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The Prevalence of Self-Destructive Behavior and its Relationship to Attachment Styles among Young Palestinian Adults in the Governorates of Bethlehem and Hebron

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Thesis Approval

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Dedication

I dedicate this thesis to myself and to my dreams,
to those who shined a light on my dark days,
and who strive for my self-actualization;
to my parents and their relentless efforts,
and to my chosen family for keeping me alive all these years.

Declaration

I certify that this thesis, submitted for the degree of master, is the result of my own research, except where otherwise acknowledged, and that this study (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Name: Amanda Mohammed Mousa Manasra

Signed: 

Date: 21/12/2021

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I would first like to extend my utmost appreciation to my supervisor, Dr. Ola Hussein, for not only her academic support, but also her relentless emotional guidance and motivation throughout this journey.

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And to the establishment of Bethlehem Hospital for Psychiatric Medicine for allowing me to facilitate my academic and professional efforts as necessary for fulfilment of obligations to obtaining this degree.

And finally, to the study participants, my generation, who made this study a reality.

Amanda Mohammad Mousa Manasra

December, 2021

Abstract:

This study aimed at identifying the prevalence of self-destructive behavior and its relationship to attachment styles (secure, dismissive, ambivalent, and disorganized) among young Palestinian adults in the governorates of Bethlehem and Hebron, in addition to identifying the differences in the prevalence of self-destructive behaviour, which are related to the study variables (age, sex, level of education, employment status, marital status, area of residence, location of residence, marital status of parents, recent exposure to violence or traumatic event, religion, and religiosity). A combination of convenient and snowball sampling recruited (412) male and female participants through an online survey. Data was collected with the Attachment Styles Questionnaire (ASQ) and a checklist-style questionnaire developed for purpose of study to assess self-destructive behaviour, after verifying questionnaires' validity and reliability, and following a descriptive correlational methodology. Statistical analysis revealed that most sample members have a moderate level of self-destructive behaviour (44.9%). Additionally, they were most likely to engage in the self-destructive behaviour subtype "Failure in Routine or Primary Self-Care" (M=1.74), then "Issues of Self-Management" (M=1.53), "Socioemotional and Sexual Behaviors" (M=1.21), "Risky, Thrilling, Defiant, and Criminal Behaviors" (M=1.09), "Substance-Use and Addiction-Related Behaviors" (M=0.85), and finally "Direct Self-Harm and Suicidal Behavior" (M=0.77). As it relates to the study variables, results indicated that only the sex, level of education, marital status of parents, recent exposure to traumatic event or violence, religion, and religiosity variables were related to significant differences in self-destructive behaviour. The differences related to sex were between "Male" and "Female" and in favour of the "Male" category, in the level of education variable between "Diploma" and "Bachelor's Degree" and in favour of the "Diploma" category, in the marital status of parents variable between "Widowed Parent / Deceased Parents" and "Married" and in favour of the "Widowed Parent / Deceased Parents" category, in the recent exposure to violence or traumatic event variable between "Yes" and "No" and in favor of confirmed having experienced violence or a traumatic, in the religion variable between "Christian" and "Muslim" in favour of "Christian" and between "Other Religious Status" and "Muslim" in favour of "Other Religious Status", and finally in the religiosity variable, differences were between the "Not Religious" and "Very Religious" categories and in favour of the "Not Religious" category. In relation to attachment styles, results indicated that "Dismissive Attachment" was the most prevalent, followed by "Disorganized Attachment", "Secure Attachment", and finally "Ambivalent Attachment". Moreover, results indicated that there was no significant relationship between secure attachment and self-destructive behaviour, but found a significant positive relationship between self-destructive behaviour and dismissive attachment, ambivalent attachment, and disorganized attachment respectively. Further analysis revealed that secure attachment showed a significant relationship with the self-destructive behaviour subtypes "Failure in Routine or Primary Self-Care" and "Issues of Self-Management", and a significant relationship between fearful attachment and self-destructive behaviour subtypes "Risky, Thrilling, Defiant, and Criminal Behaviors", "Failure in Routine or Primary Self-Care", and "Socioemotional and Sexual Behaviors". Finally, results indicated that both dismissive and ambivalent attachment styles were correlated to all self-destructive behaviour subtypes.

Keywords: Self-Destructive Behavior, Attachment Styles, Young Adults, Hebron, Bethlehem.

مدى انتشار السلوك المدمر للذات وعلاقته بأنماط التعلق لدى الشباب الفلسطينيين في محافظتي بيت لحم والخليل

إعداد: أماندا محمد موسى مناصرة

المشرف: د. علا حسين

الملخص:

هدفت هذه الدراسة إلى التعرف إلى مدى انتشار السلوك المدمر للذات وعلاقته بأنماط التعلق (الآمن، الرافض، المتناقض، وغير المنظم) لدى الشباب الفلسطينيين في محافظتي بيت لحم والخليل، والتحقق من الإختلافات في مستوى السلوك المدمر للذات تبعاً لمتغيرات الدراسة (العمر، الجنس، مستوى التعليم، حالة العمل، الوضع الزواجي، منطقة السكن، مكان السكن، الوضع الزواجي للأهل، التعرض المؤخر للعنف أو حدث صادم، الدين، التدين. إستخدمت الدراسة مزيجا من طريقة العينة المتاحة وكرة الثلج لإختيار (412) مشارك ومشاركة عبر الإنترنت، وتم جمع البيانات من خلال تطبيق مقياس أنماط التعلق (ASQ) ومقياس على شكل لائحة معيارية تم تطويره من قبل الباحثة لقياس السلوك المدمر للذات بعد التأكد من صدقهما وثباتهما، وذلك ضمن المنهجية الوصفية الترابطية. أظهرت نتائج الدراسة أن مستوى السلوك المدمر للذات جاء بدرجة متوسطة (44.9%)، وأن أكثر محاور السلوك المدمر للذات إنتشارا كان "الفشل في الرعاية الذاتية الروتينية أو الأولية" (M=1.74)، ثم "إشكاليات التنظيم الذاتي" (M=1.53)، ثم "السلوكيات الجنسية والعاطفية الإجتماعية" (M=1.21)، ثم "السلوكيات الخطيرة، المثيرة، المتحدية، والجنائية" (M=1.09)، ثم "إستخدام المواد وسلوكيات ذات علاقة بالإدمان" (M=0.85)، ونهاية "إيذاء الذات المباشر والسلوك الإنتحاري" (M=0.77). وفيما يتعلق بمتغيرات الدراسة، وجدت النتائج أن هناك فروق ذات دلالة في مستوى السلوك المدمر للذات تبعا للجنس، ومستوى التعليم، والوضع الزواجي للأهل، والتعرض المؤخر للعنف أو حدث صادم،

والدين، والتدين فقط. كما وأن النتائج أشارت إلى أن الفروق في متغير الجنس بين "أنثى" و"ذكر" كانت لصالح "ذكر"، وفي متغير مستوى التعليم بين "الدبلوم" و"البكالوريس" لصالح "الدبلوم"، وفي متغير الوضع الزواجي للأهل بين "أحد الوالدين متوفيين / كلا الوالدين متوفيين" و"متزوجين" لصالح "أحد الوالدين متوفيين / كلا الوالدين متوفيين"، وفي متغير "التعرض المؤخر للعنف أو حدث صادم" بين "نعم" و"لا" لصالح "نعم"، وفي متغير الدين بين "مسيحي" و"مسلم" لصالح "مسيحي" وبين "غير ذلك" و"مسلم" لصالح "غير ذلك"، ونهاية في متغير التدين بين "غير متدين" و"متدين جدا" لصالح "غير متدين". وأما حول أنماط التعلق، أشارت النتائج لكون أكثر الأنماط شيوعيا نمط التعلق الرافض ، ثم النمط غير المنظم، ثم النمط الآمن، ونهاية النمط المتناقض. ولم تجد النتائج علاقة ذات دلالة بين السلوك المدمر للذات ونمط التعلق الآمن، بينما وجدت علاقة طردية ذات دلالة بين السلوك المدمر للذات وكل من نمط التعلق الرافض، والنمط غير المنظم، والنمط المتناقض. وأشار التحليل الإضافي للنتائج أن هناك علاقة ذات دلالة بين نمط التعلق الآمن مع محاور السلوك المدمر للذات "الفشل في الرعاية الذاتية الروتينية أو الأولية" و"إشكاليات التنظيم الذاتي"، وبين نمط التعلق غير المنظم ومحاور السلوك المدمر للذات "الفشل في الرعاية الذاتية الروتينية أو الأولية" و"السلوكيات الجنسية والعاطفية الإجتماعية" و"السلوكيات الخطيرة، المثيرة، المتحدية، والجنائية"، وبين كلا النمطين الرافض والمتناقض وكافة محاور السلوك المدمر للذات.

الكلمات المفتاحية: السلوك المدمر للذات، أنماط التعلق، الشباب، بيت لحم، الخليل.

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List of Abbreviations

○ **ASQ**	Attachment Styles Questionnaire
○ **BPD**	Borderline Personality Disorder
○ **CDC**	Centre for Disease Control
○ **COVID-19**	Coronavirus 2019
○ **CSDC**	Chronic Self-Destructiveness Checklist
○ **CSDS**	Chronic Self-Destructiveness Scale
○ **IQ**	Intelligence Quotient
○ **ISDB**	Indirect Self-Destructive Behavior
○ **LSD**	Lysergic Acid Diethylamide
○ **MDMA**	3,4-Methylenedioxymethamphetamine
○ **NSSH**	Nonsuicidal Self-Harm
○ **NSSI**	Nonsuicidal Self-Injury
○ **NSSI-AT**	Nonsuicidal Self-Injury Assessment Tool
○ **OCD**	Obsessive Compulsive Disorder
○ **PCBS**	Palestinian Central Bureau of Statistics
○ **PTSD**	Post-Traumatic Stress Disorder
○ **RISQ**	Risky, Impulsive, & Self-Destructive Behavior Questionnaire
○ **SDB**	Self-Destructive Behavior
○ **SDBC**	Self-Destructive Behavior Checklist
○ **SES**	Socioeconomic Status
○ **SHI**	Self-Harm Inventory
○ **SPSS**	Statistical Package for the Social Sciences
○ **UNFPA**	United Nations Population Fund
○ **WHO**	World Health Organizations
○ **NIDA**	National Institute on Drug Abuse
○ **NIH**	National Institute of Health
○ **ADF**	Alcohol and Drug Foundation
○ **ACT**	Acceptance and Commitment Therapy
○ **NCCMH**	National Collaborating Centre for Mental Health
○ **DSM-4**	Diagnostic and Statistical Manual of Mental Disorders (4^{th} Edition)
○ **UNRWA**	United Nations Relief and Works Agency for Palestinian Refugees
○ **GSHS**	The Global School-Baser Student Health Survey
○ **UAE**	United Arab Emirates
○ **UN**	United Nations
○ **WAFA**	Palestinian News & Information Agency WAFA
○ **ANOVA**	Analysis of Variance
○ **LSD (Test)**	Least Significant Difference

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Chapter One:

Study Background

1.1 Introduction

The issue with self-destructive behavior or "SDB" is the clinical and ethical dilemmas it poses when faced with the question of classification as a pathological form of behavior. On the one hand, SDB has been observed as contradictive to the essentials of instinctual self-preservation (Walters, 1999), but on the other hand, the behavior's link to decreasing anxiety and assisting in short-term and intermediate coping has been found to have deep biological roots observable in some animal species, and which has been suggested as a crucial factor leading to the universality and historical prevalence of self-harm and destruction as a recognisable phenomenon (Ramsden & Wilson, 2014).

The term SDB comes to include a wide list of behaviors, which are inflicted by the person onto themselves, and which entail the increasing possibility of negative consequences, such as smoking or sexual promiscuity, and the further reduction of attaining positive ones, such as neglecting one's health or safety (Tsirigotis et al., 2013).

SDB can also be described by the numerous terminology it has come to include and overlap with over the years; examples of which are self-harm, self-injurious behaviors, self-defeating behaviors, suicidality, and aggressive behavior turned inward (Alshawashreh et al., 2013; Edelson et al., 1983; Orbach, 2007).

Examples of SDB range from poor eating habits to self-mutilation and termination of life, and they carry an impact that can be felt by the individual, their immediate surroundings, as well as others, who may be victimised as a result of the behavior (Sadeh & Baskin-Sommers, 2016).

Attempts at understanding SDB have produced multiple models of organizing the act of causing immediate harm to self or disregarding future possibilities of harm; one notable model, introduced by Baumeister and Scher in (1998), provides an analysis of different levels of SDB based on the awareness of the consequences of self-harm and the intent motivating the behavior (Alshawashreh et al., 2013), while other prominent models attempted to form classifications according to direct physical harm and indirect non-physical harm (Tsirigotis & Luczak, 2018).

Other approaches to SDB were origin-oriented and aimed at placing the behavior in the nature-nurture spectrum to analyse whether counterintuitive harm to self is biologically or genetically driven and a marker of the human condition (Caldwell, 1999).

These prominently include Sigmund Freud's early work on SDB as a primal manifestation of frustrated or repressed aggression (Dennen, 2005), as well as Emile Durkheim's presentation of suicide as a reaction towards social isolation and dysfunction in the late (1800s) (Hassana, 1998).

More recently, and following the popularization of the attachment theory as suggested by the works of John Bowlby and Mary Ainsworth, tremendous theoretical and clinical effort

has been motivated by assessing the theory's credibility in analysing children's behavior, and establishing reliable predictions of the role attachment style plays in personality and identity development, as well as resilience to traumatization, or future psychopathology (Cassidy et al., 2013).

Studies such as (Cassidy et al., 2013; Stepp et al., 2008) have suggested that a secure model of attachment would be able to counteract the severity of interpersonal issues and assist in resolving intrapersonal conflicts much more efficiently than an insecure model would, an interaction observed both in children and adults.

Attachment, which was first conceptualized by building upon ethological assumptions, began as an attempt to understand the way in which children respond and react to the absence of their mothers, what that represents about their internal unconscious world, and what that means for their intrapersonal and interpersonal functioning. Although the term was coined under its current definition by John Bowlby, and later by Mary Ainsworth, in the last century (Fraley, 2018), previous mentions of the child-parent relationship had been significant throughout much of the literature around human behavior and development (Lee, 2003); relevant examples of which include works by Klein, Sullivan, Winnicott, and other psychoanalysts. Over the years, though the definition of attachment, or the parent-child relationship, has somewhat remained the same, the classification of the types of attachment has changed. While some theorists have suggested a dyadic classification (Secure or Insecure), others have suggested a more complex model, including up to four main types of attachment; Secure Attachment, Dismissive Attachment, Disorganized Attachment, and Ambivalent Attachment (Fraley, 2018; Firestone, 2019; Bockarova, 2019).

There have been substantial efforts to examine the hypothesized role of attachment in determining the prevalence and magnitude of SDB, but little work has targeted young adults, despite clinical indications of the behavior in the generational cohort “Millennials” – today’s young adults. Unlike their predecessors, Generation X, whose ages range from (36-56) years in (2020), Millennials are often described as selfish, entitled, lazy, apathetic, disobedient, and emotionally fragile, causing them to long for an immediate sense of achievement and affiliation, rather than power (Johnson, 2017; Borges et al., 2010).

Different generations naturally experience varied levels of psychosocial distress, often depending on the exposure to civilizational factors such as industry, education, and religious influence. The characteristics of Millennials have often been correlated back to the complex nature of the world and civilization-shifts during this time-period, referred to as "The Era of High Modernity". Fuelled by the globalisation phenomenon, young adults are more inclined towards de-traditionalization and fluidity, where gender, race, and social classes are experienced on a higher level of differentiation and individuality. Although this has been linked to this generation's higher levels of anxiety and insecurity as they come of age and transition into late adulthood, the widespread development and use of the internet is believed to have assisted in the normalization and popularization of therapeutic culture, which led to a better development of healthier inclinations towards mental health in comparison to previous generations (Johnson, 2017).

Palestinian young adults share many of the characteristics and frustrations of their generation elsewhere, as well as enduring a multiple of tremendous traumatic events, which were occurring at the national scale; the youngest of the generation were born during the Second Intifada in (2001), while the oldest were born during the last Gulf War in (1990). This generation of Palestinians grew up at a time of suicide bombings, mass

shootings, military-enforced sieges, international blockades, assassinations (UN, 2014), in addition to the transition from on-going political conflict to a struggling self-governing non-state divided by an internal socio-political divide of the community, resulting in the creation of two new de facto governments in the West Bank and in the Gaza Strip (Oxfam, 2018).

The population of the southern governorates of the Palestinian West Bank (Bethlehem and Hebron) is no stranger to the previously mentioned strives, in addition to extreme levels of unemployment and illiteracy, but also increased religious diversity, higher education, and urban development (buildings, services, infrastructure) compared to other Palestinian governorates (PCBS, 2017b).

These above mentioned conceptual relationships require appropriate in-depth examination, which this study attempts to provide, by measuring the prevalence of self-destructive behavior (SDB) and its relationship to attachment styles, among young Palestinian adults in the governorates of Bethlehem and Hebron.

1.2 Problem Statement

It would appear that most of the relevant work opted to focus on SDB in specific homogenous populations, such as age or gender-groups, or gearing towards the study of suicidality as the most prominent form of SDB. This has led to the overshadowing of other forms and manifestations of self-destructiveness, such as addiction and substance abuse, recklessness and impulsivity, or avoidance and poor self-management, prevalent, according to researcher's observation in both clinical and nonclinical Palestinian populations, but especially so, in today's young adult generation, who are increasingly seeking mental health assistance. This must be recognized a sign of a distressed collective, rather than disregarded as immaturity and labelled as "attention-seeking" or undervalued and considered uninformative of a much larger phenomenon. Relevant literature, indeed, refers to the stereotypes of SDB, which are restricted to self-mutilation in young females, as hindering scientific efforts from dealing with the important factors underpinning SDB, such as childhood trauma and adversity (Curtis, 2008; Kerig, 2017; van der Kolk et al., 1991).

This has been confirmed by (Cruz et al., 2013) who found that familial patterns and childhood experiences lead to the decrease or increase in likelihood of SDB, most often peaking during young adulthood. Previous relevant works supporting this, such as (Lim et al., 2017), estimated that young adults are more likely to engage in SDB compared to any other age-group. Alongside identity formation, young adulthood as a developmental stage poses a critical challenge for adolescents as they gradually change into adulthood, characterized by important psychosocial and brain developments, often linked with the stage's implication in the rise or decrease of risky behavior, accidental death, and impulse-control (Bonnie et al. (Eds.), 2015).

The unhurried and restrained expression of distress in young adults, compared to that of adolescents, has led to the devaluation of the stage resulting in a detrimental denial of its importance, despite evidence identifying young adulthood as the peak age of onset of mental health illness (Bonnie et al. (Eds.), 2015; Jurewicz, 2015).

The World Health Organization reports that suicide is a global phenomenon, with numbers rising in low to middle income countries and among groups of individuals dealing with distress and mental health illness. According to WHO, around (800,000) people commit

suicide every year while many more are attempting suicide among other behaviors found to be detrimental to their general wellbeing (WHO, 2019).

According to a report published by the UNFPA, Palestinian young adults are daily fighting to function and self-actualize against high percentages of sexual, political, and social violence, as well as unemployment, dropping out of school, constitutionalized inequality and injustice, pressure to marry, and a drug epidemic which has been increasingly sweeping the nation for the last (10) years (Burghal, 2016; Hillal, 2017).

Over the last five years, local and international reports indicated a rise in mental health issues and criminal behaviour in Palestine; police-recorded substance use increase, slightly slowed by the impact of COVID-19 lockdowns, only to continue later in the year (2021), over (360) individuals attempted suicide in the last two years, (28) others completed a suicidal attempt, an estimated one in five people is predicted to have depression, PTSD, bipolar disorder, schizophrenia, or an anxiety disorder. Palestine, in fact, has the largest prevalence of mental health illnesses in the Middle East and one of the highest among Muslim countries, and over (250,000) Palestinians are in need for psychosocial support and psychiatric services. This is especially the case for youth and adolescent Palestinians, who are at highest risk for self-destructive behaviour and suicide, without sufficient access to primary and secondary prevention services (Eskin et al., 2019; PCBS, 2020; WAFA, n.d; WAFA, 2019; WHO, 2020).

1.3 Justification of the Study

The importance of studying SDB stems from the high prevalence of the behavior that hasn't been met with the appropriate academic work necessary to understand why the lethality of the behavior hasn't counteracted its generality. It would appear that the commonness and persistence of SDB is an indication that the human is rather inclined towards comfort and immediate survival through avoidance, rather than being naturally inclined towards long-term self-preservation.

In the Palestinian society, some academic and clinical work has been done around direct SDB, such as suicidality and self-harm, but no measure of SDB was established in its entirety, and not in its relationship to parental styles and childhood experiences. The attachment style a person develops toward their care-provider has been found to influence their resilience in the face of distress, traumatization, and psychopathology, as well as the quality of their relationships and their ability to resolve intrapersonal conflicts (Cassidy et al., 2013).

To the researcher's knowledge, there has been very little evidence-based work to examine the role of attachment in behavior within the Palestinian context, whether solely to identify the validity and reliability of the theory's assumptions and predictions, or in its connection to other behaviors, where previous studies have attempted to tread. This is unfortunate when taking into consideration the immense evidence of the role the attachment theory has played in clinical context, whether in the prevention or treatment of mental distress in children as well as adults.

The implications of this study would hopefully benefit mental health workers of various fields, such as counsellors, clinicians, and psychologists, as well as educators and care-providers, who could benefit from the results of this study in making informed decisions and decisions, in addition to developing SDB-focused treatment and prevention protocols. In addition, the results of this study would hopefully assist decision and policy makers, in

designing more appropriate and realistic programs, laws, and legislations, which benefit the young Palestinian individual in particular, as well as the community mental health.

1.4 Aim

To assess the prevalence of self-destructive behavior (SDB) and its relationship to attachment styles in young Palestinian adults in the governorates of Bethlehem and Hebron.

1.5 Specific Objectives

1. To identify the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron.

2. To identify the statistically significant differences in the prevalence of self-destructive behavior, which are related to age, sex, level of education, employment status, marital status, area of residence, location of residence, marital status of parents, recent exposure to violence or traumatic event, religion, and religiosity among young Palestinian adults in the governorates of Bethlehem and Hebron.

3. To identify the statistically significant relationship between self-destructive behavior and attachment styles (secure, dismissive, ambivalent, disorganized) among young Palestinian adults in the governorates of Bethlehem and Hebron.

1.6 Study Questions

1. What is the prevalence of self-destructive behavior in young Palestinian adults in the southern West Bank governorates?

2. Are there statistically significant differences in the prevalence of self-destructive behavior related to age, sex, level of education, employment status, marital status, area of residence, location of residence, marital status of parents, recent exposure to violence or traumatic event, religion, and religiosity among young Palestinian adults in the governorates of Bethlehem and Hebron?

3. Is there a statistically significant relationship between self-destructive behavior and each attachment style (secure, dismissive, ambivalent, and disorganized) among young Palestinian adults in the governorates of Bethlehem and Hebron?

1.6 Study Hypotheses

Questions two and three were turned into hypotheses for statistical analysis, as presented in the following:

Hypothesis One: There are no statistically significant differences at the level of significance ($\alpha \leq 0.05$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the age, sex, level of education, employment status, marital status, area of residence, location of

residence, marital status of parents, recent exposure to violence or traumatic event, religion, or religiosity variables.

Hypothesis Two: There are no statistically significant differences at the level of significance ($\alpha \leq 0.05$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the Secure, Dismissive, Ambivalent, and Disorganized Attachment Style variables.

1.7 Study Limitations

- Qualitative Boundary: Young Palestinian adults aged (18-29) years old in the governorates of Bethlehem and Hebron.
- Morphological Boundary: Measuring prevalence of SDB and its relationship to attachment styles in young Palestinian adults.
- Time Boundary: The year (2021).
- Geographical Boundary: The governorates of Bethlehem and Hebron in the Palestinian West Bank.
- Conceptual Boundary: The concepts and terms mentioned in the study (Self-Destructive Behavior SDB, Attachment Styles, Young Adults).
- Operational Boundary: The results of the study are defined by the study instruments, their psychometric qualities, and the statistical analysis employed.

1.8 Definition of Terms

Self-Destructive Behavior (SDB)

Theoretical Conceptual Definition

Self-Destructive or dysregulated behaviors are specific self-soothing and adaptive behaviors which are motivated by persistent urges towards providing short-term relief or pleasure, but accumulatively disrupt the individual's long-term satisfaction and fulfilment. They have been widely regarded as a generalised behavioral tendency, which is often linked to an increase in distress and current or past adversity. The definition has come to include all harmful behaviors which are inflicted by the individual themselves intentionally or unintentionally. These behaviors include intentional and unintentional harm, immediate and prolonged or delayed harm, harm to the body or the mind, as well as economic and social harm. These may include substance use and abuse, binge-experiences such as eating or watching TV, reckless driving, self-injury, toxic relationships or social isolation, engaging in dangerous sexual activity, procrastination and avoidance, excessive gambling or gaming, among others (Wupperman, 2015). They may be referred to as “SDB” throughout this study.

Procedural Definition

Total score of responses by the sample to The Self-Destructive Behavior Check-List or what is referred to as “SDB-C” throughout this study.

1.9 Attachment Style

Theoretical Conceptual Definition

An Attachment Style is a moderately stable pattern of behavior in which an individual experiences and interacts with relationships and life events, which is primarily based on the type and quality of their interaction with their care-providers during early childhood. Following the work of John Bowlby, who presented attachment as a survival mechanism, psychologists and sociologist have both linked attachment styles to an increase in risk for development of various pathological symptomology and a decreased immunity to traumatization and distress due to the impact of attachment on the working model of self and of others (Cozzarelli et al., 2003).

Four styles of attachment are defined; Secure Attachment Style, Insecure Dismissive Attachment Style, Ambivalent Attachment Style, and lastly Disorganized Attachment Style (Symons & Szielasko, 2011; Fraley, 2018; Firestone, 2019; Bockarova, 2019).

Procedural Definition

Responses by the sample to The Attachment Styles Questionnaire “ASQ” Subscales.

Young Adulthood

Theoretical Conceptual Definition

Young or Emerging Adulthood is a rather new terminology used to describe the transitional period between adolescence and adulthood, spanning from (18) to (29) years of age; a terminology introduced to address the recent socioeconomic demand to delay the beginning of the actualization of adulthood tasks (Arnett et al., 2014).

During this period, individuals gradually become entirely capable of leading independent lives and are of legal age to take on various political, social, and economic roles and responsibilities away from the control or guidance of their parents or guardians.

This is made possible by the physical and cognitive and psychological development necessary to perform or embark on one or more of five major adulthood milestones: entering college, joining the work-force, getting married, having children, and moving away from home (Papalia et al., 2009).

The terminology itself has been supported by the American CDC as early as (2009), and although the Palestinian Central Bureau of Statistics specifically identified this age-group in their most recent publication on population issued in (2018), it is globally referred to as the "Youth" population-group (Gupta & Kollodge, 2014).

Chapter Two

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Literature Review

2.1 Section One: Self-Destructive Behavior

As suggested by the title “Self-Destructive”, behaviors characterized as “SDB” increase the likelihood of premature death, the likelihood of long-term disability and illness, and they result in poor mental health outcomes (Sadeh & Baskin-Sommers, 2016). Self-destructiveness is viewed as a motivated wish or need, a result of emotional distress, a result of cognitive distortion, and a general personality feature. It is also referred to as an attitude consisting of cognitions, behavioral tendencies, and emotions, which work to act against one’s self-interests (Orbach, 2007).

2.1.1 Classification of Self-Destructive Behavior

Direct Harm or Indirect Harm:

- Direct Self-Destructive Behavior

Acute, direct, and immediate harm-causing behaviors committed in full awareness and willingness of future consequences, most commonly identified as self-destructive; these include suicidal attempts or self-mutilation and injury without suicidal intentions (Tsirigotis & Luczak, 2018). According to the Mayo Clinic (2018) examples of self-mutilation and injury are cutting, burning, piercing, object-insertion, head-banging, and scratching, among others (Mayo Clinic, 2018).

- Indirect Self-Destructive Behavior:

These behaviors are both intentional and unintentional behaviors, which are often chronic and regarded as normal or socially acceptable due to their wide-spread prevalence in both mentally healthy and unhealthy individuals, and sometimes as part of cultural contexts or religious rituals. Despite this, research has shown that such behaviors almost always lead to an increase in probability of future negative outcomes or a decrease in the attainment of future positive outcomes, leading to the academic and clinical interest in addressing them. Subcategories of ISDB include undertaken actions, abandonment of actions, risky and impulsive behavior, as well as neglecting or disregarding one's health and safety (Tsirigotis & Luczak, 2018).

The intentionality Classification – Desiring and Foreseeing Harm:

- Primary Self-Destruction: The individual is aware of possible harm and desires the consequential suffering. This is very uncommon among "nonclinical individuals", though they become at more risk during emotional distress.

- Trade-offs: The individual is aware of possible harm but does not desire it. This is common and typical due to inclinations towards immediate gratification with low concentration on long-term results.

- Counterproductive Strategies: The individual is unaware of possible harm and does not desire suffering. This is often a result of poor judgement and decreased insight (Baumeister, 2017).

Measuring Self-Destructive Behavior

- The "NSSI-AT":

The Non-Suicidal Self-Injury Assessment Tool was developed by Whitlock and Purington (2007) to screen for purposeful self-harm using open-ended and close-ended questions, which also collect information on motivation behind behaviors, frequency, severity, and recency of behaviors, as well as other relevant factors, such as age of onset and cessation, wound locations, self-harm patterns, habits, or rituals, and finally an examination of impact of self-harm and access to social and clinical resources (Whitlock & Purington, 2007).

- The "RISQ":

The Risky, Impulsive, and Self-Destructive Behavior Questionnaire-Scale is a (38)-item measurement interested in identifying severity and chronicity of Self-destructive behaviors and affective triggers underlying them. The behaviors are categorized into eight domains; aggressive behavior, drug and alcohol use, reckless behaviors, self-harm, gambling, risky sexual behaviors, and impulsive eating (Sadeh & Baskin-Sommers, 2016).

- The "CS-DS":

The Chronic Self-Destructiveness Scale identifies SDB as consisting of transgression and risk, poor health maintenance, personal and social neglects, lack of planfulness, and helplessness and passiveness in the face of problems (Tsirigoties et al., 2012).

- The "SHI":

The Self-Harm Inventory is a one-page, (22)-item (Yes/No) self-reporting questionnaire style instrument, designed to identify purposeful and intentional behaviors relating to self-injury, eating-disorders, suicidality, and medically-related issues. The questionnaire has been often used to diagnose Borderline Personality Disorder, but it's mainly aimed at predicting the level of lifetime prevalence of self-harm (Sansone & Sansone, 2010).

2.1.2 Traits of Self-Destructive People

SDB is essentially maladaptive coping, which began as a way to escape and avoid pain, but continued to further amplify the anxieties it was developed to counteract. Constant uncertainty about the future causes people to abandon hope and engage in aggressive and risky behaviors such as substance-use and unsafe sexual practices (Wupperman, 2015; Bolland, 2003).

Individuals who find themselves engaged in self-destructiveness are usually impulsive; they are mainly motivated by emotional factors in the present-time, and are less likely to engage in long-term cognitive consideration of actions before committing them. This is not

without guilt and shame; Self-destructive individuals create a psychological distance between what they do and the consequences of their behaviors in order to shield themselves of pain relating to disappointing expectations of themselves and others (Tsirigotis & Luczak, 2018).

Acute self-destructiveness is often a manifestation of decreased problem-solving abilities, especially within interpersonal contexts, where the individual finds themselves helpless in conflict within close relationships (Stepp et al., 2008).

Self-destructive individuals appear as indifferent to the anger and concern their behavior incites in others around them (Gvion & Fachler, 2015), but it has been suggested that self-destructiveness is actually driven by heightened sensitivity to emotion; in fact, many self-destructive people may be more empathic than others (Wupperman, 2015).

Many self-destructive individuals report experiencing adversity, neglect, or abuse during childhood; they detail histories of trauma and issues with parental care during childhood, and they often report manifestations of insecure attachment (Van der Kolk et al., 1991).

2.1.3 Risk Factors of Self-Destructive Behavior

Studies have referred to risk factors related to increasing likelihood of self-destructiveness and inclination towards self-harm. These included interpersonal problems, living in the inner-city, medical illness, mental health illness, formative and complex trauma (Bolland, 2003; Greenberg, 2015; Tsirigotis & Luczak, 2018; Carucci, 2019; Stepp et al., 2008). The following illustrates:

Interpersonal Problems

Heightened interpersonal sensitivity and issues in interpersonal relationships have been found to play an important role in self-harm and self-destructive tendencies, as reported by individuals, who engage in suicidal behaviors, who often feel influenced by others to harm themselves (Stepp et al., 2008).

Other times, interpersonal obligations guide the individual into patterns of self-destructiveness; someone may act against their best interest as part of caregiving or supportive behavior or they may push themselves past their threshold of tolerance to comply with a request or demand, within an unhealthy social climate (Turner et al., 2017).

Interpersonal stressors such as conflict, loss, feelings of rejection, and events of separation often precede self-destructive intentions and behavior. At these times, individuals may engage in self-destructiveness to alleviate psychological anguish, caused by interpersonal distress, whilst denying these motives, as to not appear as manipulate, attention-seeking, or needy (Turner et al., 2017).

Relationships with family members has been one of the strongest predictors of suicidality and self-destructiveness; individuals, who find themselves feeling like a burden to their families, who experience domestic violence, present with higher lethality of suicidal and self-injurious behavior (Van Orden et al., 2010).

Lack of family stability, caused by family discord or death of family members, can be worsened by the lack of other resources for social support. Individuals, who experience long and recurrent situations of social isolation, exhibit increased risk for lethal self-destructiveness. In contrast, individuals, who experience social integration and belonging,

or express perceived social support, demonstrate less self-destructive inclinations (Turner et al., 2017; Van Orden et al., 2010).

Living in the Inner-City

Residents of the inner-city were found more inclined to lose hope and engage in risky maladaptive behaviors such as substance use and harmful sexual practices. They are also more aggressive and violent and they have a higher prevalence of accidental injury (Bolland, 2003). Continuously existing within highly populated areas exposes individuals to increased interpersonal conflict and intrapersonal instability (Usenko et al., 2014).

In contrast, some studies revealed that living in rural residence may not also indicate decreased suicidality or self-destructiveness, as these areas are also usually much more impacted by lower education, unemployment, and resource deprivation (Kim et al., 2010).

Medical Illness

Responsiveness to physical illness can be viewed as a spectrum of attitudes, varying from a positive proactive outlook to a negative and passive stance. This strongly relies on internal dynamics of power and control, and their relationship to patterns of coping with feelings of rage, confusion, and powerlessness (Greenberg, 2015).

While some habitual self-destructiveness reactive to a medical diagnosis can be accepted as a maladaptive coping style, in psychologically-healthy individuals, a physical illness can bring about an opportunity to process and accept the limitations of the body's ability, a motivation to improving self-care and lifestyle, and building trust-based relationships and alliances with medical-care providers. Dissimilarly, psychologically-unhealthy individuals approach their illness from a place of helplessness and compromised resilience; they succumb to denial, disregard their bodies' needs, and they put themselves at higher risk. These individuals engage in self-destructiveness which cannot be overlooked as temporary or situational, but rather a manifestation of deeply-rooted interpersonal difficulties such as death and illness anxiety and a fear of losing control (Greenberg, 2015).

Attachment and interpersonal patterns play a major role in mediating the impact of physical illness on behavior, and the inclination towards either side of the responsiveness to illness spectrum. Often, physically ill individuals engage in self-destructiveness to illicit a sympathetic reaction from others. In a sense, they are masochists in how they respond to illness by furthering their pain in order to receive care and attention (Greenberg, 2015).

Mental Health Illness

Most study has focused on studying self-destructiveness in mentally healthy individuals, as to shine a light on numerous forms of self-destructive behavior, which are commonly perceived as normal. However, mental health illness plays a major role in self-destructive behaviors and self-destructiveness as a tendency (Tsirigotis, 2017).

People with mental health illness experience life with greater difficulty than the mentally healthy. For example, people with psychotic illnesses such as schizophrenia and paranoid disorders usually have bleak perceptions and outlooks on the world; they view it as full of injustice and strife, they give up on activities and find it difficult to persevere in order to achieve their goals or to avoid themselves possible harm and defend themselves in threatening situations (Tsirigotis, 2017).

People who live with a diagnosis of schizophrenia have been found to engage in higher levels of self-destructive behaviors; both in intensity and quantity. These include self-mutilation and self-injury, as well as attempted and completed suicides, and other more discrete manifestations such as feeling helpless in the face of difficult situations, approaching hardship with passivity, struggling with maintaining personal self-care and health maintenance, and engaging in risky, impulsive, and aggressive activities. They find themselves in cycles of learned helplessness continuously reinforced by inability to control or manage the impact of their psychosis on their condition (Tsirigotis, 2017).

Another mental health illness closely connected to SDB is Borderline Personality Disorder (BPD), which is often assessed in severity in relation to the severity of SDB demonstrated by individual (Sadeh & Baskin-Sommers, 2016).

Individuals with BPD are marked with high risk for suicidality, engaging in various forms of self-harm, risky and impulsive behaviors, as well as substance use, and finally disturbed interpersonal functioning characterized by intense episodes of rage and aggression, manipulation, and self-sabotage (Kreisman & Straus, 2010).

Understanding BPD has assisted in understanding and treating SDB; understanding that Borderline impulsive rage episodes stem from agitated depressive states, frustration, and feelings of helplessness and loss of control, have assisted in understanding that SDB often serves as a distracting defense against feelings of emptiness and loneliness, a way to communicate psychological distress to others, and a medium for release of self-blame and guilt through self-harm (Kreisman & Straus, 2010).

Formative and Complex Trauma

Traumatized individuals perceive the world in a negative light; this is an extension of maladaptation to the traumatic incident which was interpreted from a place of helplessness and loss of control (Gvion & Fachler, 2015).

Childhood trauma was found to predict later self-destructive behavior, especially direct self-destructive behaviors such as self-injury and suicidality. This has been analyzed by understanding that traumatized individuals will often regard and experience distress as a return of a traumatic event, where feelings of anger and fear for safety are activated, and the intensity of emotional needs brings on episodes of dissociation often resolved by resorting to self-mutilation. When this process is combined with the lack of a secure working attachment system, that resulted from a history of separation or neglect or sexual abuse, these individuals fail to contain what they experience and feel even more helpless and out of control (Van der Kolk et al., 1991).

Growing up in a dysfunctional family, experiencing events of conflict, abuse, and witnessing domestic violence, are strong indicators of direct SDB and often considered a main cause for suicidality and onset of nonsuicidal self-injury (Alkhatib, 2019).

Childhood abuse has been linked to the development of destructive behavior and the type of abuse experienced is examined as a predictor of self-directed and other-directed destructiveness. For example, sexual abuse has been correlated to self-destructive behavior, while physical abuse was more related with aggression turned to the outside – towards the “other” (Taussig & Litrownik, 1997).

2.1.4 Manifestations of Self-Destructiveness

Substance Use

Substance use is one of the most prominent manifestations of SDB and is considered both a direct and indirect form of self-destructiveness. One the one hand, individuals, who engage in substance use are willingly introducing harmful substances to their body, and on the other hand, they are neglecting their health and safety (Tsirigotis et al., 2015; Ghanbari et al., 2020).

Substance use refers to the use of legal and illegal drugs, alcohol, medications, and other psychoactive agents, at varying severity levels, with addiction being considered the most severe (NIDA, 2021a). Views on substance use distinguish the term from substance abuse or misuse, as there are distinctions made between individuals from each classification (Mclellan, 2017).

Individuals may engage in substance use for recreational purposes, but while following relatively safe guidelines, such as leaving generous time-lapses in-between each use, maintaining decreased dosages to prevent intoxication, and accounting for predisposing factors to a medical or psychiatric illness (Pavarin, 2006; Mclellan, 2017).

However, when an individual "loses control" over their safeguards against substance abuse and dependence, a substance-use disorder may come to form, and a pattern of physical dependence, continuous craving of substances, and a high risk for relapse, begins to actualize and continues to repeat itself for years (Levis et al., 2021).

Risk factors to substance abuse include family- and community-related factors, such as genetic predisposition, family dysfunction, and insecure attachment to care-givers, in addition to peer pressure, gateway-drug use and recreational substance use, as well as individual factors, such as the relief of a negative affective state (Jadidi & Nakhaee, 2014; Levis et al., 2021). Examples of substances include:

- Nicotine is used by approximately (1.3) billion people worldwide, making it the most common form of substance use as well as the most socially tolerable. Nicotine is smoked with cigarettes, vapor-cigarettes, and cigars, or chewed, or sniffed as powder (WHO, 2021).

- Alcohol is usually consumed as a drink and comes in a wide variety of tastes, flavors, and saturation levels, making it the second most common substance used globally (Rehm et al., 1999).

- Cannabinoids, which includes all Marijuana and Marijuana-related products, such as hashish, hash, hash oil, may be smoked, or consumed as edibles, pills, oils, and drinks (Mclellan, 2017).

- Opioids are substances, which act on "opioid-receptors" in the brain. These include heroin, which is injected, sniffed, snorted, or smoked, or pain-relief medications, such as fentanyl, oxycodone, hydrocodone, codeine, and morphine (NIH, n.d; 2021).

- Depressants such as Benzodiazepines, come in the form of pills, as they are originally prescribed for treatment of medical or psychiatric conditions (Mclellan, 2017).

- Stimulants include prominent names such as cocaine, amphetamines, and amphetamine derivatives such as crystal-meth- and meth-amphetamines. These agents are available legally in the form of medication, such as us Ritalin, and illegally in the form of pills or powder, such as "3,4-methylendioxy-methamphetamine "MDMA" and methylphenidate "Ritalin" (ADF, 2021).

- Hallucinogen is a term describing several types of substances, which are consumed to alter awareness of surroundings, thoughts, and feelings. Classic-hallucinogens users, such as LSD, describe experiences similar to hallucinations, while dissociative-hallucinogen users describe feeling out of control or disconnected from their bodies and their environment in addition to hallucinations (NIDA, 2019).

Nonsuicidal Self-injury

Intentional nonsuicidal self-harm or "Nonsuicidal Self-Injury NSSI" includes all self-mutilating behaviors, parasuicidal behaviors, and otherwise self-harming activities, which are aimed at causing harm to the body without the existing intention of death as consequential to the behavior. This includes cutting, burning, head banging, severe scratching, interfering with healing of wounds, among others. Many often regard these behaviors as "attention-seeking" although they have been confirmed as precursors of suicidal activity and a form of practicing for some individuals. In addition, the various forms of NSSI seem to serve the common purpose of emotional self-regulation in those who engage in them (Kerig, 2017).

When assessing for self-injury, it's important to distinguish suicidal self-injury from non-suicidal self-injury, as each category serves a distinguished purpose from the other. Most people, who engage in NSSI, report almost always experiencing overwhelming negative emotions prior to behavior and a sense of calm and relief as a result. Other, less common interpretations included using self-injury as a form of self-punishment, a form of displaying strength to others and communicating with them, as well as for signaling emotional distress (Klonsky et al., 2014; Kerig, 2017).

An estimated (6%) of adults report a history of self-injury beginning around the age of (13) and (14) years. Many, whose NSSI doesn't continue past adolescence often do not recall these experiences and others describe engaging in NSSI unknowing of its significance in relaying the state of their mental health at the time (Klonsky et al., 2014).

Exposure to traumatic incidents during early childhood, and especially, early experiences with sexual and physical abuse, are strong indicators of later NSSI. The specific mechanism in which this is mediated seems to differ between individuals; some have reported that nonsuicidal self-harm works as a distraction from psychological and emotional pain, while others have used the resulting pain of injury to combat the onset of dissociation and as reassurance that they are still alive or real (Kerig, 2017; Hankin and Abela, 2011).

Reckless and Impulsive Behavior

Recklessness has been conceptualized as a maladaptive coping strategy employed to accomplish a sense of mastery over a stressful environment in which the individual feels helpless and out of control (Kerig, 2017).Often acting against their motivation of regaining

stability, individuals, who engage in reckless behavior and risk-taking, are considered more willing to accept an ambiguous situation, in which it is undeterminable, prior to behavior, to identify the outcome of the behavior (Tymula et al., 2012).

Recklessness and impulsivity may include acting aggressively, taking large financial risks, undervaluation of health demands, and engaging in criminal activities or sexual behaviors, which may result in negative consequences (Sadeh & Baskin-Sommers, 2016).

Impulsivity can be understood as a combination of "acting without thinking, impatience, and sensation seeking". This model suggests that individuals, who are identified as impulsive, are more likely to display hyperactivity without much consideration or attention to environment, a lower threshold for reward delay endurance, and a higher threshold for sensory stimulation (Romer, 2010).

Another prominent model of understanding impulsivity and recklessness is the "Negative Urgency, Premeditation (lack of), Perseverance (lack of), Sensation Seeking, and Positive Urgency Model" or "UPPS-P Model" abbreviated. This model suggests that impulsivity is multi-faceted pattern of behavior, consisting of impulsivity-related personality traits; (1) "Urgency" and "(2) "Negative Urgency" refer to quick reactions in response to a positive or negative emotion being experienced, (3) "Lack of Premeditation" is defined by acting without previous consideration or planning, (4) "Lack of Perseverance" is identified as both inability to tolerate boredom and inability to focus attention when distractions persist, and (5) "Sensation Seeking", which indicates a tendency to seek arousal and excitement (Curry et al, 2018).

Communication and Sociability

Social and interpersonal skills are crucial for fulfilling the needs for integration and belonging to others, as well as feeling appreciation and acceptance by them. Thus, attention-seeking behaviors such as anger or rage outbursts, in addition to belittling others, talking non-stop, or interrupting them, can cost the individual the respect and admiration of their social surroundings. This also applies to defiance, opposition, and stubbornness, which are performed as part of the individual's excessive efforts to contain stress and to regain a sense of control (Carucci, 2019).

Individuals, who feel as if they can't belong to significant others or relate to others in their social environment, often act in a self-defeating manner; someone may act in a way that is deemed harmful by their interpersonal context, while others are viewed as helpful (Thau et al., 2007). People, who follow self-defeating patterns, are usually motivated by feelings of shame. They view themselves as flawed, unworthy, unfit, and essentially not good enough. Their self-defeating behaviors reflect thoughts and emotions born from an event or events, in which they perceived themselves failing to meet expectations of a significant other, their community, or their social and ethical demands (Cassiello-Robbins et al., 2020).

While some individuals are too expressive in coping with distress, others are more passive and vulnerable; they may freeze-up in high-risk situations, or resort to escapism, avoidance, and dissociation. Although at many times this is done subconsciously, it reflects an internal attitude of giving up and succumbing to helplessness, restricting the individual from self-fulfillment and exercising agency (Carucci, 2019). Indeed, social isolation is often referred to by sociologists as a precursor to psychic death, which leads individuals to regress until they lose the motivation to struggle and act independently and autonomously (Ramsden & Wilson, 2014).

Suicide and Suicidal Behavior

According to the latest update by the World Health Organization in (2019), around (800,000) people die by suicide every year. Suicide is a cross-cultural, cross-generational public health issue, which impacts people in different socioeconomic classes, though the phenomenon seems to be more common in certain sociodemographic groups. For each recorded death by suicide, there are many more unrecorded and recorded attempts, with both events sending long-lasting shockwaves of pain throughout the deceased's or survivor's family, community, and larger society (WHO, 2019).

Suicide is believed to be an ancient phenomenon and is regarded as a part of the human condition. It has been analyzed and dissected from theologian and philosophical perspectives long before it began gaining necessary attention which led to the multiplication (Hassana, 1998).

Scholars of different disciplines have addressed suicide from a variety of perspectives. Suicide was historically observed as an act of utmost individuality until sociologists such as Emile Durkheim motivated the shift to address suicide as a manifestation of social problems, which impact the individual beyond what is known to their consciousness (Ramsden & Wilson, 2014).

Lethality of suicidal attempts relies on a multitude of factors. Individuals who attempt and complete suicide seem to be epidemiologically similar to each other, but different to individuals who engage in other forms of deliberate self-harm activities (Levi-Belz et al., 2013).

Medically serious suicide attempters have fewer previous attempts, lower levels of depression, exhibit less previous help-seeking behaviors and geographical mobility in the year before the attempt, and have fewer serious medical problems. In addition, they are twice more likely to complete suicide, than their non-medically serious counterparts. Severity and lethality of suicidal behaviors seem to depend highly on the individual’s inability and reluctance to communicate and express the mental pain they're experiencing, in addition to having little to no social support from family or peers (Levi-Belz et al., 2013).

In a study by Pilyagina (2004), the psycho-pathological basis of suicidal SDB was analysed to reveal that childhood trauma plays a major role in setting forth an interaction of several factors, which can increase the lethality and risk of SDB, as well as stimulate the shift from indirect self-destructiveness to suicidality and direct self-harm. These included internalized aggression, psychological pain, impulsivity, and lower internal locus of control. These individuals, as a result of experiencing hardship and adversity during childhood, grew up with intense feelings of rage and sadness that they did not express, nor learnt to express and appropriately externalize later on. Furthermore, the reality of abuse and neglect these individuals experienced during childhood has led to the development of negative core-beliefs, understandably fuelling a vicious cycle of helplessness magnified by cognitive distortions; hence leading them to view themselves as passive or under the mercy of the world and others around them (Pilyagina, 2004).

In addition, case studies involving self-destructive processes culminating in suicidal behavior suggest that suicide may be the result of unbearable mental pain produced and generated by self-destructive patterns (Orbach, 2007).

Risk factors of suicide include:

- Having a history of suicidality or a previous attempt.
- Living in a low- and middle-income country.
- Suffering from Depressive Disorders in a high-income country.
- Suffering from Alcohol-Use Disorders in a high-income country.
- Having recently dealt with a financial crisis.
- Following the termination of a relationship.
- Suffering from a Chronic Pain Syndrome.
- Suffering from a physical illness (WHO, 2019).

2.1.5 Theories Interpreting Self-Destructiveness

Durkheim's Anomies

Emile Durkheim is possible one of the most prominent figures to address suicide from a sociological point of view. His book "suicide" discussed how suicide can be understood as a symbol for social dysfunction and that the intention and reasoning behind the act of suicide may reflect underlying causes in each victim. Durkheim also believed that suicide was more than the intentional act of taking one's own life, but rather included all positive and negative acts, which directly and indirectly produce the result of death (TenHouten, 2016; Singh, 2020). Durkheim recognized society and social interaction as the ultimate source for social regulation and integration, which guided and shaped people's behavior. He believed that social stability on the collective level maintained an underlying emotional stability on the individual level (TenHouten, 2016).

Durkheim identified four types of suicide as follows:

- Egoistic suicide: Individuals who commit egoistic suicide are motivated by a lack of social integration; they often identify as outcasts or outsiders, they seek freedom in their suicide from constantly struggling with loneliness and an abundance of individuation and independence, and they receive very little or no social attention and nurturance.

- Altruistic suicide: In altruistic suicide, individuals are too assimilated to their society and are so integrated to their groups that they would end their own lives for their group's benefit. These individuals consider themselves tributes, sacrifice themselves for the collective benefit of the group, and do not question the worth of their lives compared to the socio-political, national, or cultural causes they serve. Examples of such can be noticed across history, such as the case of suicidal bombers and kamikaze pilots.

- Anomic suicide: These individuals commit suicide as a reaction to a lack of social regulation during a time of unexpected high distress and frustration, which suicide provides an escape from. Examples of which are individuals, who have fallen into unemployment or poverty as a result of a financial crash, a natural disaster, or political unrest.

- Fatalistic suicide: These are events of suicide caused by keeping individuals under tight regulation; individuals may feel suffocated by expectations society has of them and resort to suicide to escape this exhausting reality (Singh, 2020).

Neurobiological Perspectives

Some neurobiological perspectives on self-destructiveness argue that SDB is innately acquired as a pre-existing tendency for impulsivity and pleasure-seeking, which continues onto adolescence and adulthood without proper behavioral modification (Romer, 2010). Other views suggest SDB to be founded in childhood traumatic experiences impacting the structure and functionality of the amygdala, the prefrontal cortex, and the hypothalamus. An individual who was exposed to trauma at a young age shows a heightened response to threat later on; their amygdala may indicate to the brain that an event is more threatening than it is and therefore trigger both the primal urge to defend one's self from psychological or physical pain and a consecutive decrease in prefrontal cortex activity, which is mainly responsible for reasoning, judgement, and other cognitive tasks. Rather than face distressing situations with clear-mindedness and emotional stability, those who come from traumatic childhoods act in self-preservation and seek relief and safety in habitual behaviors at the cost of change, as the hypothalamus works to regain a sense of equilibrium (Carucci, 2019).

SDB has been found to be prevalent within the animal world, despite the notion interpreting self-harm and suicide as a choice to self-destruct and a result of a reflection on life and death (Ramsden & Wilson, 2014). Indeed, SDB may be widely influenced by interrelated biochemical imbalances in Serotonin, Norepinephrine, and Dopamine, in addition to malfunctioning in the Hypothalamic-Pituitary-Adrenal Axis (Carballo et al., 2008).

Psychoanalysis

Based on Freud's proposition that the mind develops in connection to the body, the body's sensations, and the body's reactions to painful body experiences, psychoanalysis suggests that the role of the mother, as the child's primary caregiver, is essential in the development of the child's "Ego", through internalisation. When the mother is not responsive to child's need for nurturing as well as regulation, Freud suggests the child's Ego remains vulnerable and relies on more primitive defences including projection, projective identification, and splitting. This would continue onto adulthood, where the individual manifests, onto and using their body, their lack of differentiation. These individuals are considered to have confused concepts of "Good and Bad", "The Self and the Other", and "The Inner Reality and the Outer Reality" (Yakeley & Burbridge-James, 2018).

This internal turmoil may push the individual to act upon their "Death Instinct", which is related to feelings of guilt, tendency for suicidality, melancholia, and sadomasochism, and represents the psyche's perception of death as an "earlier state of things". Psychoanalysts noted that self-destructiveness is always fuelled by internal psychological pain, but shaped by a pathological mourning of an ambivalent love-hate relationship with a loved one. These individuals represent both wanting to kill and to be killed; i.e. to punish and to be punished (Orbach, 2007)

Even in antisocial individuals, who psychoanalysts consider highly self-destructive, behavior can often be regarded as a response to feelings of alienation and perceived or real experiences of rejection, which cause the Ego to lose self-regard and the Superego to relinquish control (Kerig, 2017; Yakeley & Burbridge-James, 2018). An additional layer to SDB, according to psychoanalysis, is the rewarding pleasure of toying with death by self-

exposure to dangerous events, which is closely related to actual experiences of neglect and abuse integrated within the self's organization as catalysts for an "internal saboteur" (Orbach, 2007).

2.1.6 Treating Self-Destructive Behavior

Many self-destructive behavioral patterns can be interrupted through coaching, training, and self-development activities aimed at achieving better personal growth, increasing motivation and productivity. This applies to habitual behaviors that reflect a flawed reward system focused on short-term relief rather than sustainable functionality. Insight building is crucial in changing self-destructive patterns of behavior; accessing the origin stories to where self-destructiveness began can assist in understanding the goal the behavior serves and the circumstances triggering it. Within this paradigm, when treating SDB, it is important to ask the questions:

- When was this behavior developed?
- How was it learned and reinforced?
- What purposes does it serve for the individual? (Carucci, 2019).

This is not done without serious and critical introspection; the individual must learn to confront that in their self-destructive practices they may be inflicting pain onto themselves as a way of self-enhancement, preservation of continuity of the self, establishment of boundaries, and a sense of being alive (Orbach, 2007).

Once the individual has achieved to endure the necessary process of reconciliation and healing with the psychological pain fueling pathological patterns of adaptation, they can consciously attempt to break the vicious circle of self-destructiveness by introducing alternative behaviors to self-destructive ones but serve the same purposes (Carucci, 2019).

Although most would recommend a mixed clinical methodology for addressing SDB, some have suggested certain adaptations of psychotherapeutic protocols have shown more merit than others. An example of this is "Short-Term Crisis Psychotherapy", an adaptation of Existential Psychotherapy, which has been linked to the decrease of parasuicidal SDB, in which patients attempt suicide without being motivated by the will to die. However, it was deemed impossible in patients with psychotic disorders, and less affective in non-suicidal self-destructive presentations (Pilyagina, 2004).

Another example is "Awareness and Commitment Therapy ACT", which is a third-wave cognitive-behavioral therapeutic protocol aimed at improving the quality of life through decreasing the impact of ineffective adaptation and coping strategies and enhancement of value-based behavioral change, which will ultimately increase psychological flexibility. This model focuses on mindfulness and grounding to the here and now, re-examination of values, resolving cognitive dissonance, experimenting with acceptance, building resilience factors, and commitment to confrontation rather than avoidance (Ghabari et al., 2020).

2.2 Section Two: Attachment Styles

Attachment suggests the existence of a mutual interdependent bond between the mother and the child, which serves in assisting their socio-emotional development and satisfaction. In the most basic of definitions, attachment is a biologically driven intuition towards needing to feel closeness and intimacy and the inclination to preserve this relationship and protect it for what it provides in comfort, safety, and security for the individual and therefore the collective. An attachment style develops during infancy and is later refined through experiences with others during childhood, adolescence, and adulthood. A person's attachment style can often help define the quality of their relationships, their emotional stability, their self-esteem, and their overall resilience towards distressful life experiences. It ultimately acts as the individual's psychological immunity response system (Alrashdan, 2005; Bockarova, 2019; Ehrlich, 2019).

2.2.1 Development of Attachment

Several attempts have been made to categorize the development of attachment by classifying specific stages and levels in which it is formed. Some contributions hypothesized that attachment is an on-going and dynamic process, highly dependent on experiences during the individual's early childhood, but is also subject to change and manipulation later on due to major interpersonal and intrapersonal events (Schaffer and Emerson, 1965; Alrashdan, 2005; Cozzarelli et al., 2003).

Other contributions suggested that it is possible for some aspects of attachment to become "overwritten" as new information is presented to the individual, which contradicts previously acquired representations of the self and the other, but it may still be unclear, whether this would include core models developed in the first year of life, or if it will only include more recent information and experiences (Fraley, 2018).

Bowlby and Ainsworth's model of attachment distinguished four semi-distinct stages of attachment development (Alrashdan, 2005; Wilson-Ali et al., 2019):

- First Stage (0 – 3 Months): In "Pre-attachment", the child is introduced to the feeling of attachment and becomes more and more inclined towards closeness from others without distinction of the identity of care-provider. The child interacts with everyone almost the same way and depends on his sense of hearing to predict comfort.

- Second Stage (4– 6 Months): In "Attachment in the Making", the child begins to identify mother or primary care-provider, who becomes the child's favourite in comparison to others with whom child interacts but at a lower intensity and intrigue.

- Third Stage (7 Months – 3 Years): In "Clear-Cut Attachment", the child prefers spending time in proximity to mother and begins regarding her as a launching centre for exploration, which may be observed through movements from and to mother while others are distrusted and feared causing relationships with them to weaken.

- Fourth Stage (4 Years and Older): In "Goal-Corrected Partnership", the child begins to form social relationships with others as differentiation and independence increase and child understands mother as a separate entity, with her own feelings and motives, and varying distance or closeness to child over time.

2.2.2 Theories on Attachment

The Attachment Theory

The attachment theory refers to a hypothesis stated by John Bowlby in (1994), which suggested early attachment-related experiences could possibly predict juvenile delinquency as it can be founded in separation from mothers, or inconsistent or harsh treatment by them and fathers or other men who were involved with the mothers. Bowlby's hypothesis was developed over decades of study to provide an effective understanding of attachment patterns and their origins in care-provider behaviors and attitudes towards their care-giving tasks (Cassidy et al., 2013).

The attachment theory perceives attachment as a biologically based construct, which can be applied universally across cultures, is passed on transgenerationally from caregiver to infant, and is both dynamic but yielding stable predictions overtime. Although attachment theory had been initially used for providing a better understanding of children's behavior, in recent years, it's increasingly used to conceptualize reactions to abuse and violence and their implications on mental health both in adults and children (Bolen, 2000).

Attachment theory attempted to develop an outline for understanding and treating children, in addition to coming up with predictions for future inter- and intrapersonal patterns of functioning – including psychological illness. Attachment theorists hypothesized that one's attachment style represents an internal working model of generating, regulating, interpreting, and predicting behavior, thoughts, and feelings towards the self, others, and the surrounding environment. In a sense, they are guidelines for appraisals of experiences (Levi-Belz et al., 2013; Symons & Szielaso, 2011).

Attachment theorists believed that difficult situations activate an individual's attachment behavioral system, which decides much of how an individual will cope and deal with stress, and accordingly, attachment styles have come to be viewed as general risk factors for psychopathology. This is due to the role securely-attached relationships play in communication, social competence, building resilience, and facilitating adjustment to distress, in contrast to insecurely-attached relationships, which are manifested by feelings of inadequacy and a reduced sense of ability to overcome (Levi-Belz et al., 2013; Fraley, 2018).

The attachment theory initially suggested three types of attachment still used to this day; secure attachment, anxious attachment, and avoidant attachment. However, these types were later reviewed with each original attachment style conceptualized as an aspect of a general attachment tendency. The interaction between the three attachment aspects was suggested to result in one or four styles; a secure attachment style, a dismissive attachment style, a disorganized attachment style, and an ambivalent attachment style (Mikulincer & Shaver, 2012).

The theory is certainly not impervious to criticism and limitations, and therefore much of the theory remains open for discussion and consideration while awaiting a point in which empirical findings can decide on the validity of the theory's hypotheses (Bolen, 2000).

Neurobiological Interpretation

Neurobiological study has confirmed the existence of brain circuitry providing for the development of an attachment system required to ensure the fulfilment of the infant's biological and psychological needs. The structure of the brain changes as a result of childhood experiences interacting with genetic factors. These structural changes include the number of neurons, level of complexity of dendritic branches, and number of synapses indicating communication sites between them (Sullivan, 2012).

Neurobiological study suggests that a maternal presence during difficult events significantly alters the way in which the amygdala processes the event taking place, the way these memories are stored, and whether recollection and integration of event may cause later emergence of mental health issues, especially events occurring during the preadolescence stage. During adulthood, this may appear as a tendency to engage in self-destructive behavior, as these individuals often report feeling distrustful of others and worried about social rejection, and therefor find difficulties in reaching out to others for support and ventilation (Sullivan, 2012; Stepp et al., 2008).

The Polyvagal theory, a rather modernized view on the nervous system's reaction to stress and perceived danger, suggests that a third component is at play when the brain is attempting to reconcile its behavior in a socioemotional event in addition to the classic "Sympathetic – Parasympathetic" paradigm, which have been linked to the social engagement system helping to navigate interactions and connections to others (Wagner, 2016).

The theory suggests that the "Ventral Vagal Nerve" serves to provide more flexibility in social action and reaction as part of the parasympathetic nervous system and reduces the calming and soothing wait time, which would otherwise involve several biological processes lasting up to (10) and (20) minutes before homeostasis is ensured. Additionally, the secretion of fight-flight chemicals often causes severe alterations to affect and cognition, in addition to having great risk on long-term physical health (Wagner, 2016; Cherland, 2012).

The Polyvagal perspective suggests that some individuals experience life in continuous fight-flight. They ultimately shut down due to psychological and physical fatigue until they are reawakened by stronger traumatic experiences. In this they move from states of anxiety to depression and vice versa. In contrast, there are individuals, who experience life from a place of safety and security, and who will show more activation of their social engagement system through ventral vagal nerve activation and express positive affective states and adaptive body responses despite being exposed to stress-inducing stimuli (Wagner, 2016; van der Kolk et al., 1991).

Harry Stack Sullivan

Interpersonal psychoanalysis argued for an expansion in psychoanalysis to include relational, cultural, and social influences on personality development. Harry Stack Sullivan, the movement's founder, believed that humans cannot be understood in isolation from their "interpersonal" environments; consisting of relatedness to significant others in their surroundings. Sullivan theorized that humans learn to rely on others in infancy, such as the need for mother's help in acquiring nutrition and love, and there in for the mother to sense this need and respond appropriately. This creates an emotional experience in the infant, which serves as an idiosyncratic template for future experiences (Brandell, 2010).

Sullivan identified the template created through the breastfeeding experience in early infancy as the first in many in which humans perceive the world around them and thereby themselves. He based this on his understanding of infants as egocentric and incapable of distinguishing the self from the other. Interpersonal psychoanalysis calls the collective of these templates acquired during care-taking experiences "personifications". These are generalized onto other social and relational experiences through transferences (Brandell, 2010).

In the example of a positive mutually gratifying breastfeeding experience, the infant would perceive their mother as "good nipple/breast/mother", and therefore perceiving themselves as "good me" for inducing positivity. In most cases, following this logic, a negative frustrating experience of breastfeeding, would result in the development of a negative personification where the self is "bad me" for causing the "bad nipple/breast/mother" experience. However, in certain situations, which entail profoundly painful or terrifying breastfeeding experiences, the infant would develop "the not me" and "evil mother" personifications (Brandell, 2010).

Margret Mahler

Margret Mahler was a prominent psychoanalytic scholar who focused on the study of development. She believed that infants were born "objectless" i.e. nonrelated to an object and that their growth was closely related to stages of "separation and individuation" from the objects around them (Brandell, 2010; Lapsley, 2010).

Mahler considered that infants and their mothers become tangled in mutually beneficial relationships, in which the infant is initially completely fused with the mother and incapable of perceiving themselves without her. As the infant grows from this "pre-objectal" stance, they are gradually released from their dependant states (separation) and they assume their individual selves (individuation) (Brandell, 2010).

Mahler identified four subphases for the child's growth into "Object-Constancy". In each phase, the child gradually becomes more aware of the mother as a separate person, who is independent of the child and therefore, not always available to assist the child in their interaction with the environment. To Mahler, this understanding aided the child's transition into the formation of more stable images and mental representations regarding the self and the others, in addition to acquiring the ability to integrate both good and bad qualities of the self and the others in a one unified representation. Mahler also understood the child is compelled to learn to deal with newly acquired feelings of frustration with the world and the mother; on the one hand, the child is innately driven to interact with the surrounding world, and on the other hand, set-backs during the practicing period clash with the child's early sense of omnipotence (Brandell, 2010).

She suggests that there is a level of anxiety associated with these open-ended life-long processes; worrying that that mother will go away and not return (separation anxiety) and worrying that the self is incapable of exploring objects in the surrounding world without the aid of the mother (undifferentiating), a feeling created by an unwilling or unprepared mother to relinquish physical and emotional control over the infant. In addition, failure to develop object-consistency may result in "Rapprochement Crisis", which plays a significant role in later psychopathology (Akhtar, 1994; Brandell, 2010).

2.2.3 Classification of Attachment

Secure Attachment

Secure children represent the normative aspect of Bowlby's attachment theory. Mary Ainsworth's strange-situation experiment revealed that most children (about 60%) respond according to the secure-attachment paradigm when they are faced with a strange and uncomfortable situation (Fraley, 2018). Children with secure attachment style are easily soothed and comforted; they enjoy a sufficient level of patience, and trust that negative experiences, such as pain and frustration, are temporary (Symons & Szielaso, 2011).

When these children grow into adults, they trust what they have learned during early childhood, and feel comfortable and safe seeking proximity to a significant other or care provider, who would in return always behave to show that they are available to support them and interact with them in a sensitive and responsive fashion (Mikulincer & Shaver, 2012). This is due to a process referred to as "Attunement", which is defined as emotional synchrony between the child and their care provider, achieved by matching the affective content and severity in both the child and the caregiver, and reflecting the empathy of the care provider to the child's experience and needs. Individuals, who had attuned parents, can themselves be attuned to their own needs and experiences (Ostlund et al., 2017).

Secure children learn from their caregivers how to appropriately express and navigate different emotions. They were allowed to experience vulnerability and intimacy and to express their biological and psychological needs (Mikulincer & Shaver, 2012). When these children grown into adolescents and later adults, they manoeuvre life challenges and developmental tasks with the same ease they did as toddlers. They rely on their support-systems for encouragement and guidance, they accept criticism, and they have a higher capacity for emotional and stress regulation (NCCMH, 2015).

Anxious-Avoidant "Dismissive" Attachment

Individuals with avoidant attachment styles often act upon fears of intimacy and dependence, and hold negative working models of others. These result in a deep sense of distrust of relationships with others, and therefore a reluctance to seek them out and related feelings of alienation and detachment. Individuals with this type of attachment tend to suffer quietly and in isolation as to not rely on others because they believe they will not be appropriately responsive to them. As such, they disclose little information about themselves and avoid intimate topics in their conversations (Levi-Belz et al., 2013).

Additionally, dismissive attachment style has been linked to psychopathic affective-interpersonal traits and tendency for impulsivity and irresponsibility (Conradi et al., 2015). Dismissive individuals learned through their childhood experiences to highly regulate their emotions and attachment behaviors in order to maintain proximity to their caregivers. As a result, dismissive children avoid strangers and strange situations; they respond to uncomfortable situation with great anger and distress, and they are not quickly soother or calmed by the caregiver's arrival, as the care-giver doesn't symbolize security and safety, but rather emotional atrophy (NCCMH, 2015).

Parents of dismissive children are often also themselves dismissively attached; they struggle with empathizing with their children's needs, they reject their children, and they hold them to an impossible behavioral standard, which implies that the more distressed they are, the less they should seek comfort and support from their caregivers and later on

partners. Furthermore, years of separation and frustration with caregivers have caused these individuals to develop much higher tolerance than any other attachment style for emotional distress following a separation or loss; they not only recover faster, they're also adept at suppressing their negative thoughts and feelings (Simpson & Rholes, 2018).

Anxious-Preoccupied "Ambivalent" Attachment

Individuals with an anxious-preoccupied or "Ambivalent" style of attachment are usually fearful of rejection and abandonment, and hold negative working models of themselves. These result in feelings of worthlessness and uselessness, which in turn act as amplifiers of disbelief of others' positive feelings towards them. Accordingly, ambivalently attached individuals will often experience higher levels of loneliness in romantic, familial, and otherwise social contexts (Levi-Belz et al., 2013).

Ambivalent individuals view the world as dictated by a lack of security and stability. They are continuously experiencing anxiety and fear, and in a perceived reality where there is no sense of safety, their attachment systems are often hyper-activated and many life-events are viewed as threatening and dangerous. These individuals have a relatively strong longing for intimacy and closeness, but lack the ability to trust others' reliability and consistency in responsiveness (Ahmad & Hassan, 2014); In other words, they do not necessarily believe others are "bad" but rather feel they can't trust they will always be there to provide for their needs. Regardless of their constant anticipation of abandonment, they experience intense feelings of distress and psychological pain once their fears are realized (Symons & Szielaso, 2011).

According to attachment theory, this can be explained by resorting to an understanding of these individuals' childhood experiences with their care-givers. Children of parents who were inconsistent in terms of their availability and disciplinary behaviors often develop complimentary reactions to perceived neglect and emotional malnourishment, such as attention-seeking and acting-out behaviors. Furthermore, and since ambivalent parents are themselves "emotionally hungry" and often distracted by their own insecurities, their children become mediums for satisfaction of emotional needs, and as a result of preoccupation by their own problems; the parents fail to return this service to their children when they, in turn, need reassurance and comfort (Firestone, 2019).

Most of these parents are more concerned with looking as good parents, than they are concerned about providing to their children what is needed when it is needed, thus leaving the child emotionally drained and pressured to overachieve and earn the parent's acceptance and approval, often unsure of whether they can trust and depend on others. Parents of ambivalent children are likely intrusive in their care and are not attuned to the child's needs; they have difficulties understanding what their children need, or ignore the child's cues, or they do not respond within an appropriate timing to the child's distress (Firestone, 2019; Symons & Szielaso, 2011).

Later on as these children grow into adolescents and adults, and to resolve anxiousness related to perceived abandonment and rejection, individuals with ambivalent attachment style strive for reassurance and affirmation in their relationships, albeit not trusting their partner's attempts to comfort them since they have been accustomed to receiving deceptive feedback from parents during childhood. They often demand proof that their partners truly love them, experience emotional hunger for their partners, perceive their partners as heroes or angels that rescued and completed them, and finally they cling to their partners as they used to cling to their partners hoping that this behavior would quell their thirst for safety

and security in the relationship. Ultimately, these high expectations of the partners usually combined with jealousy and possessiveness, as well as the constant demand for attention and care, put immense strain on the relationship and push the partner away, who finds themselves labelled as insensitive, cold, or apathetic to their needs (Firestone, 2019).

Fearful-Avoidant "Disorganized" Attachment

Disorganized attachment is believed to be the result of experienced abuse and trauma during early childhood. Those who grow up with disorganized attachment have received inconsistent emotional cues ranging from support to verbal and physical or sexual abuse; they have themselves been victims and/or witnessed their attachment figures commit traumatizing acts. Disorganized individuals have felt a lack of and betrayal of safety by their parental figures turned from "loving" to "threatening" and therefore becoming a source of both fear and love. Consequently, these individuals' attachment style revolves around the need to belong and love and connect with others as well as the need to survive and protect oneself from loved ones (Bockarova, 2019).

As adults, they live in a perpetual state of fear and insecurity, despite constant reassurance by their surroundings. They are in a continuous state of dissonance and incongruence; they are both compulsive caregivers and coercively controlling and they find it difficult to understand that these states counteract each other, whether for the self's or others' benefit (NCCMH, 2015).

This disrupted and disoriented interpersonal model is also manifested in relationships with romantic interests, friends, family, peers, and in their own identity formation. Due to viewing the images of their caregivers change radically from loving to inflicting pain, the self-image of someone with disorganized attachment often "splits"; they transform from overly trusting to suspicious, from being happily engaged to withdrawing abruptly. Indeed, they are often imagined with protective metaphoric walls built around themselves, shielding them from feelings of rejection and allowing them to pull away from others and further alienate them (Bockarova, 2019; NCCMH, 2015).

Disorganized individuals are moulded by their traumatic pasts to suffer from a negative self-image and self-talk and to view the world from a survival's point of view; surviving the pain and hardship that a relationship or connection they crave would inflict on them – here the feelings of abandonment, rejection, and victimization. This is mainly because they experience menial events with heightened sensitivity and respond erratically to their perception and interpretation of acts and gestures made by people around them, usually interpreted as precursors to abandonment or abuse and acted upon without validation of suspicions in a self-fulfilling prophecy of abandonment (Bockarova, 2019).

2.2.4 Impact of Attachment

Impact of Attachment Style on Relationships

The impact of attachment style extends onto the success of social and intimate relationships, as it relies on the emotional interaction between individuals and the exchange of communication between them (Firestone, 2019). In intimate and romantic relationships, attachment styles of partners are a key indicator of shared closeness and affection or discord and instability. Individuals most often than not replicate their relational patterns with their caregivers during childhood and relive them in adulthood. This is part of

the larger attachment system, which provides context for understanding the world and the self (Ahmad & Hassan, 2014).

When securely attached people engage in romantic and intimate experiences with others, they usually perceive the other as a source of protection, support, and comfort – a replication of the perception of the care-giver as a secure base from which to explore and experience the world. This is achieved through physical and emotional proximity, and reciprocated vulnerability (Ahmad & Hassan, 2014; Cassidy et al., 2013). However, when insecurely attached people attempt to form social, romantic, and intimate bonds with others, internalized pain brought on by childhood experiences of disappointment and frustration begin to interfere with their ability to trust their prospective partner or friend (Ahmad & Hassan, 2014).

Attachment theorists explain this in connection to negative internal working models "IWM" of the self and others, which are based on stories from attachment experiences, such as "I can't trust that I can go to my mother and receive comfort and care when I am hurt" (Cassidy et al., 2013).

Securely attached children grow to value their relationships as sources of joy and happiness, highlighted with feelings of safety and comfort. They are able to identify imperfections and shortcomings of their partners without lingering on the mistakes they make, but rather striving for understanding, mutual compromise, and stability (Ahmad & Hassan, 2014). In contrast, adults who have developed insecure attachment styles as children, have not been accustomed to having their needs met by others, and therefore have developed maladaptive patterns in coping with distress caused on by triggered childhood experiences of neglect and abuse (Firestone, 2019).

Hazan and Shaver (1987) noted that adult romantic relationships share similar features to infant-caregiver relationships. In both relationships, the other's responsiveness and reciprocation of emotion and communication bring on feelings of safety and joy, while their inaccessibility causes feelings of insecurity. In addition, both relationships entail an aspect of closeness, intimacy, physical contact, baby-talk, sharing discoveries with the other, and a mutual fascination and preoccupation with the other (Fraley, 2018).

Codependence and Interdependence of Attachment Styles

Despite their need for constant care and availability, individuals with ambivalent attachment often find themselves being drawn to people with an avoidant attachment style (Disorganized or Dismissive Attachment Styles). These two dynamics interact to create a pattern of codependence, in which the avoidant individual finds an excuse to emotionally withdraw from their ambivalent partner's demanding and needy nature. In turn, the ambivalent individual reacts to their avoidant partner's distance by further fuelling the relationship with passion and intensity in hope that it would act against their partner's perceived abandonment. This dangerous dynamic perpetuates each of the partner's previously acquired insecurities, extending their relationships with their parents onto their relationships with their partners, therefore creating a vicious circle of pain in the relationship (Firestone, 2019).

Initially, codependence was a term describing wives of alcoholic individuals, who were also seen as suffering with disturbed patterns of interpersonal relationships, as they continued to remain in a relationship with an abusive instable partner and by doing so, were enabling their partners to continue their substance abuse. Codependent individuals are

not considered necessarily mentally ill, but rather codependence has become a signifier, within interpersonal functioning, to an underlying problem with the level of emotional constraint practiced, the repeated process of self-sacrifice, a high threshold of endurance of interpersonal conflict and loss of control, as well as a tendency towards external focusing (Bacon et al., 2018).

Impact of Attachment Style on Mental Health

Insecure attachment styles have been linked to decreased resilience and higher tendency for maladaptive coping and therefore considered as risk and predisposing factors of mental health illness. For example, individuals with dismissive or secure attachment styles are often at lower risk for suicidal behavior than other styles. In comparison, ambivalent and fearful attachment styles struggle with emotional dysregulation and report feeling confused about who they are (Stepp et al., 2008; Mikulincer & Shaver, 2012).

Furthermore, specific attachment styles have been linked to personality psychopathology; individuals from the avoidant styles cluster showed features of narcissistic, avoidant, antisocial, and schizoid personality disorders, while individuals from the anxious styles cluster showed features of borderline, histrionic, and dependent personality disorders (Stepp et al., 2008).

Both anxious and avoidant dimensions of insecure attachment could be associated with depressive disorders, anxiety disorders, OCD, PTSD, suicidality, and eating disorders. Even more directly connected are attachment-based disorders, which represent clinically recognized patterns of pathology resulting from insecure attachment events, such as Separation Anxiety Disorder and Pathological Grief Disorder (Mikulincer & Shaver, 2012).

Studies indicated that attachment styles are both directly related to SDB and through mediating factors. For example, (Metwali et al., 2019) found significant relationships between substance use and attachment styles, while (Stepp et al., 2008) found that some attachment styles could amplify psychological pain experienced by individuals in interpersonal distress, which would possibly result in higher lethality suicides (specifically in anxious and avoidant attachment styles).

In addition, studies indicated that attachment-related factors, such as perceiving high level of mothers' inhibition of exploration and individuality, a high level of fathers' rejection, and having a low satisfaction with family relationships increased the likelihood of developing a clinical condition, while an increase in mothers' quality of emotional bond, fathers' control, family cohesion, and decrease in mothers' control lead to decreased likelihood self-destructive thoughts (Cruz et al., 2013).

2.2.5 Factors Influencing Attachment Style

- Individual differences: individual differences in early childhood experiences play a role in the stability of the organization of the attachment system over time and in situation- and person-specific manner (Fraley, 2018). For example, a person’s disordered temperament will often override attachment patterns, as it simulates a biological urge and drive away from uncomfortable situations. Furthermore, manifestation of attachment styles may be influenced by introverted / extroverted tendencies (Mangelsdorf & Frosch, 1999).

- Relational interactions: theorists on attachment have unanimously suggested that positive or negative meaningful interactions and relationships during adolescence and adulthood may move a person across attachment regions subtly or abruptly, as means of adapting with new interpersonal stress (Davila & Cobb, 2003; Mikulincer & Shaver, 2012).

- Identity of caregiver: the mother, naturally, plays a major role in the development of the attachment system, as she has already begun developing a bond with the child during pregnancy and labour. However, relationship to the father or to siblings seems to play a role in prevention of dependence on the mother or identification with her (Fraley, 2018).

- Number of caregivers: studies have shown that an increase in number of caregivers or family size may cause the child to have weaker bonds with one main caregiver and the child has (Gervai, 2009).

- Exposure to traumatic events and abuse: severe interpersonal distress, such as an abortion or miscarriage, recurrent experiences of abuse, political violence and war, or imprisonment, can move individuals towards attachment insecurity (Mikulincer & Shaver, 2012).

- Purpose of attachment: some studies are attempting to assess whether an attachment system is completely engaged in all socioemotional relationships, or if it only activates in romantic and intimate relationships, which necessarily serve attachment-related functions (Fraley, 2018).

2.3 Previous Studies

2.3.1 Self-Destructive Behavior

Taussig and Litrownik (1997) studied a sample of children who have been placed in foster care to determine whether the type of destructive behaviors they engage in (Self-directed or other-directed) could be related back to the type of abuse they had experienced during childhood (Physical abuse or sexual abuse). Results indicated the children who have experienced physical abuse tended to engage in other-directed destructiveness, while children have experienced sexual abuse tended to be more so engaged in self-directed destructiveness (Taussig & Litrownik, 1997).

In (2003) Bolland tested the relationship between inner-city life, losing hope, and risky behavior by surveying (2468) inner-city adolescents, in the city of Mobile, Alabama, on hopelessness, violent and aggressive behaviors, substance use, sexual behavior, and accidental injuries, using a multiple cohort longitudinal study design. Examples of the behaviours measured in the researcher's developed questionnaire for purpose of study included carrying a knife, smoking, drinking alcohol, a suicidal attempt, and getting into a physical fight. Around (50%) of males and (25%) of females had moderate or severe feelings of hopelessness. Hopelessness predicted each of the risky behaviors considered in the study (Bolland, 2003).

In a (2005) study by Kelly, Rollings, and Harmon, the relationship between chronic self-destructiveness, hopelessness, and risk-taking behaviors were studied using the correlational study methodology. The Beck Hopelessness Scale, the Chronic Self-destructiveness Scale, and Expected Involvement Scale of the Cognitive Appraisal of Risky Activities Questionnaire, were employed with (245) American undergraduate college students, and the analysis of the results revealed that hopelessness is a main risk-factor for SDB in both men and women, while in men SDB was positively correlated to expected involvement in risky behavior including drug use, heavy drinking, risky sexual behaviors, and irresponsible study/work behaviors. For women, however, SDB was more so positively correlated to involvement in heavy drinking and irresponsible study/work behaviors (Kelly et al., 2005).

To determine prospective pathways between child maltreatment and nonsuicidal direct self-injury, (164) 26-year-old female and male individuals from low-income backgrounds participating in the Minnesota Longitudinal Study of Parents and Children were recruited and completed a semi structured interview about self-injury, by Yates and associates in (2008). Self-injury was found to be a prominent phenomenon in the sample, experiences of childhood sexual abuse predicted recurrent injuring, while child physical abuse was more noticeable in relation to intermittent injuring. These relationships were found to be independent from common risk factors associated with child maltreatment and/or self-injury, such as cognitive ability, SES, maternal life stress, family disruption, and exposure to partner violence during childhood. Dissociation and somatization were more related to self-injury than child maltreatment, and lastly, only dissociation was found as a significant mediating factor in the observed relationship between child sexual abuse and recurrent self-injury. Based on these results, the researchers discussed the possibility of self-injury being viewed as a strategy for compensation and regulation in post-traumatic adaptation (Yates et al., 2008).

In a descripting correlational study by Kumar, Rajmohan, and Sushil conducted in (2013) in India, the sociodemographic and personality related factors contributing to suicide

attempts were assessed using Eyseneck's Personality Questionnaire (Revised), Albert Einstein College of Medicine Impulsivity Coping Scale, and the Past Feelings and Acts of Violence Scale, in a sample of (104) suicide attempters referred to psychiatric inpatient programs of varying ages and developmental stages at the Iqraa Hospital. The analysis revealed young age and being married were sociodemographic contributors of suicide, while other non-sociodemographic and psychosocial factors included feeling lonely, feeling like a burden to the family, the inability to solve daily life-problems, the presence of psychiatric diagnosis, neuroticism, impulsivity, violence, and living in a nuclear family (Kumar et al., 2013).

Lim and colleagues conducted a descriptive cross-sectional study in (2017), which was aimed at identifying the risk factors of self-destructive behaviors among Malaysian young adults, identified as non-suicidal self-injury, suicidal ideation, and suicidal attempts. (531) university students aged (18-25) years old were recruited to complete the General Health Questionnaire and a self-reported questionnaire developed by researchers. Preliminary results indicated that (8.4%) had engaged in non-suicidal self-injury, (5.8%) experienced suicidal ideation, and (3.5%) had already attempted suicide at least once. Results also found that severe depression, overall psychological distress, and some chronic physical health problems were positively associated with self-destructive behavior (Lim et al., 2017).

Chronic self-destructiveness was measured in a group of adult women experiencing domestic violence in comparison to a control group not experiencing domestic violence, in following a comparative study design, for the aim of assessing indirect self-destructiveness in women who experience domestic violence, by Tsirigotis and Luczak in (2018). Study used the Chronic Self-Destructiveness Scale "CSDC" with a Polish sample of (52) women aged (30-65) benefiting from services provided at the Crisis Intervention Centre due to experiencing domestic violence, and (150) women not experiencing domestic violence. Data analysis revealed that indirect SDB was much higher among those who were victims of domestic violence compared to the control groups, whether as a total score on the CSDS, or within its subscales (Tsirigotis & Luczak, 2018).

2.3.2 Self-Destructive Behaviour in Arab Samples

Self-harm and its relationship to Borderline Personality Disorder and Depression was studied, in a sample of (180) Jordanian inmates at a correctional and rehabilitation centre, by Musalam and associates in (2007), following a correlational descriptive methodology. The study used the Beck Depression Scale as well as a questionnaire developed by researcher to assess the prevalence of BPD symptoms based on the (DSM-4) criteria for diagnosing Borderline Personality Disorder, in addition to a semi-open interview. Results indicated there was a significant relationship between self-harm and BPD, as well as between self-harm and depression. Males were more inclined to use alcohol, get tattoos, and engage in unsafe sexual behavior than women. BPD-individuals of both genders were inclined to use sharp objects for self-injury, get big tattoos, self-hitting, and abstaining from food, compared to their non-BPD peers, while depressive-individuals were mostly inclined to abstain from food. In addition, BPD-individuals were found to have a high prevalence of depression and self-harm behaviors, and finally, results indicated the substance-use was not a risk-factor to self-harm, but having a relative or friend, who engaged in self-harm, was a strong indicator of the behavior (Musalam et al., 2007).

Sawalha investigated deliberate self-poisoning in a descriptive cross-sectional survey conducted on all patients admitted to Al-Watani Governmental Hospital in Nablus, Palestine, from May of (2008) to April of (2009), who were hospitalized due to an event of deliberate self-poisoning. Data was statistically analysed to reveal the a total of (54) individuals met study criteria, most of which used an overdose of pharmaceutical products to self-poison, and whose mean age was (23.8±7.9) years, with less than (16; 29.6%) of them under the age of (18), (35; 64.8%) women, and (37; 68.5%) residents in the city of Nablus. Additionally, significant associations were found between type of material used for self-poisoning and place of residence and gender (Sawalha, 2012).

In a descriptive correlational study by Alshawashreh, Alrabee, and Sammour, conducted in (2013) with university students in Jordan, the relationship between self-defeating behaviors and self-esteem was investigated in (435) males and females randomly selected to participate in an instrument developed by researchers. Results indicated that no significant relationship could be found between self-defeating behaviors and self-esteem, and that no significant differences were found in prevalence of self-defeating behaviors related to gender, years in college, or high school grade point in the prevalence of self-defeating behavior or self-esteem. Results did, however, indicate that students of moderate academic achievement had a higher prevalence in self-defeating behaviors compared to students of higher achievement levels (Alshawashreh et al., 2013).

In a descriptive correlational study, suicidal ideation and planning among Palestinian middle school students living in the Gaza Strip, the West Bank, and United Nations Relief and Works Agency (UNRWA) camps was studied by Itani and associates in (2017). The study recruited (14303) students, aged (13-15), participating in the Global School-based Student Health Survey "GSHS" in (2010). Questions targeted suicidal ideation and suicidal planning for the past year and a complex samples analysis was employed to explore data from sample as well as data from seven other GSHS-participating countries in the Middle East. Results indicated the overall prevalence of suicide ideation and/or planning was (25.6%), which was the highest among GSHS-participating countries (Iraq, Jordan, Kuwait, Lebanon, Morocco, Tunisia, and the UAE), with males more likely to report suicidal thinking than women. Health behaviours and exposures most associated with suicidal thinking were marijuana and tobacco use, having no close friends and feelings of loneliness, worry-induced insomnia, food insecurity, being a victim of bullying, being involved in physical violence, skipping school, and perceiving a lack of parental support (Itani et al., 2017).

In a study by Alshalan in (2018), the prevalence of nonsuicidal self-harm, its motivation, its frequency, its forms, and its relationship to the sex variable were studied in a sample of (612) Saudi university students, following a descriptive cross-sectional design. Results indicated that the prevalence of NSSH was (21.24%) and that females were more likely to engage in NSSH than males. The most prevalent forms of NSSH were scratching, pinching, carving words and symbols on skin, biting, and cutting or preventing cuts from healing, while the least prevalent forms were swallowing sharp objects or chemicals, burning, breaking bones, and using acid on skin. Sex also showed differences in inclination to some forms of NSSH; females were more likely to engage in scratching, pinching, carving words and symbols on skin, biting, and cutting or preventing cuts from healing, rubbing glass on skin, insertion of sharp objects under skin, and hair pulling. As for motivation of NSSH, results indicated that emotional factors played a stronger role than social factors, and more specifically, the motivation to process frustration or anger, then the motivation to process anxiety and or depression. In addition, males were more

influenced by peers, who also engage in NSSH, than females. Furthermore, in terms of frequency and onset, most individuals reported repeating NSSH two to three times, then only having one incident of NSSH, and then finally those, who have engaged in NSSH over ten times. Most respondents reported beginning NSSH when they were (15-20) years old, while least of the sample reported beginning NSSH when they were less than five years old (Alshalan, 2018).

In a mixed methodology study by Alkhatib in (2019), quantitative descriptive cross-sectional data was collected through self-reported questionnaires and a checklist retrospectively identifying treatment measures provided in medical record files, in addition to qualitative data collected in a semi-structured individual and focus-group interviews, was analysed to assess the risk factors of suicide and develop an understanding of current care provided to attempted suicide patients in four governmental hospitals of the Southern West-Bank. (83) suicide attempters were recruited for the quantitative aspect of study, a total of (75) medical files were examined, (116) healthcare providers and (10) key informants were interviewed, and finally (5) focus groups were conducted, one of which gathered representatives from the Palestinian National Suicide Prevention Response Committee, while the others included medical, paramedical, and police staff, who have experience with attempted suicide patients. Results were analysed thematically and statistically to reveal the most common method of attempting suicide in both genders was hanging followed by ingestion of detergents and insecticides, and that most patients have had a previous suicide attempt. Quantitative data revealed that females represented the majority of attempted suicide patients and that both female and male patients were single and lived in cities. Male patients were more likely to be uneducated, while female patients usually held an intermediate diploma. Both female and male patients belonged to the middle socioeconomic class and females were usually younger than males. Additionally, quantitative data suggested the majority of patients did not report a mental health diagnosis. Of those, who did report a diagnosis, (29%) had depression and (9.6%) reported other diagnoses. However, qualitative data indicated most suicide attempters were young, poor, depressed, and that drug addiction and mental health illnesses are risk factors to suicide. Additionally, interviews indicated that risk of reattempting suicide increases with a higher number of lifetime suicide attempts, and that social stigmatization connected to suicide and mental health illness plays a major role in proper documentation of suicide and prevention of seeking professional help by suicide attempters and their families. Finally, interviews estimated that around (75-400) individuals attempt suicide and (14) complete a suicidal attempt on a yearly basis (Alkhatib, 2019).

Self-reported suicidal thoughts, attempts, and motives were studied among university students in (12) Muslim-Majority countries, which included Arab populations such as Saudi Arabia, Egypt, Jordan, Lebanon, Palestine, and Tunisia, by Eskin and associates in (2019) following a comparative study design. (8417) individuals were recruited, of which (54.4%) were women. Results indicated (22%) reported suicidal ideation and (8.6%) reported a suicide attempt. Odds of suicidal thoughts were elevated in several countries like Saudi Arabia, while they were reduced in other countries like Egypt, Jordan, and Lebanon. Odds of suicidal attempts were high in countries like Palestine and Saudi Arabia, while they were reduced in countries like Jordan, Lebanon, and Tunisia. Taking drugs and using sharp instruments were the most common methods of suicidal attempts and only (32.7%) of suicidal attempts required medical attention, with more men needing medical attention after a suicide attempts. Furthermore, as it relates to motivation behind suicide attempts, escaping motive was more endorsed than the social motives, and data was

examined with regard to the influence or lack thereof of illegality and religious prohibition of suicide on prevalence of suicidality (Eskin et al., 2019).

In a descriptive correlational study by Mubarak and associates in (2020), a sample of (455) Egyptian university students were recruited to identify the prevalence of irrational thoughts, the prevalence of self-harm behaviors, and their relationships to each other, and the sex variable. Study used a self-reported questionnaire to assess irrational beliefs developed by researcher, in addition to the Diagnosis of Self-Harm in Normal and Abnormal Adolescents and Adults Scale. Results indicated a high prevalence of irrational thoughts and only (16%) of sample showed a high prevalence of self-harm behaviors, while the rest indicated a lower prevalence. No significant differences were found in irrational thoughts or self-harm behaviors, which could be related to sex. In addition, results indicated there as a positive direct significant relationship between irrational thoughts and self-harm behaviors (Mubarak et al., 2020).

2.3.3 Attachment Styles and Self-Destructiveness

In a study by Stepp and associates in (2008), the role of attachment styles and interpersonal problems in suicide related behaviors (self-harm, suicide attempts, and their co-occurrence) was studied in a sample of (406) predominantly psychiatric individuals. Analysis revealed that anxious and avoidant attachment styles were associated with interpersonal problems, which sometimes also mediated the relations between attachment style and type of suicidal behavior (Stepp et al., 2008).

In a literature analysis study by Live-Belz and associates in (2013), insights from attachment theory were used to address the underlying psychological mechanisms of medically serious and otherwise severe suicidal behavior. Results showed that insecure attachment and interpersonal difficulties amplify the psychological pain an individual experience. In addition, anxious and avoidant attachment patterns were able to predict medical lethality of a suicide attempt, and interpersonal difficulties played a mediating role between insecure attachment and suicide attempts (Levi-Belz et al., 2013).

In a study by Cruz and associates in (2013), the relations between SDB thoughts and behaviors and some family and individual variables were tested, in a sample of (1308) adolescents, with a mean age of (15.88) years old, from Portuguese schools and universities, who composed three study groups; a community sample, who did not report self-destructiveness, a community sample, who did report SDB, and a clinical group. Data was collected with the Inventory for Assessing Memories of Parental Rearing Behaviour, the Father/Mother Attachment Questionnaire, the Family Adaptability and Cohesion Evaluation Scale, the Satisfaction with Familial Relationships Scale, the Rosenberg Self-Esteem Scale, and the Youth Self-Report. Multinomial logistic regression analysis was employed to examine a predictive link between SDB and parental styles, parental attachment, family functioning, satisfaction with family relationships, self-esteem, and internalizing and externalizing symptoms. Results report that increase in mothers' quality of emotional bond, fathers' control and family cohesion and decrease in age and mothers' control lead to decreased likelihood self-destructive thoughts. Furthermore, being female, perceiving high level of mothers' inhibition of exploration and individuality, perceiving a high level of fathers' rejection, and having a low satisfaction with family relationships increase the likelihood of developing a clinical condition (Cruz et al., 2013).

2.3.4 Attachment Styles and Self-Destructiveness in Arab Samples

In a correlational descriptive study by Bshara and associates in (2014), adult attachment styles and their relationship to social support were studied in (209) Jordanian university students, using the Social Attachment Styles Scale and the Social Support Scale. Results indicated that the attachment style secure was the most prevalent, and that no significant differences could be found in attachment style scores, which are related to sex, education, or the interaction between them. In addition, regression analysis indicated that the attachment styles secure, avoidant, and anxious-ambivalent significantly predict social support (Bshara et al., 2014).

In correlational descriptive study by Falwa and Abu Ghazal in (2014), the relationship between attachment styles and social problem solving was examined in a sample of (627) female and male Jordanian university students. Data was collected with the Adult Attachment Styles Scale and the Social Problem Solving Scale. Results indicated that the most prevalent attachment style was secure attachment, and that students were mainly inclined towards rational problem solving methods. In addition, significant differences in attachment styles were found, which were related to sociodemographic variables; more males were found to be anxious, and more females were found to be dismissive. Furthermore, results indicated that there was a positive correlation between anxious attachment style and the tendency towards passive and apathetic impulsive problem solving methods, and a positive correlation between the secure attachment style and the avoidant problem solving method, the rational problem solving method, and the positive problem solving method (Falwa & Abu Ghazal, 2014).

Attachment styles and their relationship to self-regulation were studied in a sample of (305) Palestinian adolescent students living in the Acre area, by Kayyal and Shawareb in (2016). Data was collected with two self-report questionnaire developed by researchers, which targeted behaviours of self-regulation as well as attachment styles. Results indicated that self-regulation was at a moderate level and that there were significant differences in self-regulation level related to sex in favour of females. Results also find differences related to sex in the attachment style dismissive in favour of females and in the attachment style anxious in favour of males, but not in the attachment style secure. In addition, there was a positive correlation between self-regulation and the attachment style secure, a negative correlational relationship between self-regulation and attachment style anxious, and no correlational relationship between self-regulation and attachment style dismissive (Kayyal & Shawareb, 2016).

The attachment styles in both banjo addicts and non-addicts were studied in a correlational study, which recruited (200) female and male Egyptian high-school students, whose ages ranged from (15-18) years old, which was conducted by Metwali and associates in (2019). Data was collected with the Banjo Addiction Scale and the Attachment Styles Scale. Results indicated that there is a significant relationship between banjo addiction and attachment styles, and that attachment style scores could predict banjo-addiction, and finally, that significant differences found in banjo addiction scores were related to gender in favour of males (Metwali et al., 2019).

Attachment styles and their relationship to PTSD were studied in a correlational descriptive study, on a sample of (400) female and male Syrian refugee adolescents residing in Jordan, by Sabah and Jaradat in (2019). Data was collected with the Attachment Styles Questionnaire and the Psychological Reactions to Traumatic Experience Scale.

Results indicated that more women were dismissively attached than males, that there was a negative correlation between secure attachment and PTSD, and that there was a positive correlation between anxious and dismissive attachment styles and PTSD (Sabah & Jaradat, 2019).

The contribution of attachment styles in predicting the development of early maladaptive schemas was examined in a descriptive study, performed on a (168) adult sample in Algeria, who received mental health services provided by multi-service mobile clinics, in the years (2017-2019), by Le'zali and Luzani in (2020). The study used the Bartholomew and Horowitz Attachment Patterns Scale and the Early Maladaptive Schemas of the Young Scale. Results indicated that insecure attachment styles (preoccupied, fearful, and avoidant) predicted the development of "Rejection/Disconnection" schema domain, the attachment styles preoccupied and fearful were positively related to "Impaired Autonomy" and/or "Performance" schema domains, the attachment style fearful predicted "Over-vigilance/Inhibition" schema domain, the attachment style preoccupied was the only predictor of "Other-directedness" schema domain, and the insecure attachment styles could not predict "Impaired Limits" schema domain (Le'zali & Luzani, 2020).

2.3.5 Commentary on Previous Studies

In terms of Design

Most previous studies considered employed either a cross-sectional or correlational research design, or a combination of both. Other studies, such as (Taussig & Litrownik, 1997), used a retrospective approach, while (Levi-Belz et al., 2013) used a literature review, and (Cruz et al., 2013) used a predictive design.

In terms of Methodology

Most of the previous studies considered followed a quantitative methodology, with the exception of (Yates et al., 2008), which used mixed methods for data collection and analysis, in addition to (Levi-Belz et al., 2013), which used a completely qualitative methodology.

In terms of Sample

Several community samples were used in the considered previous studies.

In terms of age of participants, several studies focused on children and adolescents such as (Taussig & Litrownik, 1997), which studied foster children, and (Kayyal & Shawareb, 2016; Bin Et'e et al., 2020; Cruz et al., 2013; Metwali et al., 2019; Bolland, 2003), which studied adolescents.

Other studies focused on adult samples, such as (Kelly et al., 2005, Musalam et al., 2007; Yates et al., 2008; Alshawashreh et al., 2013; Alshalan, 2018; Lim et al., 2017; Kumar et al., 2013; Tsirigotis & Luczak, 2018; Mubarak et al., 2020; Bshara et al., 2014; Falwa & Abu Ghazal, 2014; Sabah & Jaradat, 2019; Le'zali & Luzani, 2020).

In terms of background of participants, many of the previous studies considered focused on university students, such as (Kelly et al., 2005; Alshawashreh et al., 2013; Kumar et al., 2013; Mubarak et al., 2020; Bshara et al., 2014; Falwa and & Ghazal, 2014).

Other studies used community samples, such as (Musalam et al., 2007), which studied inmates, (Yates et al., 2008), which studied a low-income background population, (Alshalan, 2018) and (Stepp et al., 2008), which studied psychiatric patients, (Tsirigotis & Luczak, 2018), which studied women experiencing domestic violence, and (Sabah & Jaradat, 2019), which studied refugees.

Finally, in terms of classification of previous studies considered according to proximity to Palestinian culture, some studies were of relevant cultural origin and others were not.

One study was conducted with a Palestinian population (Kayyal & Shawareb, 2016) and several were conducted in neighbouring Arab countries or further within the middle-east region. These included Musalam et al., 2007; Alshawashreh et al., 2013; Bshara et al., 2014; Falwa & Abu Ghazal, 2014; Sabah & Jaradat, 2019), which were conducted in Jordan, (Alshalan, 2018) and (Kumar et al., 2013), which were conducted in Saudi Arabia, (Mubarak et al., 2020) and (Metwali et al., 2019), which were conducted in Egypt, and (Le'zali & Luzani, 2020) and (Bin Et'e et al., 2020), which were conducted in Algeria.

Previous studies considered, which were conducted in culturally varying populations to this study included examples such as (Lim et al., 2017), which was conducted on a Malaysian sample, and (Kelly et al., 2005), which was conducted on an American population.

2.3.6 In terms of Results

Prevalence of SDB

In terms of ISDB, studies disagreed on the prevalence of NSSI; some estimated that around (8.4%) engage in non-suicidal self-injury such as (Lim et al., 2017), while others reported numbers up to (16%) (Mubarak et al., 2020) and (21.24%) (Alshalan, 2018). As for suicidality, studies indicated that up to (5.8%) experience suicidal ideation and that up to (3.5%) have already attempted suicide at least once (Lim et al., 2017).

Prominent forms of NSSI were scratching, pinching, carving words and symbols on skin, biting, and cutting or preventing cuts from healing. In comparison, the least prevalent forms of NSSI were swallowing sharp objects or chemicals, burning, breaking bones, and using acid on skin. Most individuals reported repeating NSSI two to three times and the least of individuals reported repeating NSSI over ten times (Alshalan, 2018).

SDB and the Age Variable

Studies such as (Kumar et al., 2013) indicated that SDB is related to age, while other studies such as more severe in young individuals and that most individuals begin engaging in NSSI during adolescence and early adulthood such as (Alshalan, 2018).

SDB and The Sex Variable

In some studies, significant differences were found in SDB related to the sex variable such as (Kelly et al., 2005) and (Musalam et al., 2007) while others found no significant differences such as (Alshawashreh et al., 2013).

In studies showing differences in SDB related to sex, males showed twice as much a higher prevalence of SDB to women such as (Bolland, 2003), while other studies showed the opposite such as (Alshalan, 2018) and (Mubarak et al., 2020).

Gender related differences in manifestations of SDB were reported by (Kelly et al., 2005), (Musalam et al., 2007), and (Alshalan, 2018).

For example, in males, SDB was more likely to come in the form of involvement in risky behaviors including drug use, heavy drinking, risky sexual behaviors, and irresponsible study/work behaviors. Males were also more likely to have tattoos and to have been influenced by a peer, who also engages in SDB to engage in behavior.

In women, however, SDB was more likely to come in the form of involvement in heavy drinking and irresponsible study/work behaviors, in addition to increased NSSI practices such as scratching, pinching, carving words and symbols on skin, biting, and cutting or preventing cuts from healing, rubbing glass on skin, insertion of sharp objects under skin, and hair pulling.

SDB and the Level of Education Variable

Studies disagreed on the significance of the level of education variable. In studies where differences were found, the level of academic dedication to achievement seemed to be related to significant differences in SDB in favour of moderately achieving individuals compared to higher achieving individuals such as (Alshawashreh et al., 2013).

SDB and the Marital Status Variable

Studies indicated that married individuals showed more severe forms of SDB (Kumar et al., 2013).

SDB and Area of Residence Variable

Bolland found links arguing that proximity or distance from the city and urban life may be considered risk-inducing of self-destructiveness, hopelessness, and suicide (Bolland, 2003).

SDB and the Marital Status of Parents Variable

Some studies indicated that coming from a nuclear family was related to significant differences in SDB prevalence such as (Kumar et al., 2013), and other studies confirmed that although family disruption and exposure to domestic violence may increase SDB, they are more likely to be considered secondary factors to actual and direct victimization by parent such as (Yates et al., 2008).

SDB and Exposure to Violence and Traumatic Events

Studies such as (Taussig & Litrownik, 1997) suggested that aggressive behavior directed towards others was more prevalent in events of physical abuse, while aggressive behavior directed towards the self was more prevalent in events of sexual abuse. (Yates et al., 2008) also focused on sexual abuse as it seems to predict recurrent injuring, while physical abuse was more noticeable in relation to intermittent injuring.

Other studies, such as (Tsirigotis & Luczak, 2018), also indicated that violence and SDB were related, and that specifically indirect SDB was much higher among those who were victims of domestic violence compared to control groups.

Studies indicated that a psychiatric diagnosis, generalized neuroticism, and overall psychological distress, often always predicted SDB, and that individuals who engage in

self-harm, were likely to have a BPD or Depression diagnosis or traits of these disorders, in addition to being more likely to experience dissociation and somatization phenomenons (Yates et al., 2008),

Studies such as (Taussig & Litrownik, 1997) and (Yates et al., 2008) indicated that SDB was used as a medium for processing frustration, anger, anxiety, or depression, and that emotional distress plays a stronger role in development of SDB compared to social distress.

Additionally, studies reported a relationship between SDB and feeling lonely, feeling like a burden to the family, feeling incapable of solving daily-life problems, and feeling hopeless and (Alshalan, 2018).

Depressiveness, overall, seemed to be tied to abstaining from food as a form of SDB, while hopelessness, in particular, predicted violent and aggressive behaviors, substance use, sexual behavior, and accidental injuries (Bolland, 2003; Musalam et al., 2007).

BPD-individuals showed both severe and less severe forms of SDB, which included behaviors such as using sharp objects for self-injury, getting big tattoos, or engaging in self-hitting (Musalam et al., 2007).

Some studies indicated cognitive aspects should be taken into consideration due to finding positive direct relationships between irrational thoughts and SDB (Mubarak et al., 2020), while other studies suggested that cognitive ability doesn't carry a primary significance compared to other factors such as (Yates et al., 2008).

Studies indicated that chronic physical health problems are positively associated with SDB (Lim et al., 2017).

Attachment Style Distribution

Studies such as (Bshara et al., 2014) and (Falwa & Abu Ghazal, 2014) indicated that the attachment style secure was the most prevalent.

Attachment Style and Problem Solving

Studies such as (Falwa & Abu Ghazal, 2014) indicated there is a positive relationship between anxious attachment style and tendency towards passive and apathetic problem solving, and a positive relationship between secure attachment style and avoidant problem solving, rational problem solving, and positive problem solving.

Attachment Style and Self-Regulation

Studies such as (Kayyal & Shawareb, 2016) indicated that there's a positive relationship between self-regulation and the attachment style secure, a negative correlational relationship between self-regulation and attachment style anxious, and no correlational relationship between self-regulation and attachment style dismissive.

Attachment Style and Mental health illness

Studied such as (Sabah & Jaradat, 2019) indicated that there was a negative correlation between secure attachment and PTSD, and that there was a positive correlation between anxious and avoidant attachment styles (insecure attachment styles) and PTSD.

Attachment Styles and Cognitive Schemas

Studies such as (Le'zali & Luzani, 2020) indicated that insecure attachment styles predict the development of the "Rejection/Disconnection" but not "Impaired Limits" schema domain.

More specifically, the preoccupied and Fearful attachment styles were positively related to "Impaired Autonomy" and/or "Performance" schema domains, but only the attachment style fearful predicted the "Over-vigilance/Inhibition" schema domain, and only the attachment style preoccupied could predict the "Other-directedness" schema domain.

Attachment and Self-Destructive Behavior

Studies indicated that attachment styles are both directly related to SDB and through mediating factors. For example, (Metwali et al., 2019) found significant relationships between substance use and attachment styles, while (Stepp et al., 2008) found that some attachment styles could amplify psychological pain experienced by individuals in interpersonal distress, which would possibly result in higher lethality suicides (specifically in anxious and avoidant attachment styles).

In addition, studies indicated that attachment-related factors, such as perceiving high level of mothers' inhibition of exploration and individuality, a high level of fathers' rejection, and having a low satisfaction with family relationships increased the likelihood of developing a clinical condition, while an increase in mothers' quality of emotional bond, fathers' control, family cohesion, and decrease in mothers' control lead to decreased likelihood self-destructive thoughts (Cruz et al., 2013).

Chapter Three

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Chapter Three:

Methodology

3.1 Introduction

This chapter will discuss the proposed design of the study, characteristics of the population, sampling strategies, tools and their validity and reliability, as well as the data collection and analysis processes.

3.2 Study Design

The correlational descriptive study design, which guided the study's data collection and analysis, is one of the most popular methodologies in health-related study. It is employed to identify whether a statistically significant relationship exists between two or more variables and to describe this relationship. This is administered through the quantitative measurement of each participating subject on all tested variables and then comparing the resulting data without any manipulation by the researcher. Correlational studies often attempt to prove, with as generalizable precision as possible, that one variable may assist in predicting another, which might be of assistance in explaining why individuals demonstrate different levels of the same behavior. Moreover, it merits mentioning that although correlational studies have been widely accurate in predicting the existence or nonexistence of future relationships between measured variables, the design cannot be credited for determining the causality relationship between variables (Baumgartner and Hensley, 2006).

In this study, a cross-sectional correlational descriptive approach was implemented by using two self-reported questionnaires on a sample of subjects, which is widely viewed as the leading method in surveying quantitative data.

3.3 Study Setting

The setting of the study is the community context of the governorates of Bethlehem and Hebron. The two governorates take up around (30%) of the West Bank land mass, with Hebron spreading over (1000 $km^{2)}$, and Bethlehem spreading over (655.4 km^2) (PCBS, 2017a).

3.4 Target Population

The current study population includes all young Palestinian adults residing in the governorates of Bethlehem and Hebron in the Palestinian West Bank, defined as the Bethlehem and Hebron governorates, according to the Palestinian Central Bureau of Statistics, as mentioned in (PCBS, 2015). According to the PCBS's latest published demographic census, individuals in the age-range of (18-29) years old, who fall into the intended developmental age-group of young adulthood, were recorded at (48,506) persons (24,755 males and 23,751 females) in the governorate of Bethlehem, and (161,257) persons (82,949 males and 78,308 females) in the governorate of Hebron (PCBS, 2021b; 2021c).

Young Palestinian adults, aged (18-29) years old, have witnessed the signing and implementation of the Oslo peace agreement, and as such were considered the transitional generation between Palestine as a war-ridden nation and Palestine as a self-governing non-state, inflicted with poverty and unemployment, political and economic corruption (Oxfam, 2018), as well as a bipolar political divide between the largest political parties in the country. The divide, which would eventually lead to the seclusion of one fraction of government in Gaza and the other in the West Bank, teared the Palestinian community in half and resulted in major incidents of armed aggression between affiliates of the two fractions; a situation deepened in impact by the consecutive wars on the Gaza Strip in (2008), (2012), and (2014), where the Palestinian population watched over (3700) Palestinians killed as a result of Israeli aggression (UN, 2014).

The sociocultural profile of the southern West Bank is also quite distinguishable, with observable impact on individual, group, and family subcultures. Bethlehem is considered the cultural centre of Palestine and it allows for more leniency towards progressive ideology and behavior in the cities and less so in the rural regions of the area, while Hebron is regarded as the most conservative and religious of the Palestinian governorates with the rural spread of the population enjoying a higher level of unspoken liberalism compared to the cities. Furthermore, and possibly due to the close proximity of the two governorates, studies revealed that families are more inclined towards an authoritative style of parenting with mothers often described as over-protective and fathers as neglectful in the specific region of the southern West Bank (Alteeti, 2016; Abdeen, 2010).

This reality comes to further intrigue researchers when taking into consideration the considerable differences in which the two populations manifest and manage their internal political, religious, and class conflicts, and especially when also taking into account the immense role parenting styles have on attachment, identity formation, and other aspects of interpersonal and intrapersonal functioning. An estimated large majority of Palestinian adolescents and young adults are marginalized and excluded from decision making; lives of most do not include a full experience of human rights, they have very little access to services and resources, and they must also manage socioeconomic challenges such as poverty and violence (Burghal, 2016).

3.5 Sample Size

When combined, the two governorates of Bethlehem and Hebron produce an estimated number of (209,763) individuals, who meet the main selection criteria for the study; young adults living in the governorates of Bethlehem and Hebron. The target population was statistically calculated through the following equation to produce the needed sample size:

$$SS\ (Standard\ Sample\ Size) = \frac{Z^2 \times (P) \times (1-P)}{C^2} = \frac{(1.96)^2 \times (0.5) \times (1-0.5)}{(0.05)^2}$$

Formula Description

SS: Standard Sample Size
Z: Confidence Level at 95% (standard value of 1.96)
P: Percentage picking a choice expressed as decimal (here 0.5)
C: Margin of error at 5% (standard value of 0.05)

$$Sample\ Size\ of\ Study = \frac{SS}{1 + \frac{(SS-1)}{POP}} = \frac{384.16}{1 + \frac{(384.16-1)}{209{,}763}} = 384$$

Where POP: Population (here 209,763).

In the current study, a minimum sample size of (384) individuals was identified according to the previous equation, after taking into consideration the number of individuals forming the target population of the study, as well as the acceptable margin of error, and the level of confidence in the results sufficient for studies conducted in social and psychological study.

3.6 Sampling Technique

After taking into consideration the nature, characteristics, and geographic spread of the target population, as well as movement and social gathering restrictions put in place as part of the Palestinian Ministry of Health's efforts to combat the spread of COVID-19, an online survey was chosen to conduct the data collection procedure, which required a combination of convenient and snowball sampling to access various categories of the targeted community. The online questionnaire was a replica of the approved study instrument, which was uploaded onto Google Forms and distributed via social media and email with an introduction to the research and a presentation of inclusion criteria. Individuals, who clicked on the link, and filled out the questionnaire, were considered participants of the study.

3.6.1 Inclusion Criteria

All female and male young Palestinian adults, whose ages range from (18-29) years, and who reside in the Governorate of Hebron or the Governorate of Bethlehem, and who have provided their informed consent to participating in the study.

3.6.1 Exclusion Criteria

The study excluded in data collection individuals with issues interfering with ability to complete the questionnaire, unwilling individuals, who did not click on link to participate, as well as individuals, who participated in data collection, but provided incomplete questionnaire.

3.7 Study Variables

Independent Variables

- Age: (18-21), (22-25), (26-29).
- Sex; (Male), (Female).
- Level of Education: (High School or Less), (Diploma), (Bachelor's Degree), (Graduate Studies).
- Employment Status: (Employed), (Unemployed).
- Marital Status: (Single), (Married), (Previously Married or Separated).
- Area of Residence: (City), (Town), (Village), (Camps), (Other Residence). The category (Camps and Other Residence) was later used in analysis as the two categories (Camps) and (Others) didn't meet sufficient saturation for statistical analysis on their own. It merits mentioning that within the Palestinian community, "Other" residence typically indicates residing in a Bedouin-style collective.
- Location of Residence: (Bethlehem), (Hebron).
- Marital Status of Parents: (Married), (Divorced / Separated), (Widowed Parent / Deceased Parents).

- Recent Exposure to Violence or Traumatic Event – in the past 3 months: (No), (Yes).
- Religion: (Muslim), (Christian), (Other).
- Religiosity: (1 Very Low), (2), (3), (4), (5), (6), (7), (8), (9), (10 Very Strong). These were later calculated as three new categories: (Not Religious), (Moderately Religious), and (Very Religious).

Dependant Variables

Self-Destructive Behavior

SDB was assessed by using a self-reported questionnaire which was developed for the purpose of identifying the level in which subjects find themselves characterised by SDB, and report this tendency or attitude behaviorally, cognitively, and affectively / emotionally. Corresponding values of SDB were either "Low, Moderate, High, or Severe", and suggested prevalence of SDB in the six subcategories:

(1) Substance-Use and Addiction-Related Behaviors.
(2) Risky, Thrilling, Defiant, and Criminal Behaviors.
(3) Direct Self-Harm & Suicidal Behavior.
(4) Failure in Routine or Primary Self-Care.
(5) Issues of Self-Management.
(6) Socioemotional and Sexual Behaviors.

Attachment Styles

Attachment Style was assessed by using the self-reported Attachment Styles Questionnaire (ASQ), developed by van Oudenhoven and others in (2003) (Hofstra et al., 2005). The questionnaire's results correspond to one of four attachment styles: "Secure" refers to Secure Attachment Style, "Dismissive" refers to Anxious-Avoidant Attachment Style, "Ambivalent" refers to Anxious-Dependant / Preoccupied Attachment Style, and "Disorganized", which refers to Fearful-Avoidant Attachment Style.

Distribution of Sample According to Sociodemographic and Non-Sociodemographic Variables

A total of (424) questionnaires were collected, of which (412) met the full selection criteria for the study, as (12) questionnaires were excluded for having incomplete data. Distribution frequencies were calculated with SPSS to provide a summary of the sample description according to each of the study's independent variables.

The study sample consisted of (220) individuals aged (18-21) years old, (105) individuals aged (22-25) years old and (87) individuals aged (26-29) years old. Participants of the study were distributed by the sex variable into (209) male participants and (203) female participants. In terms of level of education, the sample was distributed into (40) participants with a High-School education or less, (114) with varying Diplomas, (239) with a Bachelor's Degree, and (19) participants, who fall into the category of Graduate Studies. The study sample was distributed into a total of (142) subjects, who reported being employed, and (270) subjects, who reported being unemployed. According to the marital status variable, (284) study subjects were single, (91) subjects were married, and (37) subjects were in the category "Previously Married or Separated", which represents being divorced, widowed, or currently separated individuals. Distributions analysis revealed that (190) of study participants lived in the city, (100) participants lived in towns, (73) participants lived in villages, and (49) participants lived in Refugee Camps or other

unspecified areas of residence (lower-density population gathering). Relating to the location of residence variable, the sample was distributed into (109) individuals from the Hebron Governorate and (303) individuals from the Bethlehem Governorate. According to the marital status of the parents, (359) participants came from families, where the parents remained married, while (32) came from families with separated or divorced parents, and (21) came from families where one or both parents were deceased. (81) Participants identified experiencing violence or a traumatizing event in the past 3 months, while (331) denied any exposure. On religion, (351) subjects identified themselves as Muslim, (47) as Christian, and (14) as having other religious identification. Finally, the majority of the sample (244) reported they considered themselves very religious, while (138) stated they were moderately religious, and (30) reported not being religious. This is presented in the table below:

Table (1): Distribution of Sample According to the Study Variables

Study Variable	Variable Categories	N	%	Valid Perc.	Cum. Perc.
Age	18-21	220	53.4	53.4	53.4
	22-25	105	25.5	25.5	78.9
	26-29	87	21.1	21.1	100.0
Sex	Male	209	50.7	50.7	50.7
	Female	203	49.3	49.3	100.0
Level of Education	High-School or Less	40	9.7	9.7	9.7
	Diploma	114	27.7	27.7	37.4
	Bachelor's Degree	239	58.0	58.0	95.4
	Graduate Studies	19	4.6	4.6	100.0
Employment Status	Employed	142	34.5	34.5	34.5
	Unemployed	270	65.5	65.5	100.0
Marital Status	Single	284	68.9	68.9	68.9
	Married	91	22.1	22.1	91.0
	Previously Married or Separated	37	9.0	9.0	100.0
Location of Residence	City	190	46.1	46.1	46.1
	Town	100	24.3	24.3	70.4
	Village	73	17.7	17.7	88.1
	Camps and Others	49	11.9	11.9	100.0
Area of Residence	Hebron	109	26.5	26.5	26.5
	Bethlehem	303	73.5	73.5	100.0
Marital Status of Parents	Married	359	87.1	87.1	87.1
	Separated or Divorced	32	7.8	7.8	94.9
	Widowed Parent / Deceased Parents	21	5.1	5.1	100.0
Recent Exposure to Violence or a Traumatic Event	Yes	81	19.7	19.7	19.7
	No	331	80.3	80.3	100.0
Religion	Muslim	351	85.2	85.2	85.2
	Christian	47	11.4	11.4	96.6
	Other religious status	14	3.4	3.4	100.0
Religiosity	Not Religious	30	7.3	7.3	7.3
	Moderately Religious	138	33.5	33.5	40.8
	Very Religious	244	59.2	59.2	100.0

3.8 Study Instruments

For this study, in addition to closed-ended questions targeting the socio- and non-sociodemographic independent variables of study, one questionnaire-style scale and one checklist-style scale were used, as outlined in the following:

The Self-Destructive Behavior Checklist

The scale was initially developed by the researcher to include (76) items in a checklist-style questionnaire by reviewing relevant scales and their corresponding subcategories, including the Chronic Self-Destructiveness Scale (CSDS) from (Kelley et al., 1985), the Risky Impulsive Self-Destructive Behavior Questionnaire (RISQ) from (Sadeh & Baskin-Sommers, 2016), the Non-Suicidal Self-Injury Assessment Tool (NSSI-AT) from (Whitlock and Purington, 2013), and the Self-Harm Inventory (SHI) from (Sansone and Sansone, 2010).

The proposed scale underwent a validation process by experts from related fields who finalized it in its final (49-item) version. Each of the (49) statements represents an example of SDB, divided across (6) subscales, with each item corresponding to a (5-point) Likert scale, where (0): Doesn't describe me at all, (1): Doesn't really describe me, (2): Undecided if it describes me, (3): Somewhat describes me, (4): Very much describes me.

Furthermore, items in each subscale were initially organized in consecutive groups according to subcategory, but in the finalized version they were redistributed according to the level of danger and harm that they represent into a "High Risk SDB" group and a "Lower Risk SDB" group, as this could help ease the subjects' participation on questionnaire. For example, the statements "I don't exercise" and "I forget important dates and obligations" are less severe in impact on general well-being compared to statements "I have wilfully and consciously resulted in my admission to the hospital" and "I drive a car after consuming alcohol or using substances". Therefore, the first two statements hold the place (2) and (4), while the later are placed in (46) and (48).The subscales for the SDB-C employed on this study included:

1. Substance-Use and Addiction-Related Behaviors: Addictive behaviors or pertaining to an addictive substance or activity.

These included behaviors such as excessive of technology (phones and computers), unrestrained consumption of caffeinated drinks, gambling and betting and playing games for money, nicotine-dependency, self-medicating, the use and overuse and misuse of mind-altering substances (Marijuana, Hashish, Alcohol, MDMA, Synthesized Marijuana, Methamphetamines, Cocaine, Heroin, LSD, Magic Mushrooms).

2. Risky, Thrilling, Defiant & Criminal Behaviors: Relating to illegal activity through active or passive involvement and failure to comply with norms of integration and safety as well behaviors motivated by risk-taking or thrill-seeking.

These included wilful and conscious apathy towards negative future consequences, being attracted to- and pleased with danger and thrilling experiences (Driving fast, not wearing seatbelt or safety gear, driving while intoxicated), purposeful disobedience of laws and regulations, violent and aggressive behavior (physical violence, property damage).

3. Direct Self-Harm & Suicidal Behavior: Self-injurious behaviors with immediate implications on physical health and wellbeing.

These included trichotillomania behaviors (Pulling hair from scalp, eyebrows, eyelashes), self-biting (lip and nail biting), self-hitting (Using items or walls), excessive scratching, suicidal thoughts, parasuicidal behaviors (Cutting, strangulation, jumping from heights), suicidal attempts, and other actions that may have led to intentional hospitalization.

4. Failure in Routine or Primary Self-Care: Relating to annual tasks required to maintain general functioning and health or compliance to treatment.

These included behaviors such as not exercising, difficulties maintaining a balanced and healthy diet, difficulties caring for one's self, difficulties maintaining the wanted sleeping arrangement, and avoidance of pursuing health services until ailment is unbearable.

5. Issues of Self-Management: Relating to difficulties managing responsibilities and duties, including distraction, procrastination, and avoidance.

These were interpreted as forgetting important dates and obligations, losing personal possession, inappropriate use of time, being chaotic and disorganized, difficulties learning from- and not repeating mistakes, and difficulties maintaining a budget.

6. Socioemotional and Sexual Behaviors: Relating to sexual and intimate experiences, tendencies, and attitudes as well as general behavior in the public.

Statements here were related to making empty promises, the urge to walk-out on difficult arguments or discussions, expressing opinions in an inappropriate context, avoidance of social or familial gatherings and occasions, difficulties staying in contact with close friends and loved ones, vindictiveness, engaging in abusive emotional relationships, engaging in unsafe sexual experiences, promiscuity, and engaging in verbal violence and aggression.

The full scale can be found in Appendix A, while scoring instructions can be found in the following tables, which outline subscales, items, and scoring cut-points:

Table (2): Total Indication to SDB

Significance	Range	Interpretation
Low	49 Pts. and Under	There is very little indication to SDB
Moderate	50-89 Pts.	There is indication to moderate SDB
High	90-147 Pts.	There is indication to high SDB
Severe	148 Pts. and Over	There is indication to severe SDB

Table (3): Total indication to subscales of SDB

Subscale	Items	Verdict			
		L	M	H	S
Substance-Use and Addiction-Related Behaviours	6, 8, 23, 27, 28, 33, 34, 35, 43, 47	0-10	11-20	21-30	31-40
Risky, Thrilling, Defiant, and Criminal Behaviours	7, 9, 22, 25, 26, 36, 38, 39, 45, 48				
Direct Self-Harm & Suicidal Behaviour	20, 24, 29, 32, 41, 44, 46, 49	0-8	9-16	17-24	25-32
Failure in Routine or Primary Self-Care	4, 5, 10, 15, 30	0-5	6-10	11-15	16-20
Issues of Self-Management	2, 3, 11, 12, 13, 14	0-6	7-12	13-18	19-24
Socioemotional and Sexual Behaviours	1, 16, 17, 18, 19, 21, 31, 37, 40, 42	0-10	11-20	21-30	31-40

The Attachment Styles Questionnaire

The Attachment Styles Questionnaire was developed by Van Oudenhoven, Hofstra, and Bakker in (2003). It was originally developed in Dutch for students and midlife-stage samples. It originally consisted of (35) items, but was later deducted to (24) items. The ASQ relies on the Bartholomew and Horowitz model, which views attachment styles as quadrants and relies on one attachment statement holding an underlying value relating to the opposing quadrant or style. For example, a negative answer to statement (6) on the scale "I feel at ease in emotional relationships" – a statement relating to the secure quadrant / style – also means "I presume that others are untrustworthy", a value relating to the fearful quadrant / style (Polek, 2008).

Furthermore, unlike most other attachment scales, which observe attachment in the individual's relationship to significant others, the ASQ statements are phrased to direct attention to general sociability (Polek, 2008). This allows for a further inclusivity in addressing the respondent's view of "the other" and "the self" (Hofstra et al., 2005).

A back-translation for the ASQ was performed, where it was translated from English to Arabic by one translator, then from Arabic back to English by another translator, and then viewed for differences in wording and phrasing by a mental health expert whose English is the first-language, who confirmed that the translation was accurate. The questionnaire also underwent a validation process by experts from related fields to this study. Each of the items on the employed ASQ corresponded to a 5-point Likert-type scale, where (0): Doesn't describe me at all, (1): Doesn't really describe me, (2): Undecided if it describes me, (3): Somewhat describes me, (4): Very much describes me. The scale can be found in Appendix A, and the following table summarizes the key for scoring the scale:

Table (4): Scoring key for The Attachment Styles Questionnaire

Attachment Style	Statements	Positive Items	Negative Items
Secure	1-7	1, 3, 4, 5, 6, 7	2
Dismissive	20-24	20, 21, 22, 23, 24	--
Ambivalent	13-19	13, 14, 15, 16, 18, 19	17
Disorganised	8-12	8, 9, 10, 11, 12	--

For each respondent, scores are calculated for each of the attachment styles separately then converted into a percentage with the highest ranking style to be considered the dominant attachment style. The possible results are one of four attachment styles:

(1) "Secure" describes individuals, who have a positive self-image, generally trust others, and face their social interactions with confidence. They don't feel threatened by interactions and rely on their "secure bases" to decrease the impact of a negative experience on them.

(2) "Dismissive" describes individuals who have a positive self-image, but distrust others, and don't feel a strong need for personal connections with them. They may often perceive interactions with others as complicated and difficult; hence further alienating themselves from others

(3) "Ambivalent" describes individuals who have a negative self-image, wish to trust others, but live in wonder if they are worthy of connection with others. They are often

worrying about negative perceptions of them by others and find relief in behaviors, which may lead others to be pleased with them.

(4) "Disorganized" describes individuals who have a negative self-image, distrust others, and avoid personal connections with them, as they will often react negatively in interaction with others (Hofstra et al., 2005).

3.9 Validity and Reliability

3.9.1 Validity of The Attachment Styles Questionnaire

The validity and reliability of the ASQ have been tested within eastern and western cultural contexts with satisfactory results in measuring attachment style, including studies such as (Polek, 2008) who used the scale in Polish, Russian, and Hungarian contexts, in addition to (Firoozabadi, 2014) who used it for an Iranian sample, and (Hussein, 2016) who used it in Iraqi context.

The Arabic translation of the ASQ employed on this study was reviewed by 10 experts, who assisted in validation of instrument by providing feedback on wording and formulation of items, grammar, Likert-Scale titles, and general appropriateness to target population, as appropriateness to topic has already been established by previous studies. These experts included specialists from the fields of mental health, education, psychology, criminology, psychological counselling, social work, and clinical psychology (See Appendix B). The tool was also piloted among a (10-person) sample of the target population, whose feedback on the instrument was taken into consideration prior to release.

Furthermore, a Pearson Correlation was employed to statistically calculate construct validity by calculating the Pearson correlation coefficient of the questionnaire paragraphs in each attachment style subscale with the overall degree of the subscale. The results indicated that statistical significance was found in all the paragraphs of the questionnaire, which suggests that there is appropriate internal consistency between the paragraphs. The following table illustrate:

Table (5): Pearson Correlation Results for the ASQ Subscale Categories among Palestinian Young Adults in the Governorates of Bethlehem and Hebron

	N	Value (R)	Sig	N	Value (R)	Sig	N	Value (R)	Sig
Secure Attachment Style	1	0.405**	0.000	4	0.259**	0.000	7	0.485**	0.000
	2	0.337**	0.000	5	0.548**	0.000			
	3	0.447**	0.000	6	0.601**	0.000			
Dismissive Attachment Style	1	0.283**	0.000	3	0.806**	0.000	5	0.673**	0.000
	2	0.717**	0.000	4	0.726**	0.000			
Ambivalent Attachment Style	1	0.684**	0.000	4	0.620**	0.000	7	0.445**	0.000
	2	0.663**	0.000	5	0.323**	0.000			
	3	0.743**	0.000	6	0.561**	0.000			
Disorganized Attachment Style	1	0.635**	0.000	3	0.776**	0.000	5	0.625**	0.000
	2	0.725**	0.000	4	0.757**	0.000			

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

3.9.2 Validity of The Self-Destructive Checklist

The developed instrument was reviewed by the before-mentioned experts, who assisted in filtering out much of the repeated or similar statements, and made revisions to wording of items, grammar, and appropriateness to topic and target population. Prior to data collection, the tool was also piloted among a 10-person sample of the target population, who provided feedback on questionnaire.

Furthermore, a Pearson Correlation was employed to statistically calculate instrument construct validity, by calculating the Pearson correlation coefficient of the questionnaire items with overall degree of tool. Results indicated there was statistical significance in all the items of the questionnaire, which suggests there is appropriate internal consistency between the paragraphs. The following table illustrates this:

Table (6): Pearson Correlation Results for the Prevalence of SDB among Palestinian Young Adults in the Governorates of Bethlehem and Hebron

N	Value (R)	Sig	N	Value (R)	Sig	N	Value (R)	Sig
1	0.297**	0.000	18	0.367**	0.000	35	0.540**	0.000
2	0.424**	0.000	19	0.402**	0.000	36	0.478**	0.000
3	0.452**	0.000	20	0.406**	0.000	37	0.454**	0.000
4	0.256**	0.000	21	0.428**	0.000	38	0.571**	0.000
5	0.263**	0.000	22	0.427**	0.000	39	0.570**	0.000
6	0.331**	0.000	23	0.466**	0.000	40	0.538**	0.000
7	0.412**	0.000	24	0.462**	0.000	41	0.591**	0.000
8	0.395**	0.000	25	0.264**	0.000	42	0.493**	0.000
9	0.509**	0.000	26	0.416**	0.000	43	0.548**	0.000
10	0.486**	0.000	27	0.529**	0.000	44	0.582**	0.000
11	0.398**	0.000	28	0.531**	0.000	45	0.536**	0.000
12	0.446**	0.000	29	0.599**	0.000	46	0.596**	0.000
13	0.409**	0.000	30	0.413**	0.000	47	0.563**	0.000
14	0.315**	0.000	31	0.509**	0.000	48	0.551**	0.000
15	0.409**	0.000	32	0.480**	0.000	49	0.500**	0.000
16	0.383**	0.000	33	0.564**	0.000			
17	0.454**	0.000	34	0.534**	0.000			

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

3.9.3 Reliability of Instruments

Reliability of instruments was verified by calculating the stability of the total score of the stability factor, according to the stability equation of Cronbach Alpha, and the overall score for the results of the ASQ subscales and the SDBC.

Results indicated the reliability for ASQ results was at (0.812) and for the SDBC results at (0.914), both of which suggest that the study instruments show appropriate stability. The following table explains this:

Table (7): Reliability Coefficient Results for Instrument Subsections

Fields	N. of questions	Cronbach Alpha
ASQ Subscale: Secure Attachment Style	7	0.731
ASQ Subscale: Dismissive Attachment Style	5	0.745
ASQ Subscale: Ambivalent Attachment Style	7	0.776
ASQ Subscale: Disorganized Attachment Style	5	0.764
Total of Attachment Styles	24	0.812
Total of SDB	49	0.914

3.10 Data Collection Procedure

- Preparing the Instrument: Translation of the ASQ and SDB-C, validation by necessary professionals, piloting the scales to make sure they are clear and understandable for the target group.

- Collection of Data: Converting the tool into an online survey using online software provided by Google Forms, then distribution across communication mediums and social media.

- The tool remained online until necessary variable saturation before it was converted into an Excel data sheet suitable for analysis with SPSS. Data collection continued for three months (June 2021 – September 2021).

3.11 Ethical Considerations

Ethical approval was obtained from the ethical committee of the Deanship of Public Health at Al-Quds University. Study subjects were provided with an introduction on study before being provided with a website link, which directed them to the online survey. This introductory information included the aim of the study, its objectives, procedures, and information to each participant's right to refuse to participate in the study, or to discontinue their participation.

The participants were also informed of their right to confidentiality and privacy, which was ensured by anonymity of online data collection, as well as protection of data during storage on the researcher's personal password-protected computer.

One additional topic of ethical relevance was the concern that the study topic itself may cause certain subjects' mental health to deteriorate, as the two main issues addressed in the study are often considered triggering of negative reactions; i.e. self-destructiveness in its relation to self-harm, and attachment style in its relation to childhood experiences. Measures to address this issue included a trigger-warning at the top of the scale, as well as a list of organizations in the Governorate of Bethlehem and the Governorate of Hebron,

which could be contacted to provide crisis-intervention, psychotherapy, and counselling services.

3.12 Study Feasibility

This study was conducted as a requirement for a Master's degree in community mental health at Al-Quds University. It was self-funded and it applied within the community context of the governorates of Bethlehem and Hebron in the Palestinian West Bank.

Initially, this study was going to be implemented by collecting data in universities, public and private organizations, companies, community clubs and centres, etc., but due to movement restrictions posed by the "COVID-19" Pandemic, the data collection was conducted via Google Forums online software.

Prior commencement, ethical approval was obtained from Al-Quds University, and safe-guards for participants' autonomy, anonymity, and informed consent were employed throughout the study and after completion.

Obstacles included difficulties in obtaining the necessary sample size in the duration of time intended, ambiguities in sample answers, disparities in levels of education or acculturation of sample members, lack of financial support for the study, lack of local previous studies on the topic, issues with data saturation impacting probability sampling, and sample pollution due to online collection of data.

3.13 Data Analysis

Data was analysed using the Statistical Package for Social Sciences (SPSS) version (20), by coding answers as numbers and inputting them to program. Tests employed to analyse data included:

- Means and Standard Deviations.
- Cronbach Alpha.
- Frequencies, Sums, Percentages, and Means.
- One-Way ANOVA.
- Pearson Correlation Coefficient.
- Resolution.
- T-Test.
- LSD Test.

Chapter Four

Introduction

Data Presentation

Chapter Four:

Data Analysis

4.1 Introduction

The following chapter presents data collected and analysed statistically for the purpose of answering the study questions. Results are presented according to how they answer questions.

4.2 Presentation of Results

4.2.1 Results of First Question

What is the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, the means and the standard deviations of the sample's responses were calculated, as shown in the following table:

Table (8): Frequencies and Percentages for the Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron

N	Interpretation	N	%
2	indication to moderate SDB	185	44.9
1	very little indication to SDB	182	44.2
3	indication to high SDB	45	10.9
4	Indication to severe SDB	0	0

The total percentage for indication to moderate SDB was the highest in prevalence (185; 44.9%), closely followed by very little indication of SDB in (182; 44.2%) of individuals, a high level of SDB (45; 10.9%), and no individuals in the severe SDB category. This concludes that Young Palestinian Adults in the Governorates of Bethlehem and Hebron have a moderate level of SDB. Furthermore, means and standard deviations were also calculated for the samples' responses on each of the subscales of SDB. The following table presents this:

Table (9): Means and Standard Deviations for the Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Classified by SDBC Subscales

		N	Min.	Max.	M.	SD.
4	Failure in Routine or Primary Self-Care	412	.00	4.00	1.7437	0.80963
5	Issues of Self-Management	412	.00	3.83	1.5324	0.81643
6	Socioemotional and Sexual Behaviors	412	.00	3.10	1.2184	0.59101
2	Risky, Thrilling, Defiant, and Criminal Behaviors	412	.00	3.60	1.0985	0.64529
1	Substance-Use and Addiction-Related	412	.00	3.60	0.8529	0.66619

		N	Min.	Max.	M.	SD.
	Behaviors					
3	Direct Self-Harm & Suicidal Behavior	412	.00	3.50	0.7779	0.71983
	Average	412	.02	2.80	1.1395	0.53634

Table (9) shows that the highest scoring SDBC subscale was Failure in Routine or Primary Self-Care with a mean of (1.74), followed by Issues of Self-Management (1.53), then Socioemotional and Sexual Behaviors (1.21), Risky, Thrilling, Defiant, and Criminal Behaviors with a mean of (1.09), Substance-Use and Addiction-Related Behaviors (0.85), and finally Direct Self-Harm and Suicidal Behavior at a mean of (0.77). To further elaborate on this point, frequencies of the sample's responses on SDBC subscales were calculated in terms of severity of each subscale. The following tables present this:

Table (10): Frequencies and Percentages for the Severity of the Sample's Responses on the SDBC Subscale Substance-Use and Addiction-Related Behaviors

Interpretation	N	%
very little indication to SDB	**298**	**72.3**
indication to moderate SDB	**85**	**20.6**
indication to high SDB	**25**	**6.1**
indication to severe SDB	**4**	**1.0**

Table (10) shows that in terms of prevalence of substance-use and addiction-related behaviors, (298; 72.3%) of sample showed very little indication to SDB, (85; 20.6%) showed indication to moderate SDB, (25; 6.1%) showed indication to high SDB, and (4; 1.0%) showed indication to severe SDB.

Table (11): Frequencies and Percentages for the Severity of the Sample's Responses on the SDBC Subscale Risky, Thrilling, Defiant, and Criminal Behaviors

Interpretation	N	%
very little indication to SDB	208	50.5
indication to moderate SDB	164	39.8
indication to high SDB	36	8.7
indication to severe SDB	4	1.0

Table (11) shows that in terms of risky, thrilling, defiant, and criminal behaviors, (208; 50.5%) of sample showed very little indication to SDB, (164; 39.8%) showed indication to moderate SDB, (36; 8.7%) showed indication to high SDB, and (4l; 1.0%) showed indication to severe SDB.

Table (12): Frequencies and Percentages for the Severity of the Sample's Responses on the SDBC Subscale Direct Self-Harm & Suicidal Behavior

Interpretation	N	%
very little indication to SDB	301	73.1
indication to moderate SDB	79	19.2
indication to high SDB	29	7.0
indication to severe SDB	3	.7

Table (12) shows that in terms of direct self-harm and suicidal behavior, (307; 73.1%) of sample showed very little indication to SDB, (79; 19.2%) showed indication to moderate SDB, (29; 7.0%) showed indication to high SDB, and (3; 0.7%) showed indication to severe SDB.

Table (13): Frequencies and Percentages for the Severity of the Sample's Responses on the SDBC Subscale Failure in Routine or Primary Self-Care

Interpretation	N	%
indication to moderate SDB	189	45.9
indication to high SDB	113	27.4
very little indication to SDB	88	21.4
indication to severe SDB	22	5.3

Table (13) shows that in terms of failure in routine or primary self-care, (189; 45.9%) of sample showed indication to moderate SDB, (113; 27.4%) showed indication to high SDB, (88; 21.4%) showed very little indication to SDB, and (22; 5.3%) showed indication to severe SDB.

Table (14): Frequencies and Percentages for the Severity of the Sample's Responses on the SDBC Subscale Issues of Self-Management

Interpretation	N	%
indication to moderate SDB	182	44.2
very little indication to SDB	130	31.6
indication to high SDB	84	20.4
indication to severe SDB	16	3.9

Table (14) shows that in issues of self-management, (182; 44.2%) of sample showed indication to moderate SDB, (130; 31.6%) showed very little indication to SDB, (84; 20.4%) showed indication to high SDB, and (16; 3.90%) showed indication to severe SDB.

Table (15): Frequencies and Percentages for the Severity of the Sample's Responses on the SDBC Subscale Socioemotional and Sexual Behaviors

Interpretation	N	%
indication to moderate SDB	204	49.5
very little indication to SDB	171	41.5
indication to high SDB	36	8.7
indication to severe SDB	1	.2

Table (15) shows that in terms of socioemotional and sexual behaviors, (204; 49.5%) of sample showed indication to moderate SDB, (171; 41.5%) showed very little indication to SDB, (36; 8.7%) showed indication to high SDB, and (1; 0.2%) showed indication to severe SDB.

4.2.2 Results of Second Question

The second study question and corresponding hypothesis were divided into separate questions/hypotheses for each independent variable considered in the study (eleven sociodemographic and non-sociodemographic variables), which included age, sex, level of education, employment status, marital status, area of residence, location of residence, marital status of parents, recent exposure to violence or traumatic event, religion, and religiosity. The following presents this:

Are there statistically significant differences in the prevalence of self-destructive behaviour related to the age variable among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the age variable.

To examine the hypothesis, the means were calculated for the differences in responses of the study sample individuals on the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the age variable, as shown in the following table:

Table (16): Means and Standard Deviations for Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Age Variable

Age	N	M	SD
From 22-25	105	57.9714	23.62262
From 26-29	87	56.7011	25.83135
From 18-21	220	54.4727	27.65565

Table (16) shows that there are apparent differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the Age variable. In order to determine the significance of differences, one way ANOVA was used as shown in the following table:

Table (17): Results of One Way ANOVA Test for the Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Age Variable

	Mean Square	df	Sum of Squares	Value of "F"	Sig
Between Groups	952.796	2	476.398	0.689	0.503
Within Groups	282917.981	409	691.731		
Total	283870.777	411			

Table (17) demonstrates the value of P for the total score was (0.689) and the level of significance (0.503) is greater than the level of significance ($\alpha \geq 0.05$), meaning that there are no statistically significant differences in the prevalence of self-destructive behavior

among young Palestinian adults in the governorates of Bethlehem and Hebron related to the age variable, and thus the first hypothesis was accepted.

Are there statistically significant differences in the prevalence of self-destructive behaviour related to the sex variable among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the sex variable.

The hypothesis was examined by calculating the results of the T-test and the Mean for the differences in responses of the study sample members on the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the sex variable. The following table present this:

Table (18): T-Test Results for Independent Samples for Differences in the Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Sex Variable

Sex	N	M	SD	Value of "t"	Sig
Male	209	58.9139	26.90193	2.427	0.016
Female	203	52.6650	25.30186		

Table (18) shows that the value of "T" for the total degree was (2.427) and the level of significance was (0.016), which indicates that there are differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the sex variable, and that these differences were in favour of males, and thus the second hypothesis was rejected.

Are there statistically significant differences in the prevalence of self-destructive behaviour related to the level of education variable among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the level of education variable.

To examine the hypothesis, the means were calculated for the differences in responses of the study sample individuals on the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the level of education variable, as shown in the following table:

Table (19): Means and Standard Deviations for Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Level of Education Variable

Level of Education	N	M	SD
Diploma	114	63.9825	26.45517
Graduate Studies	19	57.1579	30.99868
High School or Less	40	54.8750	28.65013
Bachelor's Degree	239	52.0042	24.62586

It can be noted from Table (19) that there are apparent differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the level of education variable.

To identify the significance of these differences, One Way ANOVA was used as demonstrated below:

Table (20): Results of One Way ANOVA Test for the Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Level of Education Variable

	Mean Square	df	Sum of Squares	Value of "F"	Sig
Between Groups	11144.915	3	3714.972	5.558	0.001
Within Groups	272725.862	408	668.446		
Total	283870.777	411			

Table (20) demonstrates that the value of P for the total score was (5.558) and the level of significance (0.001) is less than the level of significance ($\alpha \geq 0.05$), meaning that there are statistically significant differences in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the level of education variable, and thus the third hypothesis was rejected.

Furthermore, a LSD test was used to examine the direction of differences in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the level of education variable, which indicated that the differences between individuals with a "Diploma" and individuals with a "Bachelor's Degree" were in favour of the "Diploma" category. This is shown in this following table:

Table (21): Results of LSD Test for the Direction of Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Level of Education Variable

(I) Level of Education	(J) Level of Education	Mean Difference (I-J)	Sig.
Highschool or Less	Diploma	-9.10746	0.056
	Bachelor's Degree	2.87082	0.516
	Graduate Studies	-2.28289	0.751
Diploma	Highschool or Less	9.10746	0.056
	Bachelor's Degree	11.97827*	0.000
	Graduate Studies	6.82456	0.287
Bachelor's Degree	Highschool or Less	-2.87082	0.516

(I) Level of Education	(J) Level of Education	Mean Difference (I-J)	Sig.
	Diploma	-11.97827*	0.000
	Graduate Studies	-5.15371	0.403
Graduate Studies	Highschool or Less	2.28289	0.751
	Diploma	-6.82456	0.287
	Bachelor's Degree	5.15371	0.403

Are there statistically significant differences in the prevalence of self-destructive behaviour related to the employment status variable among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the employment status variable.

The hypothesis was examined by calculating the results of the T-test and the Means for the differences in responses of the study sample members on the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the employment status variable. The following table present this:

Table (22): T-Test Results for Independent Samples for Differences in the Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Employment Status Variable

Employment Status	N	M	Std. Deviation	Value of "t"	Sig
Works	142	56.6197	24.87807	0.439	0.661
Doesn't work	270	55.4222	27.02538		

It can be noted from the previous table that the value of "T" for the total degree (0.439), and the level of significance (0.661), indicate that there are no differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the employment status variable, and thus the fourth hypothesis was accepted.

Are there statistically significant differences in the prevalence of self-destructive behaviour related to the marital status variable among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the marital status variable.

To examine the hypothesis, the means were calculated for the differences in responses of the study sample individuals on the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the marital status variable:

Table (23): Means and Standard Deviations for Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Marital Status Variable

Marital Status	N	M	SD
Previously Married or Separated	37	64.8108	27.44675
Married	91	55.8571	25.19858
Single	284	54.6585	26.33233

It can be noted from Table (23) that there are apparent differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the marital status variable. To identify the significance of these differences, One Way ANOVA was used as demonstrated below:

Table (24): Results of One Way ANOVA Test for the Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Marital Status Variable

	Mean Square	df	Sum of Squares	Value of "F"	Sig
Between Groups	3374.088	2	1687.044	2.460	0.087
Within Groups	280496.688	409	685.811		
Total	283870.777	411			

Table (24) demonstrates that the value of P for the total score was (2.460) and the level of significance (0.087) is greater than the level of significance ($\alpha \geq 0.05$), meaning that there are no statistically significant differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the marital status variable, and thus the fifth hypothesis was accepted.

Are there statistically significant differences in the prevalence of self-destructive behaviour related to the area of residence variable among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the area of residence variable.

To examine the hypothesis, the means were calculated for the differences in responses of the study sample individuals on the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the area of residence variable, as shown in the following table:

Table (25): Means and Standard Deviations for Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Area of Residence Variable

Area of Residence	N	M	SD
Camps and Others	49	64.9388	27.51167
City	190	54.9632	27.92400
Village	73	54.9315	25.77323
Town	100	53.6900	21.93088

It can be noted from Table (25) that there are apparent differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the area of residence variable. To identify the significance of these differences, One Way ANOVA was used as demonstrated below:

Table (26): Results of One Way ANOVA Test for the Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Area of Residence Variable

	Mean Square	df	Sum of Squares	Value of "F"	Sig
Between Groups	4725.171	3	1575.057	2.302	0.077
Within Groups	279145.606	408	684.180		
Total	283870.777	411			

Table (26) demonstrates that the value of P for the total score was (2.302) and the level of significance (0.077) is greater than the level of significance ($\alpha \geq 0.05$), meaning that there are no statistically significant differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the area of residence variable, and thus the sixth hypothesis was accepted.

Are there statistically significant differences in the prevalence of self-destructive behaviour related to the location of residence among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the location of residence variable.

The hypothesis was examined by calculating the results of the T-test and the Means for the differences in responses of the study sample members on the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the location of residence variable. The following table present this:

Table (27): T-Test Results for Independent Samples for Differences in the Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Location of Residence Variable

Location of Residence	N	Mean	Std. Deviation	Value of "t"	Sig
Hebron	109	56.1651	28.57301	0.153	0.879
Bethlehem	303	55.7162	25.45491		

It can be noted from the previous table that the value of "T" for the total degree (0.153), and the level of significance (0.879), indicate that there are no differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the location of residence variable, and thus the seventh hypothesis was accepted.

Are there statistically significant differences in the prevalence of self-destructive behaviour related to the marital status of parents variable among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the marital status of parents variable.

To examine the hypothesis, the means were calculated for the differences in responses of the study sample individuals on the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the marital status of parents variable, as shown in the following table:

Table (28): Means and Standard Deviations for Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Marital Status of Parents Variable

Marital Status of Parents	N	M	SD
Widowed Parent / Deceased Parents	21	65.1429	27.11141
Separated or Divorced	32	63.6250	28.38190
Married	359	54.5961	25.88578

It can be noted from table (28) that there are apparent differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the marital status of parents variable. To identify the significance of these differences, One Way ANOVA was used as demonstrated below:

Table (29): Results of One Way ANOVA Test for the Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Marital Status of Parents Variable

	Mean Square	df	Sum of Squares	Value of "F"	Sig
Between Groups	4312.271	2	2156.135	3.154	0.044
Within Groups	279558.506	409	683.517		
Total	283870.777	411			

Table (29) demonstrates that the value of P for the total score was (3.154) and the level of significance (0.044) is less than the level of significance ($\alpha \geq 0.05$), meaning that there are statistically significant differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the marital status of parents variable, and thus the eighth hypothesis was rejected.

Furthermore, a LSD test was used to examined the direction of differences in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the marital status of parents variable, which indicated that the differences between individuals under the “Widowed Parent / Deceased Parents” category and the “Married” category were in favour of the “Widowed Parent / Deceased Parents” category, as shown in this following table:

Table (30): Results of LSD Test for the Direction of Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Marital Status of Parents Variable

(I) Marital Status of Parents	(J) Marital Status of Parents	Mean Difference (I-J)	Sig.
Married	Separated or Divorced	-9.02890	0.062
	Widowed Parent / Deceased Parents	-10.54676	0.073
Separated or Divorced	Married	9.02890	0.062
	Widowed Parent / Deceased Parents	-1.51786	0.836
Widowed Parent / Deceased Parents	Married	10.54676	0.073
	Separated or Divorced	1.51786	0.836

Are there statistically significant differences in the prevalence of self-destructive behaviour related to the recent exposure to violence or traumatic event variable among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the recent exposure to violence or traumatic event variable.

The hypothesis was examined by calculating the results of the T-test and the Means for the differences in responses of the study sample members on the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the recent exposure to violence or traumatic event variable.

The following table present this:

Table (31): T-Test Results for Independent Samples for Differences in the Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Recent Exposure to Violence or Traumatic Event Variable

Recent Exposure to Violence or Traumatic Event	N	M	SD	Value of "t"	Sig
Yes	81	63.2840	27.21040	2.871	0.004
No	331	54.0121	25.76373		

It can be noted from the previous table that the value of "T" for the total degree (2.871), and the level of significance (0.004), indicate that there are differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the recent exposure to violence or traumatic event variable, and that those differences

were in favour of individuals whom have recently been exposed to violence or traumatic event, then individuals whom have not, and thus the ninth hypothesis was rejected.

Are there statistically significant differences in the prevalence of self-destructive behaviour related to the religion variable among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the religion variable.

To examine the hypothesis, the means were calculated for the differences in responses of the study sample individuals on the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the religion variable.

The following table presents this:

Table (32): Means and Standard Deviations for Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Religion Variable

Religion	N	M	SD
Other religious status	14	75.2143	39.95416
Christian	47	62.7447	21.09860
Muslim	351	54.1368	25.86379

It can be noted from table (32) that there are apparent differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the religion variable. To determine the significance of the differences, One Way ANOVA was used as demonstrated in the following table:

Table (33): Results of One Way ANOVA Test for the Differences in the Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Religion Variable

	Mean Square	df	Sum of Squares	Value of "F"	Sig
Between Groups	8514.047	2	4257.024	6.323	0.002
Within Groups	275356.729	409	673.244		
Total	283870.777	411			

The table shows that value of P for the total score (6.323) and the level of significance (0.002) are less than the level of significance ($\alpha \geq 0.05$), meaning that there are statistically significant differences in the prevalence of self-destructive behavior among Palestinian youth in the governorates of Bethlehem and Hebron related to the religion variable, and thus the eleventh hypothesis was rejected.

Furthermore, a LSD test was used to examined the direction of differences in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to religion variable, which indicated that the differences between individuals under the categories “Christian” and “Muslim” were in favour of the

"Christian" Category, and between "Other Religious Status" and "Muslim" in favour of "Other Religious Status".

This is shown in this following table:

Table (34): Results of LSD Test for the Direction of Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Religion Variable

(I) Religion	(J) Religion	Mean Difference (I-J)	Sig.
Muslim	Christian	-8.60793*	0.033
	Other religious status	-21.07753*	0.003
Christian	Muslim	8.60793*	0.033
	Other religious status	-12.46960	0.115
Other religious status	Muslim	21.07753*	0.003
	Christian	12.46960	0.115

Are there statistically significant differences in the prevalence of self-destructive behaviour related to the religiosity variable among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the religiosity variable.

To examine the hypothesis, the means were calculated for the differences in responses of the study sample individuals on the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the religiosity variable. The following table shows this:

Table (35): Means and Standard Deviations for Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Religiosity Variable

Religiosity	N	M	SD
Not Religious	30	67.0333	32.47862
Moderately Religious	138	56.8841	25.38178
Very Religious	244	53.8648	25.67272

It can be noted from Table (35) that there are apparent differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the religiosity variable. To identify the significance of these differences, One Way ANOVA was used as demonstrated below:

Table (36): Results of One Way ANOVA Test for the Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Religiosity Variable

	Mean Square	df	Sum of Squares	Value of "F"	Sig
Between Groups	4861.128	2	2430.564	3.563	0.029
Within Groups	279009.648	409	682.175		
Total	283870.777	411			

Table (36) demonstrates that the value of P for the total score was (3.563) and the level of significance (0.029) is less than the level of significance ($\alpha \geq 0.05$), meaning that there are statistically significant differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron related to the religiosity variable, and thus the twelfth hypothesis was rejected.

Furthermore, a LSD test was used to examined the direction of differences in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to religiosity variable, which indicated that the differences between individuals under the category "Not Religious" and the category "Very Religious" were in favour of the category "Not Religious", as shown below:

Table (37): Results of LSD Test for the Direction of Differences in Prevalence of SDB among Young Palestinian Adults in the Governorates of Bethlehem and Hebron Related to the Religiosity Variable

(I) Religiosity	(J) Religiosity	Mean Difference (I-J)	Sig.
Not Religious	Moderately Religious	10.14928	0.054
	Very Religious	13.16858*	0.009
Moderately Religious	Not Religious	-10.14928	0.054
	Very Religious	3.01930	0.278
Very Religious	Not Religious	-13.16858*	0.009
	Moderately Religious	-3.01930	0.278

4.2.3 Results of Third Question

Is there a statistically significant relationship between self-destructive behavior and each attachment style (secure, dismissive, ambivalent, and disorganized) among young Palestinian adults in the governorates of Bethlehem and Hebron?

In order to determine the statistically significant differences in SDB, which are related to each subtype of attachment styles, the prevalence of each style was first determined and analysed. To determine the prevalence of each Attachment subtype among young Palestinian adults in the governorates of Bethlehem and Hebron, means and standard deviations were calculated for the sample's response on the ASQ. The following table presents these results:

Table (38): Means and Standard Deviations for the Prevalence of Attachment Style Subtypes among Young Palestinian Adults in the Governorates of Bethlehem and Hebron

N	Fields	Mean	SD	Degree	%
4	Dismissive	2.2291	0.93753	Medium	55.7
2	Disorganized	2.0505	0.84172	Medium	51.3
1	Secure	1.8637	0.54892	Medium	46.6
3	Ambivalent	1.7871	0.75181	Medium	44.7
Average		1.9564	0.43377	Medium	48.9

The attachment subtype "Dismissive" obtained the highest mean of (2.22), followed by the subtype "Disorganized" with a mean of (2.05), then the "Secure" subtype with a mean of (1.86), and finally the subtype of "Ambivalent" with a mean of (1.78).

Is there a statistically significant relationship between self-destructive behavior and the attachment style "Secure" among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the Attachment Style Secure variable.

The hypothesis was examined by calculating the Pearson Correlation Coefficient and the statistical significance between the prevalence of SDB and the Attachment Style Secure variable, as shown in the following table:

Table (39): Pearson Correlation Coefficient and the Statistical Significance between the Prevalence of SDB and the Attachment Style Secure Variable

Variables		Pearson Correlation	sig
SDB	Attachment Style Secure	0.088	0.075

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

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

Table (39) shows that the value of the Pearson Correlation Coefficient for the total degree is (0.088) and the significance level (0.075), indicate that there is no statistically significant relationship at the significance level ($\alpha \leq 0.05$) between the prevalence of SDB and the Attachment Style Secure variable, thus the hypothesis was accepted.

The Pearson Correlation Coefficient and the statistical significance between the prevalence of each subtype of SDB and the Attachment Style Secure variable were calculated, as shown in the following table:

Table (40): Pearson Correlation Coefficient and the Statistical Significance between the Prevalence of SDB Subtypes and the Attachment Style Secure Variable

Variables		Pearson Correlation	sig
Attachment Style Secure	Substance-Use and Addiction-Related Behaviors	0.073	0.137
	Risky, Thrilling, Defiant, and Criminal Behaviors	0.081	0.099
	Direct Self-Harm & Suicidal Behavior	0.024	0.623
	Failure in Routine or Primary Self-Care	*0.102	0.039
	Issues of Self-Management	*0.113	0.022
	Socioemotional and Sexual Behaviors	0.033	0.506
	Total SDB	0.088	0.075

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table (40) shows that there was a statistically significant relationship at the level ($\alpha \leq 0.05$) between the prevalence of SDB subtypes "Failure in Routine or Primary Self-Care", "Issues of Self-Management", and the Attachment Style Secure variable respectively.

Is there a statistically significant relationship between self-destructive behavior and the attachment style "Dismissive" among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the Attachment Style Dismissive variable.

The hypothesis was examined by calculating the Pearson Correlation Coefficient and the statistical significance between the prevalence of SDB and the Attachment Style Dismissive variable, as shown in the following table:

Table (41): Pearson Correlation Coefficient and the Statistical Significance between the Prevalence of SDB and the Attachment Style Dismissive Variable

Variables		Pearson Correlation	sig
SDB	Attachment Style Dismissive	**0.266	0.000

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table (41) shows that the value of the Pearson Correlation Coefficient for the total degree is (0.266), and that the significance level was (0.000), which indicates that there is a positive direct statistically significant relationship at the significance level ($\alpha \leq 0.05$) between the prevalence of SDB and the Attachment Style Dismissive variable. This implies that the higher the level of SDB, the higher a person would score on the Attachment Style Dismissive subscale, and vice versa, and thus, the hypothesis is rejected.

The Pearson Correlation Coefficient and the statistical significance between the prevalence of each subtype of SDB and the Attachment Style Dismissive variable were calculated, as shown in the following table, which indicates that there was a significant relationship

between the Attachment Style Dismissive variable and each of the SDB subtypes respectively:

Table (42): Pearson Correlation Coefficient and the Statistical Significance between the Prevalence of SDB Subtypes and the Attachment Style Dismissive Variable

Variables		Pearson Correlation	sig
Attachment Style Dismissive	Substance-Use and Addiction-Related Behaviors	0.162**	0.001
	Risky, Thrilling, Defiant, and Criminal Behaviors	0.188**	0.000
	Direct Self-Harm & Suicidal Behavior	0.194**	0.000
	Failure in Routine or Primary Self-Care	0.288**	0.000
	Issues of Self-Management	0.211**	0.000
	Socioemotional and Sexual Behaviors	0.233**	0.000
	Total SDB	**0.266	0.000

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Is there a statistically significant relationship between self-destructive behavior and the attachment style "Ambivalent" among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the Attachment Style Ambivalent variable.

The hypothesis was examined by calculating the Pearson Correlation Coefficient and the statistical significance between the prevalence of SDB and the Attachment Style Ambivalent variable, as shown in the following table:

Table (43): Pearson Correlation Coefficient and the Statistical Significance between the Prevalence of SDB and the Attachment Style Ambivalent Variable

Variables		Pearson Correlation	sig
SDB	Attachment Style Ambivalent	**0.238	0.000

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table (43) shows that the value of the Pearson Correlation Coefficient for the total degree is (0.238) and the significance level (0.000), indicate that there is a positive direct statistically significant relationship at the significance level ($\alpha \leq 0.05$) between the prevalence of SDB and the Attachment Style Ambivalent and vice versa.

The Pearson Correlation Coefficient and the statistical significance between the prevalence of each subtype of SDB and the Attachment Style Ambivalent variable were calculated, as shown in the following table, which indicates that there was a significant relationship between the Attachment Style Ambivalent variable and each of the SDB subtypes respectively, and that in some subtypes the relationship was more significant than others:

Table (44): Pearson Correlation Coefficient and the Statistical Significance between the Prevalence of SDB Subtypes and the Attachment Style Ambivalent Variable

Variables		Pearson Correlation	sig
Attachment Style Ambivalent	Substance-Use and Addiction-Related Behaviors	0.126*	0.011
	Risky, Thrilling, Defiant, and Criminal Behaviors	0.105*	0.034
	Direct Self-Harm & Suicidal Behavior	0.197**	0.000
	Failure in Routine or Primary Self-Care	0.258**	0.000
	Issues of Self-Management	0.254**	0.000
	Socioemotional and Sexual Behaviors	0.222**	0.000
	Total SDB	**0.238	0.000

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Is there a statistically significant relationship between self-destructive behavior and the attachment style "Disorganized" among young Palestinian adults in the governorates of Bethlehem and Hebron?

To answer this question, it was converted to the following hypothesis: There are no statistically significant differences at the level of significance ($0.05 \geq \alpha$) in the prevalence of self-destructive behavior among young Palestinian adults in the governorates of Bethlehem and Hebron related to the Attachment Style Disorganized variable.

The hypothesis was examined by calculating the Pearson Correlation Coefficient and the statistical significance between the prevalence of SDB and the Attachment Style Disorganized variable, as shown in the following table:

Table (45): Pearson Correlation Coefficient and the Statistical Significance between the Prevalence of SDB and the Attachment Style Disorganized Variable

Variables		Pearson Correlation	sig
SDB	Attachment Style Disorganized	**0.139	0.005

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table (45) shows that the value of the Pearson Correlation Coefficient for the total degree is (0.139) and the significance level (0.005), indicate that there is a positive direct statistically significant relationship at the significance level ($\alpha \leq 0.05$) between the prevalence of SDB and the Attachment Style Disorganized and vice versa.

The Pearson Correlation Coefficient and the statistical significance between the prevalence of each subtype of SDB and the Attachment Style Disorganized variable were calculated, which indicated that there was a significant relationship between Disorganized Attachment and the SDB subtypes "Risky, Thrilling, Defiant, and Criminal Behaviors", "Failure in Routine or Primary Self-Care", and "Socioemotional and Sexual Behaviors", but not in the SDB subtypes "Substance-Use and Addiction-Related Behaviors", "Direct

Self-Harm & Suicidal Behavior", and "Issues of Self-Management". This is shown in the following table,

Table (46): Pearson Correlation Coefficient and the Statistical Significance between the Prevalence of SDB Subtypes and the Attachment Style Disorganized Variable

Variables		Pearson Correlation	sig
Attachment Style Disorganized	Substance-Use and Addiction-Related Behaviors	0.071	0.148
	Risky, Thrilling, Defiant, and Criminal Behaviors	0.144**	0.003
	Direct Self-Harm & Suicidal Behavior	0.067	0.174
	Failure in Routine or Primary Self-Care	0.253**	0.000
	Issues of Self-Management	0.001	0.989
	Socioemotional and Sexual Behaviors	0.142**	0.004
	Total SDB	**0.139	0.005

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

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

Chapter Five

Introduction

Discussion of Results

Conclusion

Recommendations

Chapter Five:

Discussion of Results:

5.1Introduction

The following chapter discusses the results of the study and attempts to interpret them in light of reviewed literature and considered previous studies.

5.2 Discussion of Results

5.2.1 What is the prevalence of self-destructive behavior in young Palestinian adults in the southern West Bank governorates?

Results indicated that most young Palestinian adults in the governorates of Bethlehem and Hebron have a moderate level of SDB. As the operational definition for SDB in this study differed from conceptualizations used in previous studies, it was not possible to identify whether this result was in accordance with previous work or not.

However, studies did consider SDB subtypes used on this study, in terms of their prevalence or their relationship to other variables also examined for this study.

Results found that most young Palestinian adults in the governorates of Bethlehem and Hebron engage in the SDB subtype "Failure in Routine or Primary Self-Care" at a mean of (1.74), then "Issues of Self-Management" at (1.53), then "Socioemotional and Sexual Behaviors" at (1.21), "Risky, Thrilling, Defiant, and Criminal Behaviors" with a mean of (1.09), "Substance-Use and Addiction-Related Behaviors" (0.85), and finally "Direct Self-Harm and Suicidal Behavior" at a mean of (0.77), which obtained the lowest score.

The variance in means for each SDB subtype implies that there are differences in what the subtypes indicate. Similar suggestions were made in (Tsirigotis & Luczak, 2018) as to the differences in motivation behind direct risky and acute SDB forms compared to indirect socially tolerated SDB forms.

In this study, the contrast in SDB forms was taken in account when designing the study instrument (The SDBC), where the questionnaire included "lower-risk" items towards the beginning of the tool and "high-risk" items towards the end of the tool.

High-risk items were mainly representative of the "Risky, Thrilling, Defiant, and Criminal Behaviors" subtype, the "Substance-Use and Addiction-Related Behaviors" subtype, and the "Direct Self-Harm and Suicidal Behavior" subtype.

These subtypes refer to more direct and acute forms of self-destructiveness, as they pose risks and consequences difficult to ignore or avoid by the individual themselves or their surroundings. Additionally, individuals, who engage in substance use and abuse, or who drastically challenge social norms and act against criminal law, are often likely to require medical attention or to be in conflict with police or community social control agents and other authority figures, such as family members, peers and friends, or neighbourhood elders, who play a role in deterring high-risk SDB.

In contrast, lower-risk SDB subtypes were mainly inclusive of the "Failure in Routine or Primary Self-Care" subtype, the "Issues of Self-Management" subtype, and the "Socioemotional and Sexual Behaviors" subtype.

These behaviors are more indicative of poor self-regulation, self-neglect not connected to severe self-blame, and decreased motivation (Tsirigotis & Luczak, 2018). They manifest as unhealthy lifestyle choices or routines, which obstruct in self-actualization and growth. These behaviors are almost always indirect forms of self-destructiveness, and they are so widely prevalent that they are almost socially tolerated. Additionally, these behaviors don't cause life-threatening short-term consequences and their impact is amplified through frequency over time.

High-risk subtypes recorded substantially lower prevalence of SDB compared to lower-risk subtypes. This was in agreement with (Lim et al., 2017) and (Kelley et al., 1985), which suggested that higher-risk SDB can only be observed in smaller percentages, but that the absence of severe SDB doesn't necessarily imply lack of thereof.

An additional inspection of severity distribution confirms this; none of sample participants reported severe SDB in total, but (1%) of sample reported severe substance-use and addiction-related behaviors, (1%) reported engaging in severe risky, thrilling, defiant, and criminal behaviors, (0.7%) reported engaging in severe direct self-harm and suicidal behavior, (5.3%) reported severe failure in routine or primary self-care, (3.90%) reported severe issues of self-management, and (0.2%) reported severe engagement in self-destructive socioemotional and sexual behaviors.

In the Palestinian society, individuals are socialized and motivated to overvalue social integration, identification with parents, enmeshment with family, and abiding to social norms at constructs at the cost of individual growth and self-actualization (Wafa, n.d). However, the now young Palestinian adults have been remarked as being significantly different to their previous generations mainly due to the impact of globalization on the education and socialization they have received.

A similar point of view was suggested by (Kanaana, 2011), which described Palestinian "Millennials" as less tolerant of social and ethical ambiguities they've inherited through parenting, preferring to live further away from the influence of the extended family, and showing more acts of defiance of authority figures and social roles.

These two incompatible realities may have caused this generation to experience "role strain" and interpersonal conflict, both detrimental to the individual's adapting and coping abilities, which in turn helps to increase engagement in SDB.

Furthermore, cognitive dissonance experienced as a result of inability to integrate both community and individual ideals into cohesive structures, as well as feeling entrapped by social demands, would imaginably increase these individuals' need and use for quick solutions to seemingly unsolvable scenarios.

On the other hand, this tight-knit system of social control, which could be assisting in the maintenance of lower-risk SDB, could also help to interpret the decrease in high-risk SDB.

(Kanaana, 2011) described the influence of the concept of reputation on the Palestinian individual as paramount and suggested that oftentimes public opinion may very vocally protest the proclamation of socially unacceptable behavior more so than the action itself or the negative lived implications of the behavior on the individual behind it.

This suggests, to our young Palestinian adults, that they may act inappropriately or pathologically, as long as this doesn't disrupt the community's collective perception of themselves. In this, the community mirrors the collective direction of addressing SDB also observed on the individual level, with Palestinian families' general tendency to ignore pathological behavior "until it becomes a problem", which in itself is a destructive approach to problem-solving and regulation, as well as counterproductive to society's aim at deterring high-risk behaviors and social pathology.

5.2.2 Is there a statistically significant relationship between self-destructive behavior and the age, sex, level of education, employment status, marital status, area of residence, location of residence, marital status of parents, recent exposure to violence or traumatic event, psychiatric or medical conditions, religion, and religiosity variables among young Palestinian adults in the governorates of Bethlehem and Hebron?

Results indicated that there were no statistically significant differences in the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron, which are related to the variables of age, employment status, marital status, area of residence, and location of residence.

This was not in agreement with a large number of previous studies considered in this study such as (Alshalan, 2018; Kumar et al., 2013; Bolland, 2003) which indicated age, marital status, and location of residence were significantly related to SDB.

In regards to the age variable, the insignificance of variable in this study was perhaps because the employed sample, despite varying in age categories, still could be identified as belonging to one developmental stage; i.e. young adulthood, with similar developmental tasks and demands, regardless of being in beginning, middle, or end of stage.

When reviewing results for the marital status variable, one main interpretation emerges to address the insignificance of marital status on SDB; today's Palestinian young adults act inside their relationships similarly to how they act outside them, they view their relationships are role requirements, and they do not experience them in a life-altering manner.

Official reports, such as (PCBS, 2021a), indicates there is a relatively steady rise in divorce cases in the last ten years. This could be further evidence to the growing disinterest and devaluation of family-life among youth, or at the very least, serve as an indication to an issue with the marriage construct in today's Palestinian young adults.

As for the employment status variable, an understanding of the socioeconomic reality of today's young adults serves beneficial in interpreting the similarity of experiences employed and unemployed individuals share; both employed and unemployed Palestinian young adults live under the supervision and reach of extended family. Neither category can claim full financial or social independence, and ultimately, they are both required to serve similar social obligations towards their families of origin.

As for area of residence, it was not much of a surprise that the "southern" west bank governorates would show very similar characteristics, as they are completely

geographically cut off from the remaining governorates, with the exception of one crossing point kept under continuous patrol of Israeli army units.

This enclosure has long strengthened the socioeconomic connection between the two governorates as the two populations grew closer and closer to each other, so much so that many families from Hebron have permanently relocated to Bethlehem and several of Bethlehem's western villages and towns are direct neighbours of Hebron's eastern villages and towns, located within a (5)-minute drive from each other.

Finally, in regard to the insignificance of SDB results related to the location of residence variable, which were not in accordance with previous studies, such as (Bolland, 2003), which found links between proximity or distance from the city, urban life, and SDB.

This result may only be relevant in the area of Bethlehem and Hebron specifically, when compared to northern and central west bank governorates, as the various areas of residence are so closely spread around the city and each other, that they no longer hold much cultural and psychosocial significance.

Furthermore, and especially when taking into consideration that young Palestinian adults often have to move between their area of residence and area of work, many of them are expected to have become acculturated to their new environments.

Moving onto statistically significant differences, results found that the sex, level of education, marital status of parents, recent exposure to traumatic event or violence, religion, and religiosity variables were all related to significant differences in prevalence of SDB among studied sample of young Palestinian adults.

Differences in sex between "Male" and "Female" were in favour of individuals in the "Male" category. These results were in agreement with studies such as (Kelly et al., 2005; Musalam et al., 2007) indicating there is significant differences in SDB severity and manifestation related to the sex variable. In addition, results came in accordance with (Bolland, 2003) but not (Alshalan, 2018) and (Mubarak et al., 2020), as differences were in favour of male participants and not female participants.

Interpretation of this result crucially depends on insights provided by feminist theories, which examined gender-normative socialization in patriarchal societies.

Even in psychopathology, gender-differences may arise to shed light on the disparities in how women and men are treated and regarded by their society. Most men enjoy a grander metaphoric and real space compared to women; they are allowed to make more mistakes and receive less reprimandation for them, they have more opportunities to leave home, and they have substantially less fear for their lives and wellbeing, as they are exempt from the prospect of an "honour-killing", a privilege most women won't experience.

A further layer to this gender-based double-standard is the further empowerment of men to engage in SDB under the assumption that aspects of men's gender role include examples of self-destructiveness, such as the readiness to engage in aggression to assert dominance or the repression of emotions, both commonly observable among young Palestinian males.

As for the level of education variable, differences in level of education between "Diploma" and "Bachelor's Degree" were in favour of individuals in the "Diploma" category. These results were in accordance with studies in terms of significance of variable and the direction of differences, as studies, such as (Alshawashhreh et al., 2013), had noted that

moderately achieving individuals would be more likely to engage in SDB compared to higher-achieving individuals.

These two categories are seemingly similar, but when compared, they indicate differences in character, motivation, SES, and self-regard.

Individuals with Diplomas are more vocationally inclined. Their study usually lasts for a shorter period of time and their degrees only enable them to maintain a low to moderate income despite accumulation of experience. They are usually individuals, who had little or no ability to continue a higher education, due to socioeconomic factors, such as low income and gender-norms and biases, or psychological factors, such as maladjustment to life circumstances and a lower IQ.

Individuals with a Bachelor's Degree are usually more academically able and inclined. They are required to invest more time and effort into their school-work and they are more likely to have career-goals and objectives. Understandably, these individuals have a higher drive for achievement and they are usually more skilled at problem-solving; a necessary component of adaptation.

Differences in marital status of parents between "Widowed Parent / Deceased Parents" and "Married" were in favour of individuals in the "Widowed Parent / Deceased Parents" category. These results were in agreement with (Yates et al., 2008), which claimed there is a relationship between family disruption and SDB.

However, even more related is (Kumar et al., 2013), which indicated that having married parents is not necessarily negatively associated with SDB, but rather that the content and nature of experiences with parents were stronger indications of SDB.

Indeed, results showed that both individuals with married parents and individuals with a deceased parent or parents were significantly related to differences in SDB, but that the absence of one or both parents may increase SDB compared to other categories of marital status of parents.

Difference in recent exposure to violence or traumatic event between "Yes" and "No" were in favor of individuals, who reported having experienced violence or a traumatic event; i.e. category "Yes". Results for this variable are in agreement with literature and previous studies indicating there is a positive significant relationship between SDB, psychological distress, and exposure to traumatic events, such as (Taussig & Litrownik, 1997; Tsirigotis & Luczak, 2018).

This notion has been so widely discussed and covered that it would be redundant to attempt to interpret it in any other light. However, it merits to mention that the experiences of violence and trauma the sample participants reported are estimated to include several forms of political and social violence deeply embedded in the daily lives of Palestinians, in addition to months of instability and fear imposed by the spread of COVID19.

Similarly to young adult samples from recent studies on COVID19 and mental health, study participants also endured extended closures, curfews, individual and group quarantine periods, as well as the possibility of having been infected or having had lost a loved one to the virus.

As for the religion variable, differences in religion between "Christian" and "Muslim" were in favour of individuals in the "Christian" category and between "Other Religious Status" and "Muslim" in favour of individuals in the "Other Religious Status" category.

This suggested that individuals, who identified as having another religious status to Christianity and Islam, had the highest prevalence of SDB, followed by individuals, who identified themselves as Christians, then individuals, who identified themselves as Muslim.

None of the previous studies considered the religion variable in relation to self-destructiveness, but existing literature, such as (Behere et al., 2013) indicates that belief and behavioral systems, which are acquired through belonging to a religion, strongly influence the mental health of the worshipper.

An additional point of view is adopted from sociological interpretation of minority mentality and the use of collective identity to combat social threats to the community.

Individuals, who do not identify with the two main religions in the Palestinian society, exist as a religious minority living constantly under the attack of their social environment for failing to comply with what is deemed one of the most basic and integral aspects of Palestinian identity. These individuals are usually outcasted from social circles and may be subjected to several incidents of intimidation and threats to security and safety.

Palestinian Christians also experience psychosocial pressures related to their status as a religious minority in almost every Palestinian city, town, and village. These experiences vary and can include harassment and hate speech and they ultimately impact the social integration of Christians in their communities as well as the general social fabric of the Palestinian society, which has long claimed to encourage and protect diversity.

Differences in religiosity between "Not Religious" and "Very Religious" were in favour of individuals in the "Not Religious" category. None of the previous studies focused on the religiosity aspect to the individual, which could be related to SDB. However, insights from relevant literature help to interpret the relationship between religiosity and SDB.

(Behere et al., 2013) suggests that religiosity is considered to be a strong positive resource for mental health, coping, and adaptation, in individuals with an "intrinsic orientation" to religion.

Indeed, individuals, who only find religion useful when it is aligned with their primary needs and interests, will probably be more likely to experience a breakdown of their belief system when faced with existential crises, such as death or solitude. Often times, these individuals are in fact compartmentalized and acting upon reaction formation to prove their religiosity and virtue.

In contrast, individuals, who have internalized their religious beliefs and embraced them as guiding principles for navigating life, show better harmony in their reactions, and they are more reconciled, through faith, with existential truths. These individuals don't usually describe themselves as extremely religious, since they are humbled by their religious practices and pride themselves on abandoning pride and recognition.

5.2.3 Is there a statistically significant relationship between self-destructive behavior and each attachment style (secure, dismissive, ambivalent, and disorganized) among young Palestinian adults in the governorates of Bethlehem and Hebron?

First, as it relates to the prevalence of attachment styles, the attachment subtype "Dismissive" obtained the highest mean of (2.22), followed by the subtype "Disorganized" with a mean of (2.05), then the "Secure" subtype with a mean of (1.86), and finally the subtype of "Ambivalent" with a mean of (1.78).

Results on the prevalence of attachment styles were not accordance with previous studies or literature on distribution and prevalence of attachment styles such as (Bshara et al., 2014) and (Falwa & Abu Ghazal, 2014), which stated the attachment style secure would be the most prevalent. Attempts to interpret this result necessarily depend on an understanding of child-rearing patterns of Palestinian parents.

Many Palestinians still use corporal punishment as a parenting method, many still have no real grip on unconditional love and positive regard, and most are fixed in the same pathological patterns of regarding childhood abuse as strict parenting, which they themselves received as children.

Dismissive children, and later adults, originally grew up with dismissive parents that asked too much, ambivalent parents, who were unclear of how they felt, or disorganized parents, who switched between states of kindness and destruction. Furthermore, they were raised in an emotionally-restricted environment and taught to repress and avoid their problems and pains in order to receive care and attention.

A similar process was discussed in Freud's fixation notion; while underattentive and inconsistently attentive mothers cause the child to fixate and become stuck in one psychosexual stage of development, the overattentive mother may cause the same outcome, but with different internal processes. Freud called this "castration" behavior and considered it a sign of an overbearing mother.

In the Arab society, it has been long believed that the stereotypical father figure plays a key role in parenting through enforcing punishment, while the mother provides care and support. This is enough to create an ambivalent collective, as children receive mixed messages from their parents and continue on to create ambivalent interpersonal patterns with others (Altaan & Alomari, 2016).

However, it would appear that there has been a shift in the way families raise their children and assign power and authority roles, with more and more young people acting against the extended family's control and the nuclear family's demand for enmeshment without proper nurturing connections to compensate for psychosocial sacrifices made for and on behalf of the family unit.

Finally, as it relates to the relationship between SDB and attachment styles, results found no statistically significant relationship between the prevalence of SDB among young Palestinian adults in the governorates of Bethlehem and Hebron and the Attachment Style Secure, but found that there is a positive direct statistically significant relationship between the prevalence of SDB and the Attachment Style Dismissive Avoidant, the Attachment Style Anxious Preoccupied – Ambivalent, and the Attachment Style Fearful Avoidant – Disorganized. This was in partial agreement with previous studies and literature, such as

(Metwali et al., 2019; Stepp et al., 2008; Cruz et al., 2013), as some studies found a negative correlation between secure attachment and SDB.

This can be made logical when taking into consideration that SDB is initially a maladaptive coping mechanism, which may develop into a generalised tendency, but may also remain reactive to a distress or a difficult event (Ferentz, 2016).

It may be assumed that these secure individuals are currently overcoming a crisis, distress, or interpersonal conflict. However, it may also be assumed that SDB can oftentimes be learned and acquired from the collective, without much consideration for the symbolism behind the behavior, and therefore these individuals' SDB would not be considered an indication to underlying pathology or disruption. Eventually, no one is perfect, and some maladaptation is acceptable, especially when taking into consideration that the relationships between SDB subtypes and the attachment style secure were only found in the "Failure in Routine or Primary Self-Care" and "Issues of Self-Management" subtypes, both of which are lower-risk SDB manifestations.

Furthermore, results found there was a significant relationship between the attachment style Disorganized and the SDB subtypes "Risky, Thrilling, Defiant, and Criminal Behaviors", "Failure in Routine or Primary Self-Care", and "Socioemotional and Sexual Behaviors", but not in the SDB subtypes "Substance-Use and Addiction-Related Behaviors", "Direct Self-Harm & Suicidal Behavior", and "Issues of Self-Management".

Finally, results indicated there was a significant relationship between each of the SDB subtypes respectively with both the Attachment Style Dismissive and the Attachment Style Ambivalent; a result in accordance with previous studies and literature, such as (Falwa & Abu Ghazal, 2014) and (Kayyal & Shawareb, 2016), and in partial accordance with (Sabah & Jaradat, 2019).

5.3 Conclusion:

This study aimed at identifying the prevalence of self-destructive behavior and its relationship to attachment styles (secure, dismissive, ambivalent, and disorganized) among young Palestinian adults in the governorates of Bethlehem and Hebron, in addition to identifying the differences in the prevalence of self-destructive behaviour, which are related to the study variables (age, sex, level of education, employment status, marital status, area of residence, location of residence, marital status of parents, recent exposure to violence or traumatic event, religion, and religiosity).

Statistical analysis revealed that most sample members have a moderate level of self-destructive behaviour (44.9%). Additionally, they were most likely to engage in the self-destructive behaviour subtype "Failure in Routine or Primary Self-Care" (M=1.74), then "Issues of Self-Management" (M=1.53), "Socioemotional and Sexual Behaviors" (M=1.21), "Risky, Thrilling, Defiant, and Criminal Behaviors" (M=1.09), "Substance-Use and Addiction-Related Behaviors" (M=0.85), and finally "Direct Self-Harm and Suicidal Behavior" (M=0.77).

As it relates to the study variables, results indicated that only the sex, level of education, marital status of parents, recent exposure to traumatic event or violence, religion, and religiosity variables were related to significant differences in self-destructive behaviour.

The differences related to sex were between "Male" and "Female" and in favour of the "Male" category, in the level of education variable between "Diploma" and "Bachelor's Degree" and in favour of the "Diploma" category, in the marital status of parents variable between "Widowed Parent / Deceased Parents" and "Married" and in favour of the "Widowed Parent / Deceased Parents" category, in the recent exposure to violence or traumatic event variable between "Yes" and "No" and in favor of confirmed having experienced violence or a traumatic, in the religion variable between "Christian" and "Muslim" in favour of "Christian" and between "Other Religious Status" and "Muslim" in favour of "Other Religious Status", and finally in the religiosity variable, differences were between the "Not Religious" and "Very Religious" categories and in favour of the "Not Religious" category.

In relation to attachment styles, results indicated that "Dismissive Attachment" was the most prevalent, followed by "Disorganized Attachment", "Secure Attachment", and finally "Ambivalent Attachment".

Moreover, results indicated that there was no significant relationship between secure attachment and self-destructive behaviour, but found a significant positive relationship between self-destructive behaviour and dismissive attachment, ambivalent attachment, and disorganized attachment respectively. Further analysis revealed that secure attachment showed a significant relationship with the self-destructive behaviour subtypes "Failure in Routine or Primary Self-Care" and "Issues of Self-Management", and a significant relationship between fearful attachment and self-destructive behaviour subtypes "Risky, Thrilling, Defiant, and Criminal Behaviors", "Failure in Routine or Primary Self-Care", and "Socioemotional and Sexual Behaviors". Finally, results indicated that both dismissive and ambivalent attachment styles were correlated to all self-destructive behaviour subtypes.

5.4 Recommendations

For mental health practitioners

- The implementation of counselling programs to decrease the moderate level of SDB.
- The implementation of psychoeducation programs for educators and parents on the parenting skills and establishing secure attachment.
- The implementation of supportive protocols, individual, group, and family therapy for the following groups of people in order to decrease SDB tendencies:

For decision makers

- Working to write better laws, which ensure children's rights and protection from abuse, motivated by the understanding of the role it plays on attachment, and therefore SDB.
- Working to educate on considering SDB as a manifestation of psychopathology, and those, who engage in SDB, are in need for support as well as discipline and not discipline alone.

For researchers and academics

- Conducting qualitative, mixed, and experimental research on the topic, especially lived experience and narrative research, which could help deepen understanding of experiences and perceptions of self-destructive individuals.
- Conducting comparative research to analyse similarities and differences in results from other Palestinian areas and age-groups.
- Conducting research specifically targeting lower-risk SDB subtypes.

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Appendices:

Appendix A: Study Tool after Validation

الدراسات العليا – كلية الصحة العامة

برنامج الصحة النفسية المجتمعية / مسار العلاج النفسي

تحية طيبة وبعد،

تقوم الباحثة / الطالبة بإجراء دراسة بعنوان "**مدى انتشار السلوك المدمر للذات وعلاقته بأنماط التعلق لدى الشباب الفلسطينيين في محافظتي بيت لحم والخليل**" وذلك استكمالا لنيل درجة الماجستير في الصحة النفسية، ولتحقيق هذه الرسالة، تضع الباحثة / الطالبة بين أيديكم استبانة تتكون من ثلاثة أقسام لجمع المعلومات اللازمة للدراسة.

أرجو من حضرتكم التكرم بالإجابة على جميع أسئلة وأقسام الاستبانة والتي تعكس شعوركم وأفكاركم وسلوكياتكم، دون استثناء وبكل صراحة ومصداقية وأمانة، مع التأكيد أن جميع المعلومات ستعامل بسرية كاملة ولن تستخدم إلا لغرض البحث العلمي، وأن مشاركتكم في هذه الدراسة طوعية، كما أنكم تستطيعون الانسحاب متى شئتم.

شاكرين لكم حسن تعاونكم،

الباحثة / الطالبة امانذا مناصرة،

المشرفة علا حسين.

** تنويه **

المقياس التالي يتضمن إشارات إلى بعض المواضيع الحساسة، مثل إيذاء الذات، قتل الذات، استخدام المواد (المخدرة والكحولية)، العلاقات المسيئة، اضطرابات الأكل، والسلوك الإجرامي. إذا شعرت أثناء مشاركتك في هذا الاستبيان بضيق أو انزعاج، توقف وتواصل مع أحد المقربين أو مقدم رعاية صحية أو نفسية مثل طبيب، ممرض، أخصائي نفسي، أخصائي اجتماعي، أو طبيب نفسي.

إن كنت تمر حاليا في أزمة أو وضع ضاغط، يفضل ألا تستمر في المشاركة في هذا الاستبيان، واعلم أن هناك موارد متوفرة لتقديم الرعاية الصحية النفسية في منطقتك مثل المؤسسات التالية:

وحدة الصحة النفسية مديرية صحة بيت لحم	مركز للصحة النفسية	بيت لحم، شارع الجبل	022741756
وحدة الصحة النفسية مديرية صحة جنوب الخليل	مركز صحة نفسية مجتمعية	دورا، وسط البلد	022281411
وحدة الصحة النفسية مديرية صحة الخليل	مركز صحة نفسية مجتمعية	الخليل، عين عرب	022293721
مستشفى الدكتور كمال للطب النفسي (مستشفى بيت لحم)	مستشفى للطب النفسي	بيت لحم، شارع الجبل	022741155
مركز أجنحة الأمل للصدمات النفسية	مركز تدريب وإرشاد نفسي	بيت لحم، شارع القطعة	022767413
مركز الإرشاد والتدريب للطفل والأسرة	مركز تدريب وإرشاد نفسي	بيت لحم، شارع المهد	022770489
جمعية الهلال الأحمر الفلسطيني	مركز للصحة العامة	الخليل، شارع واد التفاح	022220101
الرقم الوطني المركزي للحالات الطبية الطارئة 101			

إذا كنت تود المشاركة في هذا الاستبيان، انتقل إلى الصفحة التالية

القسم الأول: البيانات الأولية

الرجاء الإجابة عن الأسئلة التالية من خلال وضع إشارة (X) في الخانة المناسبة لك:

العمر ( ) 18–21 عام ( ) 22–25 عام ( ) 26–29 عام

الجنس ( ) أنثى ( ) ذكر

المستوى التعليمي ( ) إعدادي فما دون ( ) ثانوي ( ) دبلوم ( ) بكالوريوس ( ) دراسات عليا

الحالة الوظيفية ( ) أعمل ( ) لا أعمل

الحالة الاجتماعية ( ) أعزب / عزباء ( ) متزوج / متزوجة ( ) مطلق / مطلقة ( ) انفصال ( ) أرمل / أرملة

مكان السكن ( ) مدينة ( ) بلدة ( ) قرية ( ) مخيم ( ) غير ذلك

منطقة السكن ( ) بيت لحم ( ) الخليل

الحالة الاجتماعية للوالدين ( ) متزوجين ( ) طلاق / انفصال ( ) غير ذلك: _____

هل تعرضت في فترة 3 أشهر الماضية إلى عنف أو تجربة صادمة؟ ( ) نعم ( ) لا

تجربة صادمة: أزمة أو حدث مهدد للحياة أو الاستقرار النفسي أو الصحة الجسدية

إذا كانت الإجابة نعم، وضح/ي ذلك _____

هل لديك ( ) مشكلات نفسية؟ ( ) مشكلات جسدية؟ ( ) لا يوجد

إذا كان يوجد لديك مشكلات نفسية أو جسدية، وضح/ي ذلك _____

الديانة ( ) مسلم/ة ( ) مسيحي/ة ( ) غير ذلك

حدد/ي على المتدرج التالي درجة التدين لديك حيث تعني (1) مستوى ضعيف جدا من التدين وتعني (10) مستوى قوي جدا من التدين:

ضعيف جدا (1) (2) (3) (4) (5) (6) (7) (8) (9) قوي جدا (10)

القسم الثاني: لائحة السلوك المدمر للذات

التعليمات: لكل من الجمل الواردة في الجدول، الرجاء تحديد مدى وصف الجملة لك خلال السنة الماضية من خلال وضع رقم في الخانة المقابلة للجملة، وذلك وفقا للمتدرج التالي: (0) لا تصفني الجملة على الإطلاق، (1) لا تصفني الجملة، (2) تصفني الجملة إلى حدٍ ما، (3) تصفني الجملة، (4) تصفني الجملة بشكل كبير جداً.

	العبارة	الإجابة
.1	أقوم بقطع الوعود دون وجود الإمكانية أو النية لتحقيقها	
.2	أنسى المواعيد والإلتزامات الهامة	
.3	أقوم بإضاعة أغراضي الشخصية	
.4	لا أمارس التمارين الرياضية	
.5	أواجه صعوبة في المحافظة على نظام غذائي صحي ومتوازن	
.6	أشعر بحرقة أو ألم في العيون نتيجة للاستخدام المطول للهاتف المحمول أو الحاسوب	
.7	لا أكترث بما سيحصل لي في المستقبل	
.8	أتناول ثلاثة (أو أكثر) فناجين من القهوة أو الشاي أو مشروبات الطاقة بشكل يومي	
.9	أقدم على فعل سلوكيات مع علمي بأن لها نتائج وعواقب سلبية	
.10	أشعر بأنني غير قادر على رعاية نفسي	
.11	أميل نحو قضاء وقت الفراغ في اللهو وتأجيل واجباتي المختلفة	
.12	يقيمني الآخرون كشخص فوضوي وغير منظم	
.13	أواجه صعوبة في الالتزام بميزانية (خطة مالية)	
.14	أواجه صعوبة في التعلم من أخطائي وعدم تكرارها	
.15	أواجه صعوبة في الخلود إلى النوم والاستيقاظ منه في الوقت المناسب	
.16	أشعر بالرغبة بالانسحاب من النقاشات أو الجدالات الصعبة	
.17	أعبر عن آرائي في الوقت أو المكان غير المناسب بما قد يكون له عواقب سلبية	
.18	أميل إلى تجنب المناسبات والمسؤوليات الإجتماعية والأسرية	
.19	أشعر بصعوبة في الإبقاء على التواصل مع المقربين	
.20	أمزع أو أسحب الشعر من الرأس، الرموش، الحواجب، أو مناطق أخرى في جسدي	
.21	أشعر بأهمية الانتقام من الأشخاص الذين ألحقوا بي الأذى	
.22	أُفضل المهن والوظائف التي يترتب عليها درجة ما من الخطر	
.23	أشعر بالانجذاب للمقامرة، المراهنة، وأمثلتها من الألعاب والنشاطات المكسبة للمال	
.24	أقوم بعض ذاتي (مثل عض الشفاه أو الأظافر)	
.25	لا ارتدِ حزام الأمان إلا اذا كان ذلك مطلوب قانونيا	
.26	أشعر بالإثارة عند قيامي بسلوكيات قد تعتبر خطيرة	
.27	استهلك ما يزيد عن عشرين سيجارة في غضون يوم واحد	
.28	استخدم الأدوية بشكل زائد عما نصحني به الطبيب	
.29	أقوم بضرب نفسي باستخدام الجدران والأغراض عن عمد	

.30	أتجنب الذهاب إلى الطبيب عند المرض إلا اذا تطلب ذلك الشعور بالألم الشديد الذي لا احتمله	
.31	أنخرط في علاقات عاطفية قد تؤدي إلى عواقب سلبية	
.32	أحك جلدي بشكلٍ شديد بما يترك علامات وندوب عليه	
.33	استخدم المواد المخدرة (مثل الحشيش، الماريجوانا، المشروبات كحولية، حبوب الاكستازيا "العجال")	
.34	تعرضت لحالة من التسمم أو فقدان الوعي نتيجة تناول كميات كبيرة من المشروبات الكحولية أو المواد المخدرة	
.35	أذهب إلى العمل أو الدراسة أو حدث اجتماعي عام تحت تأثير الكحول أو مادة مخدرة ما	
.36	أحب سياقة سيارتي بسرعة كبيرة أو الركوب مع أشخاص يسوقون بسرعة كبيرة	
.37	أنخرط في أحداث الشجار باستخدام العنف اللفظي مع الآخرين (السب، التهديد، التحقير، الإهانة، الصراخ، ومثلها)	
.38	أنخرط في أحداث الشجار باستخدام العنف الجسدي مع الآخرين (الدفع، الضرب بالأيدي أو الأشياء، الطعن، الجرح بأغراض حادة)	
.39	أقدم على سلوك يعاقب عليه القانون بوعي وقصد	
.40	أقمت علاقات جنسية متعددة في نفس الوقت	
.41	أفكر بإنهاء حياتي	
.42	أنخرط في تجارب جنسية مع الغرباء دون استخدام إجراءات الوقاية اللازمة	
.43	استخدم مواد مخدرة ذات درجة عالية من الإدمان والخطورة (النايس، الكريستال، الكوكايين، الهيروين، الLSD، الفطر السحري)	
.44	أقدمت على إلحاق الأذى الجسدي بذاتي دون رغبة في الموت (جرح الجلد، الخنق، القفز عن مرتفعات، ومثلها)	
.45	أقوم بتدمير أو تخريب ممتلكات الآخرين	
.46	تصرفت بقصد ووعي بما أدى إلى إدخالي إلى المستشفى	
.47	استخدم أشكال مختلفة من المواد المخدرة أو المشروبات الكحولية في نفس الوقت أو اليوم	
.48	أقوم بسياقة سيارة بعد استخدام الكحول أو المواد المخدرة	
.49	حاولت إنهاء حياتي	

القسم الثالث: مقياس أسلوب التعلق لدى البالغين

التعليمات – لكل من العبارات الواردة في الجدول، الرجاء تحديد مدى وصف الجملة لك بشكل عام من خلال وضع رقم في الخانة المقابلة للجملة، وفقا للمتدرج التالي: (0) لا تصفني الجملة على الإطلاق، (1) لا تصفني الجملة، (2) تصفني الجملة إلى حدٍ ما، (3) تصفني الجملة، (4) تصفني الجملة بشكل كبير جداً.

#	العبارة	الإجابة
.1	أشعر بالارتياح في العلاقات العاطفية	
.2	أتجنب العلاقات العميقة	
.3	أنا أثق في الآخرين ويعجبني عندما يستطيع الآخرين الاعتماد علي	
.4	أشعر بعدم الراحة عندما تصبح العلاقات مع الآخرين قوية	
.5	أجد أنه من السهل الانخراط مع الآخرين في علاقات قريبة	
.6	أشعر بالراحة في العلاقات الحميمة	
.7	أعتقد أنه من المهم أن يستطيع الناس الاعتماد على بعضهم البعض	
.8	أثق بأن الآخرين سيكونون بجانبي عندما أحتاجهم	
.9	أود أن أنفتح على الآخرين، لكني أشعر بأنني لا أستطيع أن أثق بهم	
.10	أود أن يكون لدي علاقات قوية مع الآخرين، لكنني أجد أنه من الصعب أن أثق بهم تماما	
.11	اخشى أن آمالي ستتخدع عندما أصبح مقربا من الآخرين	
.12	أكون حذرا من الانخراط في علاقات عميقة لأنني أخاف التعرض للأذى	
.13	كثيرا ما أتساءل إن كان الآخرون يحبونني	
.14	لدي الانطباع بأنني عادة ما أحب الآخرين أكثر مما يحبونني	
.15	أخشى غالبًا أن الاخرين لا يحبوني	
.16	أخشى أن أترك وحيدا	
.17	لا اقلق حول كون الناس يحبونني أم لا	
.18	أجد أنه من المهم معرفة إذا كان الآخرين يحبونني	
.19	عادة ما أجد أن الآخرين أكثر إثارة للاهتمام من نفسي	
.20	أشعر بالراحة دون أن يكون لي علاقات قوية مع الآخرين	
.21	من المهم لدي أن أكون مستقلا	
.22	أفضل أن يكون الآخرون مستقلين عني، وأن أكون أنا مستقلا عن الآخرين	
.23	أحب أن أكون مكتفي ذاتيا (أن لا أحتاج لأحد)	
.24	لا اقلق ان أكون وحيدا، لأنه ليس لدي حاجة قوية للآخرين	

Appendix B: List of Experts Consulted for Instrument Validity

Table: List of Experts who contributed to Validation of Study Tools

	Field	**Place of Work**
Asst Prof Najah Al Khatib	Mental Health	Al-Quds University
Assoc Prof Suheir Al Sabbah	Education & Psychology	Al-Quds University
Prof Tayseer Abdallah	Psychology	Al-Quds University
Assoc Prof Iyad Al Hallaq	Clinical Psychology	Al-Quds University
Asst Prof Kifah Manasra	Criminology and Psychology	Al-Istiqlal University
Asst Prof Kamal Salameh	Psychological Counselling	Al-Istiqlal University
Asst Prof Amer Shehadeh	Psychology	Al-Istiqlal University
Assoc Prof Nabil Al Jundi	Education & Psychology	Hebron University
Asst Prof Ibrahim Al Masri	Psychological Counselling	Hebron University
Asst Prof Ferdous Al Ayasah	Mental Health	Bethlehem University