

Comparative Study

Non-Suicidal Self-Injury and Trauma Symptoms Among Emerging Adults of Kashmir and Delhi-NCR: A Comparative Study

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ABSTRACT

Introduction: Trauma symptoms external to the formal diagnosis of PTSD are common in individuals with non-suicidal self-injury (NSSI), but there is a lack of literature linking the two variables directly. **Objectives:** The primary objective was to study and compare NSSI and trauma symptoms among emerging adults of Kashmir and Delhi-NCR. **Method:** The NSSI Assessment Tool (NSSI-AT), and The Trauma Symptom Checklist-40 (TSC-40) were administered to a sample of 124 individuals falling between the age range of 18-29 years. **Results:** NSSI was absent in 52.4% and present in 47.6% of the sample and trauma symptoms were more profound in the individuals with NSSI than those without NSSI. A strong positive correlation between NSSI and trauma symptoms and a significant difference of trauma symptoms and NSSI between the two groups was discovered. Trauma symptoms significantly added to the prediction of NSSI, whereas domicile did not have a significant impact on it. Kashmiri emerging adults were 2.385 times more likely to present with NSSI than Delhi-NCR emerging adults. Our findings also suggest that experiencing trauma symptoms increase the risk of having NSSI. **Conclusion:** At risk individuals with high magnitude of trauma symptoms should be identified and examined in clinical settings for NSSI to prevent its intensification into possible suicides; safe and effective interventions targeting traumatic symptoms in preliminary stages to manage and prevent NSSI and future suicide attempts should be designed; and interventions at governmental and institutional levels for trauma symptoms should be introduced to curb the prevalence of NSSI and therefore, suicides.

Keywords: NSSI, Trauma Symptoms, Kashmiri, Delhi-NCR, Emerging Adults

Trauma symptoms such as headaches, flashbacks, anxiety attacks, etc. have been reported frequently by individuals who engage in non-suicidal self-injury (NSSI), but the data establishing the relationship between the two is inadequate. The presence of trauma symptoms in general, and not a clinical diagnosis of post-traumatic stress disorder (PTSD) has hardly received any attention in the understanding of NSSI. The contribution of

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Non-Suicidal Self-Injury and Trauma Symptoms Among Emerging Adults of Kashmir and Delhi-NCR: A Comparative Study

trauma symptoms to the development and maintenance of NSSI which may be explained by its reinforcing properties has been found. Past research has also inconclusively established that NSSI plays a significant functional role as a coping mechanism for trauma symptoms (Smith, et al., 2013).

NSSI is defined as the act of destroying one's own body tissue (like cutting, burning, breaking one's bones, banging, hitting, scratching, etc.) without the intention of suicide for reasons other than those socially and culturally approved like tattooing and piercing. (Klonsky, et al., 2014). Unintentional and secondary self-harming behaviours such as substance abuse and those associated with eating disorders like starving and misuse of laxatives are not included in the definition of NSSI. Many psychological issues like anxiety, substance abuse, post-traumatic stress disorder (PTSD), eating disorders, mood disorders, borderline personality disorder and suicidal behaviour have been found to be associated with NSSI. A past history of NSSI, feelings of hopelessness, suicidal ideation, suicidal behaviour, dysfunctional relationships, bullying, peer engagement in NSSI, self-prediction of engaging in NSSI in future, cluster B personality disorders, transgender sexual orientation, gender dysphoria, adverse childhood experiences and abuse among others have been identified as possible risk factors for the development of NSSI. NSSI has also been found to be more widespread in females than males, and adolescents as a result of increased impulsivity and emotional reactivity (Brown & Plener, 2017; Jackman, et al., 2018). The overall prevalence of NSSI among adolescents and young adults is high, ranging from 13-17 percent, making it a very common issue that requires clinical attention (Taylor, et. al., 2018).

Experiencing trauma such as a near death experience, sudden loss of someone close, severe injury or sexual abuse, directly or vicariously, is almost pervasive, with more than 70 percent of the population in 24 countries reporting an exposure to a traumatic event in their lifetime (Benjet, et. al., 2016), but it is not the trauma experience itself, rather the clinically significant and persistent symptoms resulting from trauma exposure which are associated with psychopathology (Smith, et al., 2013). Presence of trauma symptoms without meeting the criteria for the diagnosis of PTSD and reporting trauma symptoms which do not fall in the symptomatology clusters of PTSD are quite common (Frazier, et al., 2009). Trauma symptoms may fall within the subscales of sleep disturbance, sexual problems, dissociation, anxiety, depression and sexual abuse, and include flashbacks; insomnia; waking up too early or not feeling rested in the morning; nightmares; restless sleep; midnight waking; dizziness; headaches; temper problems; anxiety attacks or having difficulty in breathing; losing weight without dieting; stomach problems; sexual problems; dissatisfaction with sex life; low sex drive; sexual overactivity; confusion about sexual feelings; having sex without enjoying it; bad thoughts or feelings during sex; inappropriate sexual feelings; feelings of isolation, loneliness, sadness, guilt, tension, inferiority, not being in your own body or things being unreal; fear of men or women; memory problems; spacing out; passing out; uncontrollable crying; trouble getting along with others, desire to physically hurt yourself or others; and excessive washing, incorporating most features of PTSD as well as other reported traumatic symptoms (Rizeq, et al., 2020).

A research gap of 8 years exists in the study of NSSI and trauma symptoms, and the two variables have not been studied in India, especially in the context of Kashmiri population where traumatic experiences are extensive (Dar & Deb, 2021) and suicide ideation and suicide attempts are widespread (Nisa, 2019). Yet no study has been conducted on NSSI and trauma symptoms which have been found to be associated with trauma experiences and have

Non-Suicidal Self-Injury and Trauma Symptoms Among Emerging Adults of Kashmir and Delhi-NCR: A Comparative Study

also been identified as significant risk factors for suicidality (Alniak & Guney, 2021; Tunno, et al., 2021). The Covid-19 pandemic has become a harbinger of trauma and is likely to foster trauma symptoms among the masses (Qiu, et. al., 2021), thus, expected to promote engagement with NSSI as a maladaptive yet effective way of coping (Smith, et al., 2013). The present research aims to study the relationship between NSSI and trauma symptoms among emerging adults of Kashmir and Delhi-NCR and provide a comparison with the purpose of establishing a difference between the two populations owing to the widespread trauma experiences and related symptoms in the Kashmiri population. The study defines emerging adults as individuals falling between the age range of 18-29 years.

METHODOLOGY

Sample

The sample was selected using purposive sampling. The sample consisted of 124 individuals falling between the age range of 18-29 years, out of which 62 were from Kashmir and 62 from Delhi-NCR.

Measures

The NSSI Assessment Tool (NSSI-AT) (Whitlock & Purington, 2013), a web-based measure of NSSI, designed for use in community populations of young adults and adults for research purposes was used. The NSSI-AT is comprised of 12 modules: a) behaviour-based screening questions (self-injury forms); b) functions; c) recency and frequency (and age of cessation); d) age of onset; e) wound locations; f) initial motivations; g) severity; h) practice patterns; i) habituation and perceived life interference; j) NSSI disclosure; k) NSSI treatment experiences; and l) personal reflections and advice. For the present research only the first two modules to screen those who were positive to the initial NSSI assessment were used. For the first two modules which are being used in the current study the reliability has been found to be high ranging from 0.73 to 0.80. Concurrent, convergent and discriminant evidence of validity, as demonstrated by associations between NSSI-AT scores and other variables has been found to be 0.75.

Trauma Symptom Checklist-40 (TSC-40) (Briere & Runtz, 1989), a 40-item self-report measure of symptomatic distress in adults arising from childhood or adult traumatic experiences was utilized which measures aspects of posttraumatic stress as well as other symptoms found in some traumatized individuals. Respondents are asked to rate how often they have experienced each symptom in the last two months using a 4-point frequency rating scale ranging from 0 ("never") to 3 ("often"). In addition to yielding a total score (ranging from 0 to 120), the TSC-40 has six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index, Sexual Problems, and Sleep Disturbances. The total score was used for the present study as it is a more reliable indicator of trauma sequelae. The total TSC-40 score has very good reliability, with $\Omega = .93.3$. The TSC-40 total score as well as subscale scores demonstrate psychometric properties that support its validity as a research tool indexing complex trauma sequelae across different and multiple types of traumas. Its validity has been found to be 0.80 and it has been found to have predictive validity with reference to a wide variety of traumatic experiences.

Procedure

For the purpose of this research, a sample of 124 emerging adults, 62 from Kashmir and 62 from Delhi-NCR were selected using purposive sampling design. Data was collected using the first two modules of NSSI-AT and TSC- 40 by creating google forms which included

Non-Suicidal Self-Injury and Trauma Symptoms Among Emerging Adults of Kashmir and Delhi-NCR: A Comparative Study

demographic details and consent forms to be filled by the participants. The participants were briefed about the purpose and nature of the study including a trigger warning to enable them to make an informed decision about their participation. Strict confidentiality of the data was ensured. Their right to withdraw from the study anytime at their own discretion was also communicated. They were asked to contact the researcher in case of any doubts or questions. Once the data was collected, scoring was done accordingly. The ethics of data collection were kept in mind throughout the process.

Data Analysis

The data collected were analysed by applying both descriptive as well as inferential statistics using the Statistical Package for Social Sciences (SPSS). Frequency, mean and histogram were used as descriptive measures to demonstrate the two variables (NSSI and trauma symptoms). Inferential statistics measures used include Pearson's Product Moment Correlation to bring out the relationship between the two variables, and Independent Samples T-Test to bring out the difference between the two groups i.e., Kashmiri emerging adults and Delhi-NCR emerging adults. Since the dependent variable was categorical, logistic regression was used for prediction analysis of the model after confirming all the assumptions for its conduction were met by the data.

RESULTS

The purpose of the research was to study and compare NSSI and trauma symptoms among emerging adults of Kashmir and Delhi-NCR. The results were calculated by using correlation, comparison and regression analysis across the variables. Figures and tables were made to show the statistical output of the scores obtained from the sample. NSSI was found to be Absent in 52.4% (n=65) of the sample and Present in 47.6%(n=59) of the sample (N=124). The mean of the trauma symptoms in the sample (N=124) was calculated to be 39.73 with a standard deviation of 25.462. The mean of trauma symptoms demonstrated was significantly greater in the sample of NSSI Present (Mean=60.37) than NSSI Absent (Mean=21).

Table 1 Correlation between NSSI and Trauma Symptoms

Variables	NSSI	Trauma Symptoms	Sig. (2-tailed)
NSSI	1.00	.775	<.001
Trauma Symptoms	.775	1.00	<.001

Note. A significant strong positive correlation ($r = .775$, $N=124$, $p < .001$) was found between NSSI and Trauma Symptoms at an alpha level of 0.01 (2-tailed) among emerging adults of Kashmir and Delhi-NCR.

Table 2 Independent T-Test comparing the means of NSSI and Trauma Symptoms in Kashmiri emerging adults and Delhi-NCR emerging adults

	t	df	Sig. (2-tailed)
NSSI	2.758	122	0.007
Trauma Symptoms	2.617	122	0.010

Note. A significant difference at an alpha level of 0.01 (2-tailed) was found in the scores of Kashmiri emerging adults ($M = 0.60$, $SD = .495$) and Delhi-NCR emerging adults ($M=0.35$, $SD=.482$) on NSSI conditions; $t(122) = 2.758$, $p = 0.007$. A significant difference at an alpha level of 0.01 (2-tailed) was found in the scores of Kashmiri emerging adults ($M =$

**Non-Suicidal Self-Injury and Trauma Symptoms Among Emerging Adults of Kashmir and Delhi-NCR:
A Comparative Study**

45.58, SD = 28.459) and Delhi-NCR emerging adults (M=33.89, SD=20.685) on Trauma Symptoms conditions; $t(122) = 2.617, p = 0.010$.

Logistic regression analysis revealed that the overall model was statistically significant compared to the null model ($X^2(2) = 106.279, p < .001$). Hosmer-Lemeshow Test found the predictions made by the model fit perfectly with observed group memberships ($X^2(8) = 9.931, p = .270$). The model was also found to explain 76.8% of the variation of NSSI (Nagelkerke $R^2 = .768$).

Table 3 Classification table comparing the actual and predicted groups

Observed		Predicted		
		Absent	Present	Percentage Correct
NSSI	Absent	58	7	89.2
	Present	9	50	84.7
Overall				87.1
Percentage				

Note. The model was found to correctly classify 87.1% of cases overall. 84.7% cases of NSSI were found to be predicted by the model to have NSSI and 89.2% cases to not have NSSI were found to be predicted by the model to not have NSSI. Positive predicative value was found to be 87.7% ($100 \times 50 \div (50 + 7)$). Negative predicative value was found to be 86.6% ($100 \times 58 \div (58 + 9)$).

Table 4 Logistic Regression Results

	B	Wald	df	Sig.	Exp(B)	95% Confidence Interval (C.I.) for EXP(B)	
						Lower	Upper
Trauma Symptoms	.144	30.231	1	<.001	1.155	1.097	1.215
Domicile (Kashmir)	.869	1.707	1	.191	2.385	.648	8.781

Note. Trauma symptoms ($p < .001$) were found to add significantly to the prediction of NSSI, whereas domicile ($p = .191$) was found to not significantly add to the model, but the odds of having NSSI was found to be 2.385 greater for Kashmiri emerging adults as opposed to Delhi-NCR emerging adults. The results also revealed that exposure to trauma symptoms increased the odds of having NSSI ($\text{Exp}(B) = 1.155 > 1.0$), Lower C.I. = $1.097 > 1$, Upper C.I. = $1.215 > 1$).

DISCUSSION

Trauma Symptoms are known to be frequently reported with NSSI, but the theoretical base linking the two variables directly was lacking (Smith, et al., 2013). Reports of trauma symptoms have increased and are expected to escalate further as a result of the COVID-19 pandemic (Lonsdorf, 2022), and vulnerable groups such as Kashmiris could be more at risk of its influence. Thus, the present research had four main objectives: first, to study the relationship between NSSI and trauma symptoms among emerging adults in Kashmir and Delhi-NCR, second, to study the difference of NSSI and trauma symptoms between the two groups, third, to study the impact of trauma symptoms on NSSI among the two groups, and fourth, to study the impact of domicile on NSSI among the two groups. The findings

Non-Suicidal Self-Injury and Trauma Symptoms Among Emerging Adults of Kashmir and Delhi-NCR: A Comparative Study

suggested the presence of NSSI in 47.6% of the sample (N=124) and were alarming considering the interpersonal theory of suicide which places NSSI and suicide on a continuum (Gandhi, et. al., 2016). Trauma symptoms were found to be substantially higher in individuals with NSSI as compared to those in which NSSI was absent and can be explained by the functional role that NSSI has been found to play as a coping mechanism for trauma symptoms (Smith, et al., 2013).

NSSI and Trauma Symptoms in the sample were found to be highly correlated ($r = .775$) at an alpha level of 0.01 (2-tailed) which indicated a strong positive correlation and suggested that the chances of the presence of NSSI increase with increase in the magnitude of trauma symptoms. Our findings are consistent with a number of studies associating NSSI with different trauma symptoms like depressive symptoms, dissociative symptoms, anxiety, sleep problems, sexual problems, eating problems, etc. (Cayubit, et. al., 2022; Qian & Xingyu, 2022; Casey, et. al. 2022; Shoko et. al. 2021).

Within the two groups, i.e. Kashmiri emerging adults and Delhi-NCR emerging adults, a significant difference of NSSI ($p = 0.007$) and Trauma Symptoms ($p = 0.010$) was found at an alpha level of 0.01 (2-tailed) which implied that the Kashmiri emerging adults were experiencing significantly more trauma symptoms and a greater presence of NSSI as compared to the Delhi-NCR emerging adults which can be a direct implication of the Kashmir conflict and the double lockdown following the abrogation of Article 370 in Kashmir and the COVID-19 pandemic (Connah, 2021).

A logistic regression was performed to determine the effects of trauma symptoms and domicile on NSSI. The logistic regression model was statistically significant, ($X^2(2) = 106.279$, $p < .00$). The model explained 76.8% of the variance of NSSI (Nagelkerke $R^2 = .768$) and correctly classified 87.1% of cases. Of all the cases predicted as having NSSI, 87.7% were correctly predicted by the model, whereas, of all the cases predicted as not having NSSI, 86.6% were correctly predicted. Trauma symptoms ($p < .001$) significantly added to the prediction of NSSI, whereas domicile ($p = .191$) did not. Kashmiri emerging adults were 2.385 times more likely to exhibit NSSI than Delhi-NCR emerging adults. Our findings also suggested that trauma symptoms increased the risk of having NSSI consistent with the findings that reported NSSI to be a consequence of continued exposure to trauma and violence (Sami & Hallaq, 2018)

Clinical Implications

The results of the study have important clinical implications. Since, NSSI has been associated with emotional, mental and physical distress and has been found to be a stronger predictor of suicide attempts than depression, bipolar disorder, impulsivity, anxiety and a history of past suicide attempts (Klonsky, et. al., 2014), the inferences of the present study are to identify at risk individuals with high magnitude of trauma symptoms in clinical settings and examine them for NSSI to prevent its intensification into possible suicides (Gandhi, et. al., 2016); to call on the researchers to design safe and effective interventions targeting traumatic symptoms in preliminary stages to manage and prevent NSSI and future suicide attempts; and to appeal on the policy makers to introduce interventions at governmental and institutional levels for trauma symptoms to curb the prevalence of NSSI and therefore, suicides in emerging adults among which suicide rates of the students were found to escalate progressively over the years and were recorded to be at its peak since 1995 (National Crime Records Bureau, 2020) , especially in vulnerable populations like

Non-Suicidal Self-Injury and Trauma Symptoms Among Emerging Adults of Kashmir and Delhi-NCR: A Comparative Study

Kashmiris, whose suicide rates have been increasing alarmingly possibly due to facing a lockdown within a lockdown as a result of the abrogation Article 370 in the state and the subsequent COVID-19 pandemic (Connah, 2021).

Limitations

The present study had a cross-sectional design, therefore causal inferences cannot be given, and incidence cannot be measured. A longitudinal research is encouraged for future studies. A mixed-methods research is also recommended to gain a more complete picture and include individuals who could not read and fill the questionnaires in English i.e., future research should make the sample more representative of the general population since the present study utilized a purposive sampling design. A larger sample is also suggested. Our study also did not consider the gender differences among the trauma symptoms and NSSI, future work considering such differences in the risk factors for trauma symptoms and NSSI would be instrumental in identifying the youth most susceptible to these variables.

CONCLUSION

The current research was the first of its kind to study NSSI and trauma symptoms, to compare the differences among emerging adults of Kashmir and Delhi-NCR across the variables and to study the impact of trauma symptoms and domicile on NSSI. NSSI was found absent in 52.4% and present in 47.6% of the sample. Trauma symptoms were found to be more profound in the individuals with NSSI than those without NSSI. A strong positive correlation was found between NSSI and trauma symptoms and as hypothesized a statistically significant difference of trauma symptoms and NSSI was discovered between the emerging adults of Kashmir and Delhi-NCR. Our results demonstrate that trauma symptoms significantly add to the prediction of NSSI, whereas domicile does not significantly impact NSSI. Kashmiri emerging adults were found to be 2.385 times more likely to present with NSSI than Delhi-NCR emerging adults. Our findings also suggest that experiencing trauma symptoms increase the risk of having NSSI.

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**Non-Suicidal Self-Injury and Trauma Symptoms Among Emerging Adults of Kashmir and Delhi-NCR:
A Comparative Study**

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Non-Suicidal Self-Injury and Trauma Symptoms Among Emerging Adults of Kashmir and Delhi-NCR: A Comparative Study

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Conflict of Interest

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