. In addition, there is no study in the literature in which the concepts in this study are discussed together. Findings of this study are considered to contribute to the Turkish adult population and psychology literature.

Moreover, this study aims to explore the factors related to self-injury, providing a better understanding of this problem. The findings are expected to shed light on the treatment of individuals who are self-injurers. In line with these goals, specific research questions investigated in this study were as follows:

1. What are the frequency and characteristics of self-injurious behaviors in the present sample of the Turkish population?

2. Which functions of self-injury did self-injurers report the most?

3. Which functions of self-injury are most associated with psychological pain?

4. Do self-injurers differ from non-injurers regarding gender, educational status, marital status, and psychological disorder status?

1.9. Hypothesis

The main hypotheses of the study are as follows:

1. Participants who are self-injurers are expected to have higher scores on the psychological pain, perception of the false self, and hyper and hypomentalization scores than non-injurers.

2. Self-injury, psychological pain, perception of the false self, hypomentalization, and hypermentalization are expected to be positively correlated.

3. Having a perception of the false self, psychological pain, hypomentalization, and hypermentalization are expected to be predictors of engaging in self-injury.

CHAPTER 2: METHOD

2.1. Participants

The sample of the present study consisted of 422 participants. The sample characteristics are given in Table 1. 305 females and 117 males participated in the study ages of which ranged from 18 to 62 (*M*=34.04, *SD*=10.85).

Table 1: Distribution of Demographic Variables in the Study Sample

	Self-injurers (%)	**Non-injurers (%)**	**Total (%)**
Gender			
Female	102	203	305 (72.3)
Male	41	76	117 (27.7)
Other	0	0	0 (0.0)
Education Level			
Literate	0	0	0 (0.0)
Elementary school	4	5	9 (2.1)
High school	11	42	53 (12.6)
Bachelor's degree	95	177	272 (64.5)
Master's degree	30	50	80 (19.0)
Doctoral degree	3	5	8 (1.9)
Marital Status			
Married	44	142	186 (44.1)
Single	92	120	212 (50.2)
Divorced	6	17	23 (5.5)
Widowed	1	0	1 (0.2)
Psychological Health Problem			
Yes	30	24	54 (12.8)
No	113	255	368 (87.2)
Total	143	279	422

In the study, 437 individuals were participated. However, 15 subjects were excluded due to uncompleted scales and extreme values.

The inclusion criteria in the study were; being literate, being between the age of 18-65, having signed the informed consent form and accept to participate in the study, and having Turkish as native language. The exclusion criteria in the study were; not being between the age of 18 to 65, leaving unanswered questions in the questionnaires, unwilling to participate in the study, and/or requesting withdrawal from the research after participation.

2.2. Instruments

In this study, the following scales were given to the participants, for the following purposes; Personal Information Questionnaire to obtain socio-demographic information of the participants, Inventory of Statements About Self-injury (ISAS) to evaluate whether the participants were engaged in self-injurious behavior and characteristics and functions of self-injurious behaviors, Psychache Scale to assess the psychological pain the participants suffer, The Reflective Functioning Questionnaire (RFQ-54) to assess mentalizing capacities of the participants and Perception of False Self Scale (POFSS) to evaluate false self perception of participants.

2.2.1. Personal Information Questionnaire

The Personal Information Questionnaire is a form that includes demographic information such as age, gender, educational status, marital status of the participants, whether the participants have any chronic illnesses/ psychological disorders or not (APPENDIX D). The researcher prepared the form.

2.2.2. Inventory of Statements About Self Injury (ISAS)

ISAS was developed by Klonsky and Glenn (2009) to comprehensively evaluate the frequency and functions of intentional self-injurious behaviors without suicidal intent (APPENDIX E). While the first part of the ISAS measures the lifetime frequency of 12 SIBs such as cutting, biting and burning, 39 items evaluate the 13 functions of self-injury in the second part. In the first part of ISAS, participants are asked to estimate how many times they have engaged in each method of self-injury

their lifetime, and five additional questions assess descriptive and contextual factors such as the age of onset, the experience of pain during engaging in SIBs. According to Klonsky and Olino (2008), the behaviors in the first part of this scale show good validity and reliability (α=.84). The participants would fill in the second part of the scale if they indicated that they have engaged one and/or more SIBs in the first part. In the second part, functions consist of two subordinate categories: intrapersonal and interpersonal functions. Interpersonal functions consist of autonomy, interpersonal boundaries, interpersonal influence, peer-bonding, revenge, self-care, sensation seeking, and toughness; on the other hand, intrapersonal functions involve anti-dissociation, affect regulation, anti-suicide, marking distress, and self-punishment. The 39 items in which all functions are composed are measured with a 3-point Likert type scale (0: not relevant, 1: somewhat relevant, or 2: very relevant), and the mean score of the functions is obtained by adding the items of the relevant subscales and dividing them by the number of subscales, which is five for the intrapersonal scale and eight for the interpersonal scale. The coefficient alpha for the interpersonal scale was .88, and for the intrapersonal scale was .80.

Turkish validity and reliability study of ISAS was conducted by Bildik et al. (2013). Internal consistency coefficient α= .79 was found for SIBs, which was the first part of the scale. The internal consistency coefficient of the functions section of the scale was .93; it was found to be .81 for intrapersonal functions and .86 for interpersonal functions. Furthermore, test-retest reliability was .66 for the first section, and it was .64 for the second section of the scale. The analyses demonstrate that the psychometric features of the version in Turkey are comparable to those of the original scale. In the adaptation study of the scale, since the severity of the behaviors in the first section were not the same, directly adding the frequency of the behaviors to obtain the total score of this section may result in misleading conclusions. In this direction, the frequency distribution of each SIB was examined, and the behaviors were re-scored as "0: none, 1: few, 2: moderate, 3: many" and a total score was obtained.

In this study, in the first part of the scale, in which the frequency of 12 behaviors was questioned, the frequency distribution of each behavior was examined in order to obtain the total score, similar to the adaptation study, and the frequencies of the behaviors were divided into four groups (0,1,2,3) and re-scored. The total score of the Behaviors section was obtained by adding the re-scored values. While the Cronbach's alpha value for the first part of the scale was .73, it was .86 for the

intrapersonal subscale, .87 for the interpersonal subscale and .92 for the whole functions in the second part.

2.2.3. The Psychache Scale (PS)

The Psychache Scale is a 13-item measure developed by Holden et al. (2001), based on Shneidman's (1993) definition of psychache as chronic, free-floating, non-situation-specific pain resulting from the frustration of vital psychological needs (APPENDIX F). The measurement is done utilizing a 5-point Likert-type scale with items ranging from 'never' to 'always' or 'strongly disagree' to 'strongly agree.' The 13 items of the scale were formed by selecting from a pool of 31 self-report items, and the resulting Cronbach's alpha coefficient was .92. The scale is revealed to provide information about suicidal thoughts. It has been observed that this scale, which was developed to investigate the relationship between suicide and psychological pain, successfully distinguishes those who attempt suicide and those who do not. Higher scores explain higher levels of psychological pain.

The Turkish validity and reliability study of the scale was carried out by Demirkol et al. (2018). In the internal consistency analysis of this study, Cronbach's alpha coefficient was found to be 0.98, and the item-total score coefficients were between 0.80 and 0.92. The factor analysis revealed that it was collected under a single factor with an Eigenvalue of 10.09, which explains 77.60% of the total variance. The scale was also found to significantly distinguish between those who have attempted suicide, and those who have not. This relationship was also found between healthy people and those with depression (Demirkol et al., 2018).

In this study, the Cronbach's alpha value for the PS was found to be .96. In addition, "if you were engaging in self-injury before and if you are not doing it now, please answer these questions considering the time you engage in self-injury" instruction was given to the participants so that the results of the relationship between self-injury and psychological pain were expected to be healthier.

2.2.4. The Reflective Functioning Questionnaire (RFQ-54)

RFQ-54 (APPENDIX G) was developed by Fonagy and Ghinai (2008) to measure mentalization capacity to the interpretation of mental states. It is a 54-item 7-point Likert type (1: strongly disagree to 7: strongly agree) self-report scale. Previous

studies have shown that the RFQ-54 having a good internal consistency of .82 (Fonagy et al., 2016). Fonagy et al. (2016) suggested re-scoring the items for the two sub-dimensions of RFQ-54 according to their studies. These two sub-dimensions; RFQ Certainty or Hypermentalization, expresses that being too certain about mental states of oneself or others, and RFQ Uncertainty, or Hypomentalization, expresses that being too uncertain about mental states of oneself or others. High scores on both subscales indicate greater impairment in mentalizing capacity. The Cronbach's alpha of RFQ Uncertainty was .77 for the clinical sample and .63 for the non-clinical sample. Internal consistency scores of RFQ Certainty were .65 and .67 for the clinical and non-clinical samples, respectively.

The Turkish version of the scale was obtained from the website of the scale developers (https://www.ucl.ac.uk/psychoanalysis/research/reflective-functioning-questionnaire-rfq). Köksal (2017) used the Turkish version of the scale in her study and reached results that support its validity and reliability. Köksal (2017) reported Cronbach's alpha coefficient as .90 for Certainty / Hypermentalization sub-dimension and as .81 for Uncertainty / Hypomentalization sub-dimension. In this study, the Cronbach's alpha value for the RFQ Certainty subscale was .87, while it was .83 for the RFQ Uncertainty subscale.

2.2.5. Perception of The False Self Scale (POFSS)

POFSS, developed by Weir and Jose (2010), is a 16-item, 5-point Likert type (1: strongly disagree to 5: strongly agree) self-report scale (APPENDIX H). It consists of two subscales: 11 items of the false self (Cronbach's alpha value .83) and five items of social concern (Cronbach's alpha value .63). Items 1, 7, and 12 are reverse coded. A score between 16 and 80 can be obtained from the scale, and high scores indicate a high level of false self-perception. The test-retest reliability coefficient of the scale was found to be .84. A positive correlation was found between false self-perception and depression and anxiety, and their values were r= .62 and r= .61, respectively. The two-factor model explained 39.2% of the variance, and these two factors positively related with r= .47.

The Turkish validity and study of POFSS was conducted by Akın et al. (2013). Their language equivalence study showed a very high (.83) correlation between the Turkish and English versions of the POFSS. The correlations between Turkish and English items of POFSS ranged from .49 to .81. The internal consistency coefficient

of the Turkish version of the scale is .75, and the corrected item-total correlations range from .18 to .49. While the test-retest reliability coefficient was .84 for the whole scale, it was .74 for the false self subscale and .73 for the social concern subscale.

In this study, analyses were made to reach the total false self perception score with the sum of all the items that did not use the sub-dimensions separately, and the total Cronbach's alpha coefficient for POFSS was found to be .86.

2.3. Procedure

In this study, the scales were sent to the participants via Google Form, and the purpose of the study, who could participate, how to fill it out, a consent form, and the researcher's contact information were given. The research link is transmitted to all cities in Turkey through mail groups, social media, etc. Participants were informed that their identities would be kept confidential and that they could withdraw from the research at any time. Participants are identified only by a number code. If the participant who read the explanations agreed to participate in the research, s/he could start filling out the scales by clicking 'Yes.'. It took approximately 25 minutes to complete the study. The researcher was able to reach the recorded answers via Google Forms after participation.

2.4. Statistical Analysis

Statistical Package for Social Sciences (SPSS), version 25 was used for statistical analysis in this study. Before the analysis, the accuracy of the data was examined, and the missing values were checked. According to descriptive statistics, there was no missing value. The alpha values of the scales used in the study were calculated according to the Turkish validity and reliability studies, and all alpha values were similar to the original studies. In addition, analyses of normality were conducted, and all study variables were normally distributed except for the Inventory of Statements About Self-Injury (ISAS) behaviors section. For this non-normally distributed part, analysis was performed with non-parametric tests.

For descriptive statistics, mean, standard deviation, percentage analysis, and frequency values were examined. One participant was excluded from the analysis because the participant was under 18 years old. In addition, Spearman Correlation Coefficient Analysis was conducted to examine the relationship between study variables. The Pearson Correlation Analysis was conducted to investigate the

correlation between participants' level of psychological pain and functions of self-injury. For comparison analysis, participants were grouped according to their self-injury status (self-injurers and non-injurers). Chi-Square Analysis was performed to examine the difference between self-injury status and gender, educational status, marital status, and psychological health problem. T-Test Analysis was used to assess differentiation in levels of psychological pain, perception of the false self, reflective functioning certainty, reflective functioning uncertainty between self-injury status. Binary Logistic Regression Analysis was used to assess the prediction of engaging in SIBs by using variables that are gender as categorical variables and psychological pain, false self-perception, RF certainty, and RF uncertainty.

CHAPTER 3: RESULTS

This part of the study consists of analyses run to test hypotheses and answer research questions. First of all, the characteristics of self-injury and the frequency of functions of self-injury were examined. In the next step, the descriptive statistics of the variables of the study were investigated. Then, the difference between self-injurers and non-injurers in demographic variables was examined. The relationship between participants' level of psychological pain and functions of self-injury was investigated thoroughly. The relationship between the variables was examined, then a t-test analysis was applied to examine the difference in self-injury status concerning study variables. Lastly, the predictors of self-injury were assessed.

3.1. Descriptive Analysis

3.1.1. Characteristics and Frequency of Self-Injury and its Functions

Of the participants (*N*=422) who participated in the study, 143 (33.88%) reported that they had engaged in self-injury at least once in their lifetime. The mean age at which the participants injured themselves for the first time was 15.16 (*SD*= 6.67).

Participants' responses to the ISAS were analysed to determine the characteristics of NSSI among self-injurers. The lifetime frequencies of NSSI behaviors reported by participants in the NSSI group are listed in Table 2. First three most commonly endorsed NSSI behavior as reported by participants was interfering with wound healing (*n*= 84, 58.74%), banging or hitting self (*n*= 64, 44.75%), biting (*n*= 37, 25.87%), and the least commonly endorsed behavior was burning (*n*= 6, 4.19%). As ordered in frequency, other reported NSSI behaviors were pulling hair (n = 33, 23.07%), cutting (*n*= 32, 22.37%), pinching (*n*= 32, 22.37%), carving (*n*= 28, 19.5%), sticking self with needles (*n*= 23, 16.08%), severe scratching (*n*= 23, 16.08%), swallowing dangerous substances (*n*=14, %9.79), and lastly rubbing skin against rough surface (*n*= 11, 7.69%).

Table 2. The frequency of self-injurious behaviors reported at least once in the study sample (*N* = 143).

SIBs	*N*	%
Interfering with wound healing	84	58.74
Banging or hitting self	64	44.75
Biting	37	25.87
Pulling hair	33	23.07
Cutting	32	22.37
Pinching	32	22.37
Carving	28	19.5
Sticking self with needles	23	16.08
Severe scratching	23	16.08
Swallowing dangerous substances	14	9.79
Rubbing skin against rough surface	11	7.69
Burning	6	4.19

Considering which methods were reported the most by male and female participants, it was found that women reported the most wound picking (*N*=42, 60.8%), and men reported the most hitting themselves (*N*= 22, 53.7%).

Participants of the self-injurers (*N*=143) reported that 38.5% (*N*=55) of them felt physical pain while injuring themselves, 21% (*N*=30) felt no physical pain, and 40.6% (*N*= 58) sometimes experienced pain. In addition, 56.6% (*N*= 81) of the participants reported that they were alone during self-injury whereas, 12.6% (*N*=18) reported that they were not alone, and 30.8% (*N*=44) reported that they were sometimes alone. Moreover, 51% (*N*=73) of the participants stated that they engaged in self-injurious behavior in the last year, 40% (58) stated that they engaged in SIBs between the last two years and ten years, and 8.4% (*N*=12) stated that they engaged in SIBs before the last ten years. Furthermore, 87.4% (*N*=125) of the participants said they injure themselves within the first hour after the urge to harm themselves, 9.8% (*N*=14) said they injure themselves 1 to 3 hours after the urge came, 0.7% (*N*=1) said s/he hurts him/herself 12 to 24 hours later and, 2.1% (*N*=3) reported that they injure themselves one day after the impulse. Lastly, while 80.4% (*N*=115) of the participants stated that

they wanted to end their self-injurious behaviors, the remaining 19.6% (*N*=28) stated that they did not want to end these behaviors.

Regarding the functions of NSSI, the most frequently reported function of NSSI was affect regulation (*N*= 128, 89.51%). After affect-regulation function, self-punishment (*N*= 102, 71.32%), and marking distress (*N*= 100, 69.93%) were other most frequently endorsed functions of NSSI. The least frequently endorsed function was bonding with peers (*N*= 19, 13.28%). Among individual items, the most commonly reported items were "calming myself down" (*N*= 104, 72.72%), "releasing emotional pressure that has built up inside of me" (*N*= 100, 69.93%), and "reducing anxiety, frustration, anger, or other overwhelming emotions" (*N*= 97, 67.83%) which together make up the affect regulation subscale of the ISAS. The least frequently endorsed items were "fitting in with others" (*N*= 7, 4.89%) and "amused myself or others by doing something extreme" (*N*= 9, 6.29%).

3.1.2. Descriptive Statistics of Study Variables

The mean, standard deviation, the minimum and the maximum values of the scores obtained from the scales assessing the behaviors of self-injury, functions of self-injury, psychological pain, false self perception, the certainty of reflective functioning, the uncertainty of RF, and the sub-dimensions of ISAS that are interpersonal and intrapersonal functions levels of the participants are presented in Table 3. The total number of samples is 143 as Functions of ISAS contains only the self-injurers while the total sample of the study (self-injurers and non-injurers) is 422.

Table 3. Descriptive Information of the Study Measures

Scales	***M***	***SD***	**Min.**	**Max.**
Behaviors of ISAS (N=422)	1.19	2.32	0	16
Functions of ISAS (N=143)	17.09	12.61	0	63
Psychache Scale (N=422)	27.29	12.30	13	65
False Self Perception (N=422)	38.20	9.71	16	77

Table 3 (continued). Descriptive Information of the Study Measures

Scales	***M***	***SD***	**Min.**	**Max.**
RFc (N=422)	27.83	13.92	0	73
RFu (N=422)	13.32	10	0	54
Intrapersonal Functions of ISAS (N=143)	7.69	7.15	0	35
Affect Regulation	2.99	1.89	0	6
Anti-suicide	.93	1.65	0	6
Marking distress	2.15	1.96	0	6
Self-punishment	2.13	1.92	0	6
Anti-dissociation	1.34	1.92	0	6
Interpersonal Functions of ISAS (N=143)	9.54	6.69	0	28
Interpersonal boundaries	.99	1.36	0	6
Interpersonal influence	.93	1.38	0	6
Revenge	1.20	1.36	0	6
Sensation Seeking	.74	1.15	0	4
Peer bonding	.29	.79	0	4
Toughness	1.39	1.75	0	6
Autonomy	.69	1.15	0	6
Self-care	1.46	1.39	0	6

Note. RFc: Reflective Functioning certainty, RFu: Reflective Functioning uncertainty, ISAS: Inventory of Statements About Self-Injury

3.2. The Difference Between Demographic Variables and Self-Injury Status

A series of chi-square analyses were conducted in order to explore the difference in self-injury status (among self-injurers and non-injurers). First, the relationship between gender, and self-injury status was analysed. The difference between males and females on self-injury status was not deemed significant, $\chi 2(1) =$

.10, p >.05. As for the education status on self-injury status, there was no significant difference either, $\chi 2(4) = 5.17$, p >.05. In addition, when the participants are group by marital status as married and single, the difference between these two groups on self-injury status was significant, $\chi 2\ (1) = 15.54$, p <.001. Last, as for psychological health problems (having a psychological disorder or not) and self-injury status, the difference was significant, $\chi 2\ (1) = 12.98$, p <.001.

As for NSSI behaviors, pulling hair was more common among women than men, $\chi 2(1, N= 143) = 3.83$, p <.05. For other NSSI behaviors, the interaction of gender and frequency of NSSI was not significant.

3.3. Correlation Among the Study Variables

3.3.1. Correlations between Self-Injury, Psychological Pain, False self, Hypomentalization and Hypermentalization

The Spearman Correlation Analysis results of the participants' self-injury, psychological pain, perception of the false self, reflective functioning uncertainty (RFu), and reflective functioning certainty (RFc) levels are provided in Table 4.

According to the results, there seems to be a positive and moderate correlation between psychological pain and self-injury, r= .51, p= .000, whereas the correlation between perception of the false self and self-injury positive one even though it was low, r= .24, p= .000. On the other hand, the results presented a positive and low correlation between RFu and self-injury, r= .16, p= .001, and no significant correlation between RFc and self-injury, r= -.08, p= .113.

Furthermore, there was a positive and low correlation between psychological pain and perception of false self levels, r= .38, p= .000, and between psychological pain and RFu, r=. 28, p= .000, while there was a negative and low correlation between psychological pain and RFc, r= -.23, p =.000.

The results also showed a positive and low level of correlation between perception of the false self and RFu, r= .35, p =.000, and negative and low correlation between perception of false self and RFc, r= -.39, p=.000.

Lastly, there was a negative and low level of correlation between RFu and RFc, r= -.35, p=.000.

Table 4. Spearman's Correlation Analysis Results for the Variables

	ISAS	PP	FS	RFu	RFc
ISAS	1				
PP	.51**	1			
FS	.24**	.38**	1		
RFu	.16**	.28**	.35**	1	
RFc	-.08	-.23**	-.39**	-.35**	1

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Note. ISAS: Inventory of Statements About Self-Injury, FS: False self, RFu: Reflective Functioning uncertainty, RFc: Reflective Functioning certainty, PP: Psychological Pain

3.3.2. Correlations between Psychological Pain and Functions of Self-Injury

The Pearson Correlation Analysis was conducted to investigate the correlation between participants' level of psychological pain and functions of self-injury.

According to the results there was a positive and moderate correlation between psychological pain and marking distress (r= .46, p= .000), self-punishment (r= .46, p= .000), and anti-suicide (r= .41, p=.000).

Additionally, there was a statistically positive and low correlation between psychological pain and affect regulation (r= .32, p= .000), interpersonal boundaries (r= .26, p= 002), self-care (r= .22, p= .010), anti-dissociation (r= .38, p= .000), interpersonal influence (r= .36, p= .000), autonomy (r= .23, p= .007), and revenge (r= .32, p= .000).

No significant relationship was found between psychological pain and sensation seeking (r= -.01, p= .934), peer bonding (r= .08, p= .374), and toughness (r= .15, p= .082).

3.4. T-Test Comparisons of Self-Injurers and Non-Injurers

Firstly, an independent samples t-test was carried out to compare self-injurers and non-injurers on age. Self-injurers (M = 29.97, SD = 8.97) were younger than non-

injurers (M = 36.13, SD = 11.16), and the difference between those was significant, $t(346) = -6.13$, p=.000.

Secondly, another independent sample t-test was conducted to examine whether the levels of psychological pain, perception of the false self, RF certainty, and RF uncertainty were significantly different in self-injury status. As shown in Table 5, self-injurers have higher psychological pain level (M = 36.59, SE = 1.13), than non-injurers (M = 22.53, SE = .50) and the difference was also significant $t(199)$= 11.39, p= .000. Moreover, self-injurers seem to have a higher perception of false self level (M= 41.01, SE= .79), than non-injurers (M= 36.77, SE= .57). The difference between them was also significant, $t(420)$= 4.33, p=.000. In addition, self-injurers have a higher RF uncertainty level (M= 15.22, SE= .90), than non-injurers (M= 12.35, SE= .57). This difference was a significant one as well, $t(420)$= 2.81, p=.005. Lastly, there was no significant difference between self-injury status and RF certainty, $t(420)$= -1.91, p=.057.

Table 5. Independent Sample T-Test Variables with Self-Injury Status

	Group	*N*	Mean	SD	*t*	*df*	*p*
Age	Self-injurers	143	29.97	8.97	-6.13	346	.000**
	Non-injurers	279	36.13	11.16			
Psychological Pain	Self-injurers	143	36.59	13.502	11.391	199	.000**
	Non-injurers	279	22.53	8.304			
Perception of False self	Self-injurers	143	41.01	9.462	4.330	420	.000**
	Non-injurers	279	36.77	9.540			
RF uncertainty	Self-injurers	143	15.22	10.720	2.807	420	.005*
	Non-injurers	279	12.35	9.495			
RF certainty	Self-injurers	143	26.04	13.020	-1.909	420	.057
	Non-injurers	279	28.76	14.300			

**p<0.01, *p<0.05

Lastly, a paired sample test was conducted to compare self-injurers' scores on interpersonal and intrapersonal functions. Because of the different item numbers in these dimensions, the average scores were computed by dividing each dimensions' total score by the number of items. As a result, it was discovered that self-injurers

reported intrapersonal (M = 1.90, SD= 1.33) functions more frequently than interpersonal functions, and this difference was significant (M = .94, SD= .87), $t(142)$= 11.90, p= .000.

3.5. Regression Analysis to Assess the Predictors of Self-Injury

In order to assess the prediction of engaging in SIBs by using variables that are gender as a categorical variable and psychological pain, perception of the false self, RF certainty, and RF uncertainty, a binary logistic regression analysis was performed with engaging or not engaging in self-injury entered as the binary dependent variable. When the variables were added, it was noted that the model was statistically significant to predict the presence of self-injury, $\chi 2(5) = 134.23$, $p < .001$, Nagelkerke R2= .38. Hosmer and Lemeshow test showed that the observed model matched the expected model, $\chi 2(8) = 21.49$, $p = .006$. When all of the predictors were included in the equation, the overall correct classification rate was 80.1%. Based on the Wald criterion, psychological pain significantly predicted participants' self-injury status, Wald(1) = 76.14, $p < .000$. As the participants' psychological pain increased, their probability of engaging in self-injury also increased.

Table 6. Logistic Regression Analysis of Self-Injury Status

	B	Wald	Odds Ratio Exp(B)	95% CI Lower	95% CI Upper
FS	.002	.021	1.002	.963	1.044
PP	.117	76.139	1.124*	1.095	1.044
RFu	-.011	.624	.989	.962	1.017
RFc	-.001	.010	.999	.979	1.019
Gender	.387	1.900	1.472	.849	2.551
Constant	-4.001	33.937	.018		

*p<.001

Note. FS: False self, PP: Psychological Pain, RFu: Reflective Functioning uncertainty, RFc: Reflective Functioning certainty.

CHAPTER 4: DISCUSSION

4.1. Discussion of The Main Findings

4.1.1. Characteristics of Self-Injury

In this section, the frequency of self-injury and the methods used, the comparisons between self-injurers and non-injurers regarding age, gender, marital status, educational status, and the frequency of functions of self-injury will be discussed with references to the literature.

4.1.1.1. Frequency of Self-Injury

In this study, 33.88% of the participants stated that they had engaged in self-injury once or several times in their lives. Hasking et al. (2008) found in their study with young adults that 43.6% of the participants reported that they practiced self-injury one or more times in their lives. Moreover, while Andover (2014) found 23% of self-injurers in his study with adults, de Klerk et al. (2011) found this rate to be 55% in adults. The study of de Klerk et al. (2011) was the only research that found in the literature conducted between the ages of 18-65 so far. However, this study was conducted in the Netherlands. For this reason, there might be cultural differences between our study and de Klerk et al.'s (2011) study. Moreover, other studies have mainly been conducted with adolescents or young adults (e.g., Oktan, 2014; Hasking et al., 2008; Andover et al., 2010). To conclude, the frequency of self-injury in this study is comparably high as in other studies.

4.1.1.2. Age of Self-injurers

In this study, the mean age at which the participants injured themselves for the first time was 15.16. While Zetterqvist et al. (2013) found the average age of onset to be 13.9, Heath et al. (2008) stated that the age of onset is between 13 and 15 years old. Our results are very similar to the literature in the context of age. Friedman et al. (1972) explain the onset of self-injurious behavior in adolescence with the psychoanalytic view of the revival of oedipal issues. Accordingly, sexual fantasies and accompanying aggressive impulses have reached a level that adolescents cannot bear, and adolescents who cannot bear this burden engaged in self-injurious behavior. In this way, they try to destroy or purify their bodies apart from themselves.

Moreover, in this study, self-injurers' age (*M*= 29.97, *SD*= 8.97) was younger than non-injurers (*M*= 36.13, *SD*= 11.16). There are similar pieces of evidence that those self-injurers are younger than non-injurers (de Klerk. et al., 2011; Kahraman and Çankaya, 2020). Similarly, Klonsky (2011) revealed that 30-year-olds engage in significantly more self-injury compared to older people.

4.1.1.3. Methods of Self-Injury

In this study, the most used self-injury methods by the participants were interfering with wound healing, banging or hitting self, and biting, respectively, while the least applied method was burning. Similarly, Kahraman and Çankaya (2020) reported the most applied method in the Turkish population as hitting self in their study. Oktan (2014) found that the most applied methods are interfering with wound healing and hitting self. In line with these findings, it is noteworthy that the most common methods are from compulsive self-injurious behaviors (Menninger, 1938). There may be a possibility that the reason for these compulsive self-injurious behaviors can be encountered in individuals without a pathological disorder. (Favazza, DeRosear and Conterio, 1989).

On the other hand, many studies have reported cutting as the most applied method in the literature (Ross and Heath, 2002; Hasking et al., 2008). In this study, the number of people using the cutting was the fifth method (N=32, 22.37%). This situation might be due to the relatively small number of pathological groups in this study. In contrast, the severity of cutting is much higher than interfering with wound healing, banging or hitting self, and biting methods. Considering this situation, the frequency distributions of the methods were made separately. However, if people are interfering with wound healing without the intention of harming themselves, they may have reported in the questionnaire as well. They may have misunderstood the scale and responded to it in this way. In addition, burning was the least used method. Burning is one of the most severe methods, and the number of participants with psychopathology is relatively low.

4.1.1.4. Sex Differences in Self-Injurers

In this study, no difference was found between males and females in terms of self-injury status. While some of the findings in the literature report that women

engage more than men in self-injury (Ross and Heath, 2002; Sornberger et al., 2012), some report that there is no difference between the genders (Bresin and Schoenleber, 2015; Hasking et al., 2008). There was no difference in this study because both men and women may use the functions of the NSSI in some way (Bresin and Schoenleber, 2015).

Pulling hair was applied significantly more among women than men. According to Zoroğlu et al. (2003) reached the same conclusion in their study on the Turkish population. However self-injurious cutting is more common among women than men in the literature (see Andover et al., 2010; Bresin and Schoenleber, 2015). In this study, no difference was found between other methods, but it was revealed in the literature that there is a difference in terms of gender among other methods (Andover et al., 2010; Sornberger et al., 2012). On the other hand, in this study, while men reported that they mainly used the method of hitting themselves, women reported that they used the method of wound picking most. Although the differences in the methods used between the genders are not yet fully understood, it is thought that it reflects the gender difference in the chosen suicidal behaviors (Andover et al., 2010). Specific suicide methods are more likely to be perceived as "masculine" or "feminine" (McAndrew and Garrison, 2007). McAndrew and Garrison (2007) suggested that men's suicide methods are more lethal, such as shooting oneself or hanging, while women's methods are slitting wrists or overdosing.

Hawton, Zahl and Weatherall (2003) revealed that the self-injury method used by individuals and the suicide method is similar in their long-term follow-up study. Since this study was conducted between 18-65, this finding may differ from the literature. On the other hand, studies that found differences in the methods used between the genders included cutting precisely for women and hitting oneself for men, study with adolescents and young adults in general.

4.1.1.5. Educational & Marital Status in Self-Injurers

In this study, there was no difference in education status between self-injurers and non-injurers. Similarly, Hasking et al. (2008) found no difference between the two groups regarding education status. Our education status variable consisted of 6 categories (literate, elementary school, high school, bachelor's degree, master's degree, and doctoral degree), so no difference could be found. There are findings in the literature that self-injurers are associated with lower education (de Klerk et al., 2011).

Kapur et al. (2006) reported that social disadvantages such as low education were associated with suicide attempts. Accordingly, low education may also be a risk factor for self-injury.

Moreover, in this study, single participants were higher rates of self-injury than married participants. Stack (1990), reviewed that unmarried people have higher suicide rates than married ones. Considering the relationship between suicide and self-injury, it seems felicitous that single participants report higher self-injury than married.

4.1.1.6. Psychological health problems in Self-Injurers

In this study, having psychological health problems was higher in self-injurers. Comparably, de Klerk et al. (2011) found that self-injury was positively associated with general psychopathology. In addition, Hasking et al. (2008) reported that self-injurers experienced more psychological distress than non-injurers. It can be said that those with psychological disorders engage in self-injury to cope with the overwhelming emotions they experience due to their inability to use healthy coping mechanisms.

4.1.1.7. Functions of Self-Injury

In this study, the participants' most reported function of self-injury was "affect regulation," in line with the literature (Nock and Prinstein, 2004; Zetterqvist et al., 2013). Affect regulation is followed by self-punishment and marking distress. Taylor et al. (2018) found in their meta-analysis that the most prominent self-injury function was affect regulation, but marking distress and self-punishment were also widely reported. According to affect regulation model, individuals engage in self-injurious behaviors to express, concrete, and manage their bothering emotions. This relief from overwhelming emotions may be provided by the endorphins released during self-injury (Chapman, Gratz, Brown, 2006). On the other hand, the self-punishment function is associated with a learned form of self-abuse with a repeated abuse history (Nock, 2009). The function of marking distress has meanings such as leaving a sign that the person feels very bad, revealing the reality of psychological pain, and making sense of the stress experienced.

As the result of this study, other studies reported that intrapersonal functions were reported more than interpersonal functions (Taylor et al., 2018; Lindholm,

Bjärehed, Lundh, 2011; Klonsky and Glenn, 2009). Moreover, intrapersonal functions (including affect regulation, anti-suicide, marking distress, self-punishment, anti-dissociation) were reported more than interpersonal functions (interpersonal boundaries, interpersonal influence, peer bonding, revenge, self-care, autonomy, toughness, sensation seeking). While interpersonal functions refer to situations where self-injury is socially reinforced, intrapersonal functions refer to situations where reinforcement is self-focus. In this case, it is more critical for self-injurers that the reason they engage in self-injury works with an internal mechanism rather than an interpersonal reinforcement.

4.1.2. Correlations between Self-Injury and Study Variables (Psychological Pain, False self, Hypomentalization, and Hypermentalization)

This section will discuss the relationship between self-injury and psychological pain, perception of the false self, hypomentalization, and hypermentalization.

In the present study, a positive and moderate relationship was found between self-injury and psychological pain. Considering suicidal behavior, which is the expected result of psychological pain (Shneidman, 1993), and self-injury (Wilkinson et al., 2011), the result of the current study is meaningful. Nahaliel et al. (2014) revealed that self-injury directly affects suicidal tendencies, while psychological pain has a mediating role. These findings are also compatible with the "marking distress" function of self-injury. Psychological pain, which is inner pain, is transformed into a concrete expression and directs individuals to self-injury. In addition, the feeling of guilt is a common emotion by individuals who suffer psychological pain and who engage in self-injury. While self-injured individuals engage in it because they feel guilty, they also feel guilty for engaging in self-injury (Klonsky, 2009). This could be both a cause and a consequence of their psychological pain. In addition, the feeling of emptiness is also present in both self-injurers and those who suffer psychological pain. In conclusion, these findings support the results of the current study.

This study revealed a low and positive relationship between self-injury and perception of the false self. There are no studies in the literature investigating these two concepts directly. It is thought that the reason for this result is suicidal behavior, which is the common point of the concepts of self-injury (Klonsky, 2007) and false self (Winnicott, 1960). This finding may support that there is at least a low association between self-injury and perception of the false self.

There are few studies in the literature that directly investigate the relationship between self-injury and capacity of mentalization. The current study found that while there was a low and positive relationship between self-injury and hypomentalization (RFu), there was no significant relationship between self-injury and hypermentalization (RFc). Fonagy et al. (2016) found the uncertainty subscale of RFQ (RFu) to be highly associated with self-injury and explained that it was not associated with certainty (RFc). Since RFc was negatively associated with caseness, individuals who are hypermentalizing may not engage in self-injury. Moreover, RFu outperformed RFc in diagnosing borderline personality disorder and identifying personality traits (Fonagy et al., 2016). These studies also show that being too certain about one's own and others' mental states is not always associated with impairments, but being too uncertain is associated.

4.1.3. Differences in Self-Injury Status in Study Variables

In this section, how self-injurers and non-injurers differ in terms of psychological pain, perception of the false self, hypomentalization, and hypermentalization will be discussed in the context of the literature.

Holden, Campos and Lambert (2020) reported that self-injurers are in great psychological pain due to their study with 2474 university students. The findings revealed that self-injurers higher level of psychological pain than non-injurers. Moreover, According to Orbach's (2009) term *suicidal body*, the suicidal body must transform the unendurable psychological pain into self-injury. Individuals in psychological pain are at risk of suicide (Shneidman, 1993), and some self-injurers stated that they engage in self-injury to prevent their suicidal ideation (Klonsky and Muehkenkamp, 2007). The finding that self-injurers suffer more psychological pain than non-injurers is consistent with the literature.

Self-injurers were found to have a high level of perception of the false self. While depression is primarily seen in self-injurers (Klonsky, Oltmanns and Turkheimer, 2003), it has been revealed that individuals with false self also have depressive symptoms (Harter et al., 1996; Weir and Jose, 2010). In addition, it was revealed by Winnicott (1960) that individuals with false self are more prone to suicide because they cannot cope with the feeling of emptiness and different selves within them. These findings support those self-injurers are at a higher level of perception of the false self than non-injurers.

It was revealed that self-injurers had significantly higher hypomentalization (RFu) scores than non-injurers but not for hypermentalization (RFc). In the study of Badoud et al. (2015) with 253 adults, 51 adults (30 women, 21 men) reported a history of self-injury. In this sample, they found that the presence of self-injury and RFu and RFc were associated. Fonagy et al. (2016) explained that the participants, who stated that they were too certain about their own or others mental states, tended to perceive themselves as good-mentalizers. The responses of these individuals to the self-report scale (RFQ-54) may be biased by their tendency to perceive themselves as genuine mentalizers. In conclusion, while our findings reveal that hypermentalization may not always be associated with an impairment, it may also be related to the biased responses of the participants.

4.1.4. Correlations between Psychological Pain and Functions of Self-Injury

In this section, the functions of self-injury, which are most closely related to psychological pain, will be discussed.

A positive and moderate relationship was found between psychological pain and functions of "marking distress," "self-punishment," and "anti-suicide." By definition, psychological pain is expressed as feeling distressed, soreness, anguish in the mind (Shneidman, 1993). It is understood that those who suffer psychological pain symbolize these internal feelings by causing harm to themselves. In this way, they can see the pain with scars or blood. In addition, individuals who suffer psychological pain often feel extreme shame and guilt (Shneidman, 1993). These feelings that they feel about themselves lead to punishing themselves by engaging in self-injury. Moreover, psychological pain leads to suicide (Orbach et al., 2003a) since this pain is unbearable. These individuals try to prevent suicide by engaging in self-injury. In this way, the death phantasies averted by uncovering injuries on the body tissues.

4.1.5. Predictors of Self-Injury

In this study, while psychological pain was predicted self-injury; gender, perception of the false self, hypomentalization, and hypermentalization were not predicted to self-injury.

Only one study has been found in the literature investigating whether psychological pain predicts self-injury. According to the study conducted by Holden,

Campos and Lambert (2020), psychological pain was a significant predictor of engaging in self-injury. In addition, a moderate and positive relationship was found between psychological pain and self-injury. In contrast, a low relationship between perception of the false self and hypomentalization and self-injury and the absence of a relationship between hypermentalization and self-injury supports this finding. It can be said that psychological suffering may be sufficient for engaging in self-injury, but having an impairment in mentalization capacity or having a perception of the false self is not sufficient for engaging in self-injury.

4.2. Limitations and Recommendations for Future Studies

In this section, the limitations of this research will be discussed, and suggestions for future research will be made.

One of the limitations of this research is that since it was conducted during the Covid-19 period, the data were collected online, and the conditions under which the participants filled the scales are not known. Moreover, the sample structure revealed some limitations. The number of female participants is much higher than that of males, and non-injurers outnumber self-injurers. Furthermore, this study was cross-sectional, causing the results not to reflect the cause-effect relationship between NSSI-related factors. In order to prevent this limitation, individuals who reported that they practiced self-injury a long time ago but no longer engage in it were asked to respond according to the time they engaged in self-injury when filling out the psychological pain scale. However, due to the passage of time, participants may not have been able to give accurate answers while answering psychological pain questions. The scarcity of longitudinal studies in NSSI research is noteworthy, and longitudinal studies are recommended for future studies to address this critical gap. Another limitation is that the scales are self-reported, and participants may have made biased statements.

In the Inventory of Statements About Self-Injury Scale (ISAS), some of the participants who reported that they harmed themselves wrote in the additional notes section of the questionnaire that "I did not do these behaviors to harm myself.". The statement above shows that the participants filled out the questionnaire without adequately understanding the concept of self-injury. Moreover, in this scale, participants were asked how many times they used each self-injury method in their lives or at what age they injured themselves for the first time. These questions were difficult for the participants to remember, and most of them made statements such as

"I don't remember.". In addition, in this study, whether the participants had psychological disorders were asked only with a question in the Personal Information Questionnaire. Fifty-five participants reported that they had a psychological disorder. Conducting this study with clinical and non-clinical samples will lead to different and essential results. In addition, the measurement tools used for studies in this field differ and the self-injury methods included in the scales may differ. An important area for future studies may be to be conducted according to the NSSI criteria of DSM-5, in terms of obtaining more common and associate literature.

Another recommendation for future studies is to study the meanings of preferred self-injury methods. For example, it may be a difference in certain aspects between those who prefer to cut themselves and those who prefer to burn themselves.

Considering that psychological pain is associated with the loss of a loved one (Freud, 1917; Looser, 2000), evaluating the *grief* experienced by individuals may lead to important results regarding the relationship between self-injury and psychological pain for future studies.

The mediator variable effect could not be examined due to the non-normal distribution of ISAS. Examining the mediating variable effect of the concepts of the false self, hypomentalization, and hypermentalization may reveal valuable results. In addition, adding the concepts of affect regulation and suicide, which are thought to be closely related to the variables of the study, will lead to a more comprehensive and detailed result. The submitting recommendation based on the results revealed that false self and hypomentalization are associated with self-injury and psychological pain is that more comprehensive studies should be conducted to support these relationships. Moreover, as this study disclosed, self-injury is more observed in adolescence and young adulthood than in older ages. Given that relationship between age and self-injury is not fully understood, a recommendation is for future studies to conduct more research on this neglected area. Furthermore, the functions of self-injury that reveal the needs of individuals have been mentioned; the suggestion is that the treatments or prevention programs can be shaped by evaluating the functions of NSSI.

CHAPTER 5: CONCLUSION

5.1. Conclusion

Given its prevalence among adolescents and young adults, self-injury is a vital area to research. The findings of this study revealed that self-injury is very common, beginning very early and continuing into young adulthood. Self-injurers reported that they mainly engage in this to regulate their overwhelming affects. In addition, they widely reported that they engage in this to punish themselves and embody the stress they experienced. Furthermore, it has been shown that self-injurers suffer more psychological pain than non-injurers, and this is an important finding when considering its relation to suicide.

Self-injurers with suffering psychological pain reported that they engage in self-injury to express their distress, punish themselves and prevent their suicide ideas and attempts. In addition, it was revealed that self-injurers have higher false self-perceptions and lower mentalization capacities. No relationship was found between hypermentalization, another impairment of mentalization capacity, and self-injury. Lastly, it has been revealed that psychological pain predicts self-injury. Overall, more studies are needed to understand better self-injury, which has a very complex structure, and to point out its importance in our population.

5.2. Implications

This study was conducted online with participants from many parts of Turkey. Considering that self-injury is mainly studied with adolescents in the literature, it was carried out with participants between the ages of 18-65. In addition, the number of studies examining these concepts in Turkish society is relatively low. The results presented are essential in terms of these deficiencies in the literature. The prevalence of self-injury in this population was revealed, and the reasons for participants' self-injury were revealed and shed light on clinical interventions.

Furthermore, there are no study has been found directly investigating the relationship between self-injury and false self. In this sense, this study contributed to the literature by revealing a relationship between two concepts. In addition, while there was a relationship between being too uncertain about own and other's mental states and self-injury, no relationship could be found between being too certain. The overall results pointed out that hypermentalization does not always indicate an impairment. Lastly, it

is an essential finding for self-injurers that psychological pain predicts self-injury. With the addition of false self and mentalization concepts, contributions have been made to research and clinical practice.

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APPENDICIES

APPENDIX A: ETHICS COMITTEE APPROVAL

SAYI : B.30.2.İEÜ.0.05.05-**020**-*132* 28.04.2021

KONU : Etik Kurul Kararı hk.

Sayın Büşra Gülsün,

"An Investigation of the Non-suicidal Self-injury in the context of Psychological Pain, Mentalization, and False Self" başlıklı projenizin etik uygunluğu konusundaki başvurunuz sonuçlanmıştır.

Etik Kurulumuz 19.04.2021 tarihinde sizin başvurunuzun da içinde bulunduğu bir gündemle toplanmış ve projenin incelenmesi için bir alt komisyon oluşturmuştur. Projenizin detayları alt komisyon üyelerine gönderilerek görüş istenmiştir. Üyelerden gelen raporlar doğrultusunda Etik Kurul 28.04.2021 tarihinde tekrar toplanmış ve raporları gözden geçirmiştir.

Sonuçta 28.04.2021 tarihinde **"An Investigation of the Non-suicidal Self-injury in the context of Psychological Pain, Mentalization, and False Self"** konulu projenizin etik açıdan uygun olduğuna oy birliğiyle ile karar verilmiştir.

Gereği için bilgilerinize sunarım.

Saygılarımla,

[redacted]

Prof. Dr. Murat Bengisu

Etik Kurul Başkanı

APPENDIX B: INFORM CONSENT FORM

SAYIN KATILIMCI,

Bu çalışma, İzmir Ekonomi Üniversitesi Klinik Psikoloji Yüksek Lisans programı kapsamında, Prof. Dr. Falih KÖKSAL danışmanlığında, Büşra Gülsün tarafından hazırlanan bir tez çalışmasıdır. Bu araştırmanın amacı; kendine zarar verme davranışını incelemektir.

Çalışma yaklaşık olarak 20 dakika sürecektir. Çalışmaya katılabilmeniz için 18- 65 yaş arasında olmanız gerekmektedir.

Bu çalışmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Çalışmaya katılmama veya katıldıktan sonra herhangi bir anda çalışmadan çıkma hakkına sahipsiniz. Çalışma yürütülürken sizden hiçbir kimlik bilgisi talep edilmeyecektir. Cevaplarınız gizli tutulacak, yalnızca araştırmacı tarafından değerlendirilecektir.

Ölçeklerden elde edilen sonuçlar, yalnızca bilimsel amaçlar doğrultusunda kullanılacaktır. Ölçeklerde bulunan sorulara vereceğiniz yanıtların doğruluğu, araştırmanın niteliği açısından oldukça önemlidir. Lütfen her bir ölçeğin yönergesini dikkatli okuyunuz ve sorulara sizi en iyi ifade eden cevabı vermeye çalışınız.

Katılımınız için teşekkürler.

Herhangi bir soru ya da sorun bildirmek için Büşra Gülsün (busragulsun7@gmail.com) ile iletişime geçebilirsiniz.

Bu çalışmaya tamamen gönüllü olarak katılmayı ve verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum.

- Evet
- Hayır

APPENDIX C: PERSONAL INFORMATION QUESTIONNAIRE

Bu bölümdeki sorulara size uygunluğuna göre cevap veriniz.

Yaşınız: ……

Cinsiyetiniz:

- Kadın
- Erkek
- Diğer

Eğitim Seviyeniz:

- Okur-yazar
- İlkokul
- Lise
- Üniversite
- Yüksek Lisans
- Doktora
- Diğer

Medeni Durum:

- Evli
- Bekar (hiç evlenmemiş)
- Bekar (boşanmış)
- Bekar (eşi vefat etmiş)

Anne & Baba:

- Birlikte
- Boşanmış
- Boşandılar birlikte yaşıyorlar
- Boşanmadılar ayrı yaşıyorlar
- Anne ve/veya babamı kaybettim

Çalışma durumu:

- Çalışıyor
- Çalışmıyor
- Emekli

Meslek: ……

Herhangi bir kronik/fiziksel rahatsızlığınız var mı?

- Evet
- Hayır

Cevabınız evet ise fiziksel rahatsızlığınızı açıklayınız: …….

Herhangi bir psikolojik rahatsızlığınız var mı?

- Evet
- Hayır

Cevabınız evet ise psikolojik rahatsızlığınızı açıklayınız: ……

Düzenli kullandığınız psikiyatrik ilaç var mı?

- Evet
- Hayır

Cevabınız evet ise ilaçlarınızın adını yazınız: ……

APPENDIX D: INVENTORY OF STATEMENTS ABOUT SELF-INJURY

BÖLÜM I: DAVRANIŞLAR

Aşağıdaki anket çeşitli kendini yaralama davranışlarını sorgulamaktadır. Lütfen yalnızca belirtilen davranışı **kasıtlı olarak (isteyerek, amaçlı)** ve **intihar amacı olmaksızın** gerçekleştirmiş iseniz işaretleyiniz.

1.Lütfen aşağıdaki maddeleri kasıtlı olarak yaşamınız boyunca kaç kez yaptığınızı belirtiniz (0, 5, 10, 100 vb.):

Kesme	…….	Tırnaklama (deriyi kanatacak kadar)	……..
Isırma	…….	Kendini sert bir yere çarpma veya kendine vurma	……..
Yakma	…….	Yaranın iyileşmesine engel olma (ör: kabuklarını koparma)	…….
Cilde bir harf/yazı şekil kazıma	…….	Cildi sert bir yüzeye sürtme	……..
Çimdikleme	…….	Kendine iğne batırma	……..
Saç kopartma (kökünden)	…….	Tehlikeli/zararlı madde içme/ yutma	……..
		Diğer	…….

****

Önemli: Eğer yukarıda belirtilen davranışlardan bir ya da daha fazlasını gerçekleştirmiş iseniz anketin kalan kısmını doldurunuz. Eğer belirtilen

davranışlardan hiç birisini gerçekleştirmemiş iseniz anketin kalan kısmını doldurmayınız ve bir sonraki ankete geçiniz.

****

2.Eğer temel bir kendine zarar verme davranışınız varsa birinci sayfadaki bu tür davranış (lar)ı daire içine alınız.

3.Hangi yaşta?

İlk kez kendinize zarar verdiniz? .....

En son ne zaman kendinize zarar verdiniz? (yaklaşık gün/ay/yıl) …….

4.Kendinize zarar verme davranışı sırasında fiziksel acı hisseder misiniz?

Lütfen daire içine alınız EVET BAZEN HAYIR

5.Kendinize zarar verme davranışı sırasında yalnız mı olursunuz?

Lütfen daire içine alınız EVET BAZEN HAYIR

6.Tipik olarak kendinize zarar verme dürtüsü oluştuktan ne kadar süre sonra eylemi gerçekleştirirsiniz?

Lütfen daire içine alınız

<1 saat	1-3 saat	3-6 saat
6-12 saat	12-24 saat	>1gün

7.Kendinize zarar verme davranışınızı sona erdirmek ister misiniz / istediniz mi?

Lütfen daire içine alınız EVET HAYIR

BÖLÜM II: İŞLEVLER

Yönerge:

Bu anket intihar amaçlı olamayan kendine zarar verme davranışı deneyimini daha iyi anlamamızı sağlamaya yönelik oluşturulmuştur. Aşağıda sizin kendinize zarar verme deneyiminizle ilişkili olabilecek ya da olmayabilecek durumlar bir liste olarak verilmiştir. Lütfen sizin için en uygun olan durumları belirleyiniz.

- Belirtilen durum size **hiç uygun değilse** "0" işaretleyiniz
- Belirtilen durum size **kısmen uygunsa** "1" işaretleyiniz
- Belirtilen durum size **çok uygunsa** "2" işaretleyiniz

"Kendime zarar verdiğimde, …	**Yanıt**		
1…. kendimi sakinleşmiş hissederim	0	1	2
2…. kendim ve başkaları arasında sınır çizmiş olurum	0	1	2
3…. kendimi cezalandırmış olurum	0	1	2
4… kendime özen göstermek için bir yol bulmuş olurum (yaramla ilgilenerek)	0	1	2
5… uyuşukluk hissinden kurtulmak için acı oluşturmuş olurum	0	1	2
6…. intihar girişimi dürtümden kaçınmış olurum	0	1	2
7…. heyecan ve coşku yaşatan bir şey yapmış olurum	0	1	2
8…. akranlarımla aramda bir bağ kurulmuş olur	0	1	2
9…. başkalarının hissettiğim duygusal acının boyutunu anlamalarını sağlamış olurum	0	1	2

10… acıya dayanıklılığımı görmüş olurum	0	1	2
11… kendimi berbat hissettiğime dair bir işaret bırakmış olurum	0	1	2
12… birisinden hıncımı çıkartmış olurum	0	1	2
13… kendi kendime yeterliliğimi kanıtlamış olurum	0	1	2
14… içimde biriken duygusal baskıdan kurtulmuş olurum	0	1	2
15… başkalarından ayrı olduğumu göstermiş olurum	0	1	2
16… değersiz veya akılsızlığımdan dolayı kendime duyduğum öfkeyi göstermiş olurum	0	1	2
17… duygusal stresime kıyasla baş etmesi daha kolay olan bir fiziksel yara yaratmış olurum	0	1	2
18… fiziksel acı bile olsa bir şeyler hissetmiş olurum (hiçbir şey hissetmemektense)	0	1	2
19… İntihar düşüncelerime gerçekten intihar girişiminde bulunmak yerine başka şekilde yanıt vermiş olurum	0	1	2
20… uç bir şey yaparak kendimi veya başkalarını eğlendirmiş olurum	0	1	2
21… başkalarına uyum sağlamış olurum	0	1	2
22… başkalarından ilgi ya da yardım istemiş olurum	0	1	2
23… güçlü veya dayanıklı olduğumu göstermiş olurum	0	1	2
24… duygusal acımın gerçekliğini kendime göstermiş olurum	0	1	2
25… başkalarından intikam almış olurum	0	1	2
26… başkalarının yardımına bel bağlamadığımı göstermiş olurum	0	1	2

“Kendime zarar verdiğimde, …	**Yanıt**		
27… kaygı, hüsran, öfke ve diğer bunaltıcı hislerim hafiflemiş olur	0	1	2
28… kendim ve başkaları arasında bariyer inşa etmiş olurum	0	1	2
29… kendimden hoşnut olmamam ya da kendimden iğrenmeme bir yanıt vermiş olurum	0	1	2

30… kendimi yaramın iyileşmesine odaklarım, bu; benim için sevindirici ya da tatmin edici olabilir	0	1	2
31… kendimi gerçek hissetmediğimde hala hayatta olduğumdan emin olmuş olurum	0	1	2
32… intihar düşüncelerimi sonlandırmış olurum	0	1	2
33… sınırlarımı zorlamış olurum (paraşütle atlamak ya da uçta bir şey yapmak gibi	0	1	2
34… arkadaşlarım ve sevdiklerimle aramda bir dostluk ya da akrabalık bağı simgesi oluşturmuş olurum	0	1	2
35… sevdiğim birinin benden ayrılmasına ya da beni terk etmesine engel olmuş olurum	0	1	2
36… fiziksel acıya katlanabileceğimi kanıtlamış olurum	0	1	2
37… yaşadığım duygusal stresi anlamlandırmış olurum	0	1	2
38… bana yakın birini incitmeye çalışmış olurum	0	1	2
39… özerkliğimi / bağımsızlığımı ortaya koymuş olurum	0	1	2

(İsteğe bağlı) Aşağıdaki boşluğa, sizin için yukarıda sıralanmış olanlardan daha doğru durumlar var ise bir liste halinde yazınız:

(İsteğe bağlı) Aşağıdaki boşluğa, size uymasa bile yukarıda sıralanmış olanlara eklenmesi gerektiğini düşündüğünüz durumlar var ise bir liste halinde yazınız:

APPENDIX E: PSYCHOLOGICAL PAIN SCALE

Aşağıdaki ifadeler fiziksel/bedensel DEĞİL psikolojik acınızla ilgilidir.

Lütfen uygun sayıyı daire içine alarak aşağıdakilerin her birinin hangi sıklıkla ortaya çıktığını belirtiniz.

1: Asla 2: Bazen 3: Sıklıkla 4: Çok sık 5: Her zaman

1. Psikolojik acı hissediyorum

1: Asla 2: Bazen 3: Sıklıkla 4: Çok sık 5: Her zaman

2. Acıyı içimde hissediyorum

1: Asla 2: Bazen 3: Sıklıkla 4: Çok sık 5: Her zaman

3.Psikolojik acım herhangi bir fiziksel/bedensel acıdan daha çok canımı acıtıyor

1: Asla 2: Bazen 3: Sıklıkla 4: Çok sık 5: Her zaman

4. Acım, çığlık atma isteği uyandırıyor

1: Asla 2: Bazen 3: Sıklıkla 4: Çok sık 5: Her zaman

5. Acım, hayatımın kapkara görünmesine neden oluyor

1: Asla 2: Bazen 3: Sıklıkla 4: Çok sık 5: Her zaman

6. Neden acı çektiğimi anlayamıyorum

1: Asla 2: Bazen 3: Sıklıkla 4: Çok sık 5: Her zaman

7. Psikolojik olarak kendimi berbat hissediyorum

1: Asla 2: Bazen 3: Sıklıkla 4: Çok sık 5: Her zaman

8. Kendimi boşlukta hissettiğim için canım acıyor

1: Asla 2: Bazen 3: Sıklıkla 4: Çok sık 5: Her zaman

9. Ruhum acıyor

1: Asla 2: Bazen 3: Sıklıkla 4: Çok sık 5: Her zaman

Lütfen belirtilen şekilde aşağıdaki soruları cevaplayarak ölçeği doldurmaya devam ediniz

1.Kesinlikle katılmıyorum 2.Katılmıyorum 3.Emin değilim 4.Katılıyorum 5.Kesinlikle katılıyorum

10. Artık acıma katlanamıyorum

1.Kesinlikle katılmıyorum 2.Katılmıyorum 3.Emin değilim 4.Katılıyorum 5.Kesinlikle katılıyorum

11. Acımdan dolayı, dayanılmaz durumdayım

1.Kesinlikle katılmıyorum 2.Katılmıyorum 3.Emin değilim 4.Katılıyorum 5.Kesinlikle katılıyorum

12. Acımdan dolayı paramparçayım

1.Kesinlikle katılmıyorum 2.Katılmıyorum 3.Emin değilim 4.Katılıyorum 5.Kesinlikle katılıyorum

13. Psikolojik acım yaptığım her şeyi etkiliyor

1.Kesinlikle katılmıyorum 2.Katılmıyorum 3.Emin değilim 4.Katılıyorum 5.Kesinlikle katılıyorum

APPENDIX F: REFLECTIVE FUNCTIONING QUESTIONNAIRE-54

Lütfen aşağıdaki cümleleri dikkatlice okuyunuz. Her bir cümle için, cümleye ne kadar katıldığınızı ifade etmek üzere 1 ile 7 arasında bir numara seçip cümlenin yanına yazınız. Cümleler üzerinde çok fazla düşünmeyin- ilk tepkiniz genellikle en iyisidir. Teşekkür ederiz.

1'den 7'ye kadar olan aşağıdaki ölçeği kullanın:

Kesinlikle Katılmıyorum	1	2	3	4	5	6	7	Kesinlikle Katılıyorum

1. ___İnsanların düşünceleri benim için bir bilinmezdir.
2. ___Bir başkasının ne düşündüğünü ya da nasıl hissettiğini anlamak benim için kolaydır.
3. ___Ben değiştikçe ebeveynlerimin zihnimdeki resmi de değişir.
4. ___İnsanların duygu ve düşünceleri hakkında çok fazla endişelenirim.
5. ___Davranışlarımın başkalarının duyguları üzerindeki etkisine dikkat ederim.
6. ___Başkalarının duygu ve düşüncelerini anlamam uzun zaman alır.
7. ___Yakın arkadaşlarımın ne düşündüğünü tam olarak bilirim.
8. ___Ne hissettiğimi her zaman bilirim.
9. ___Kendimi nasıl hissettiğim, bir başkasının davranışını nasıl yorumladığımı kolayca etkileyebilir.
10. ___Birisinin gözlerinin içine bakarak nasıl hissettiğini anlayabilirim.
11. ___En iyi arkadaşlarımın tepkilerini bazen yanlış anlayabileceğimi fark ediyorum.
12. ___Ne hissettiğim konusunda sıklıkla kafam karışır.
13. ___Rüyalarımın anlamını merak ederim.
14. ___Bir başkasının aklından geçenleri anlamak benim için asla zor değildir.
15. ___Ebeveynlerimin bana karşı davranışlarının, onların yetiştirilme biçimiyle açıklanmaması gerektiğine inanıyorum.
16. ___Neyi neden yaptığımı her zaman bilmem.

17. ___İnsanların başkalarına verdiği tavsiyelerin, genellikle kendi yapmak istedikleri şeyler olduğunu fark ettim.

18. ___İnsanların aklından neler geçtiğini anlamak benim için gerçekten zordur.

19. ___Diğer insanlar bana iyi bir dinleyici olduğumu söyler.

20. ___Sinirlendiğimde, neden söylediğimi gerçekten bilmediğim şeyler söylerim.

21. ___Sıklıkla başkalarının davranışlarının ardında yatan anlamı merak ederim.

22. ___Diğer insanların duygularını anlamlandırmak için gerçekten çok çabalarım.

23. ___Sıklıkla, istediğim şeyleri yapmaları için insanları zorlamak zorunda kalırım.

24. ___Genellikle yakınlarım, yaptığım şeyleri neden yaptığımı anlamakta zorluk çekerler.

25. ___Eğer dikkatli olmazsam, bir başkasının hayatına çok fazla karışabileceğimi hissediyorum.

26. ___Başkalarının duygu ve düşünceleri benim için kafa karıştırıcıdır.

27. ___Bir başkasının ne yapacağını çoğunlukla tahmin edebilirim.

28. ___Güçlü duygular genellikle düşüncelerimi bulanıklaştırır.

29. ___Anladım ki, birisinin tam olarak ne hissettiğini bilmek için bunu ona sormam gerekir.

30. ___Bir kişi hakkındaki sezgilerim neredeyse hiç yanlış çıkmaz.

31. ___İnanıyorum ki, insanlar kendi inanç ve deneyimlerine bağlı olarak bir durumu çok farklı şekillerde görebilirler.

32. ___Bazen kendimi bir şeyler söylerken bulurum ve onları neden söylediğim hakkında hiç fikrim olmaz.

33. ___Davranışlarımın ardındaki nedenler üzerine düşünmeyi severim.

34. ___Normalde insanların aklından geçenleri tahmin etmede iyiyimdir.

35. ___Hislerime güvenirim.

36. ___Sinirlendiğimde, sonradan pişman olacağım şeyler söylerim.

37. ___İnsanlar duyguları hakkında konuştuklarında kafam karışır.

38. ___İyi bir zihin-okuyucuyumdur.

39. ___Sık sık zihnim boşmuş gibi hissederim.

40. ___Eğer güvensiz hissedersem, diğerlerini sinirlendirecek şekilde davranırım.

41. ___Başkalarının bakış açılarını anlamakta zorlanırım.

42. ___Genellikle diğer insanların tam olarak ne düşündüğünü bilirim.

43. ___Güçlü duygular beslediğim şeyler hakkındaki hislerimin bile zamanla değişebileceğini öngörebilirim

44. ___Bazen neden yaptığımı gerçekten bilmediğim şeyler yaparım.

45. ___Duygularımı dikkate alırım.

46. ___Bir tartışmada, diğer kişinin bakış açısını aklımda tutarım.

47. ___Bir başkasının düşünceleri hakkındaki içgüdülerim genellikle çok doğrudur.

48. ___İnsanların davranışlarının nedenlerini anlamak onları affetmeme yardımcı olur.

49. ___Herhangi bir durumu değerlendirmenin DOĞRU bir yolu olmadığını düşünüyorum.

50. ___İçgüdülerimden çok mantığımla hareket ederim.

51. ___Çocukluğuma dair çok şey hatırlamıyorum.

52. ___Başkasının aklından geçenleri tahmin etmeye çalışmanın bir anlamı olmadığına inanırım.

53. ___Benim için insanın davranışları söylediklerinden daha önemlidir.

54. ___Diğer insanların, çözmeye kalkışmak için fazla karmaşık olduklarına inanırım.

APPENDIX G: PERCEPTION OF THE FALSE SELF SCALE

Bu anketlerden elde edilen sonuçlar bilimsel bir çalışmada kullanılacaktır. Sizden istenilen bu ifadeleri okuduktan sonra kendinizi değerlendirmeniz ve sizin için en uygun seçeneğin karşısına çarpı (X) işareti koymanızdır. Her sorunun karşısında bulunan; (**1) Hiç Katılmıyorum (2) Katılmıyorum (3) Kararsızım (4) Katılıyorum ve (5) Tamamen Katılıyorum anlamına** gelmektedir. Lütfen her ifadeye mutlaka TEK yanıt veriniz ve kesinlikle BOŞ bırakmayınız. En uygun yanıtları vereceğinizi ümit eder katkılarınız için teşekkür ederim.

1	Başkalarının görüşünden farklı olsa bile ne düşündüğümü söylerim.	1	2	3	4	5
2	Görüşlerimi açıkça söyleyemem.	1	2	3	4	5
3	Farklı bir şekilde davranmak istesem de bunu çoğunlukla başaramam.	1	2	3	4	5
4	İnsanların beni gerçekte olduğum gibi görmelerine izin vermem.	1	2	3	4	5
5	Benim düşüncelerim başkaları için önemli değildir.	1	2	3	4	5
6	Diğer insanlar gibi görünerek gerçek benliğimi saklarım.	1	2	3	4	5
7	Gerçekten kim olduğumu gösteren şekilde hareket ederim.	1	2	3	4	5
8	Başkalarını üzeceğimi düşündüğümde, gerçek düşüncelerimi gizlerim.	1	2	3	4	5
9	Dışarıya söylediklerim, içimde düşündüklerimden farklıdır.	1	2	3	4	5
10	Bir şey düşünsem bile, farklı bir şey söylemeye eğilim gösteririm.	1	2	3	4	5
11	İnsanlar gerçekte nasıl bir insan olduğumu bilselerdi, benden hoşlanmazlardı.	1	2	3	4	5
12	Duygularım hakkında başkalarıyla açıkça konuşabilirim.	1	2	3	4	5
13	Diğer insanların düşüncelerine katılmadığımda sessiz kalırım.	1	2	3	4	5
14	Diğer insanlardan farklı görünmeyi sevmem.	1	2	3	4	5
15	Diğer insanların nasıl hissettiğini düşünerek çok zaman harcarım.	1	2	3	4	5
16	Başkalarının hissettikleri benim hislerimden daha önemlidir.	1	2	3	4	5