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Betrayal trauma, dissociative experiences and dysfunctional family dynamics: Flashbacks, self-harming behaviors and suicide attempts in post-traumatic stress disorder and dissociative disorders

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Abstract

Betrayal trauma consists of negative life experiences in which the victims are close to the traumatizing people as well as institutions for which they rely upon protection, support, resources and survival. In most cases, it operates as a dynamic of dysfunctional families which are described as pathologically-structured patterns of thoughts, emotions and behaviors, which function as violence-oriented negative child-rearing styles and generate childhood traumas. Trauma-related psychopathologies frequently discussed with these notions tend to be correlated to a high risk of self-harming behaviors and suicide attempts. It is, thus, of great importance to comprehend, explain and approach suicide attempts in trauma-related psychopathologies such as post-traumatic stress disorder and dissociative disorders by taking the dysfunctional familial dynamics and succeeding betrayal trauma both in clinical and forensic settings. Thus, in this review, betrayal trauma, dissociative experiences and dysfunctional family dynamics were discussed in terms of the dissociogenic reactions directed to them as well as flashbacks, suicide attempts and self-harming behaviors.

Keywords: Betrayal trauma, dissociation, dysfunctional families, flashbacks, self-harming behaviors, suicide attempts, childhood trauma, trauma-related psychopathologies, intergenerational transmission of trauma

Introduction

Betrayal trauma, first introduced by Jennifer Freyd, is described as a type of trauma consisting of negative life experiences in which the victims are close to the traumatizing people as well as institutions for which they rely upon protection, support, resources and/or even survival [1,2]. It is emphasized that the violation of the trust and/or psychological and physiological well-being of the victims by such close perpetrators is a fundamental precedent of dissociative experiences which are used for the purpose of sustaining the original relationship with the caregiver. It is, thus, proclaimed that an increased level of dissociative defense mechanisms would be required in order to process the trauma when individuals faced traumatization from those they are reliant or dependent [3]. It is postulated that all human beings originally possess an ability to recognize and differ such violations from everyday life experiences and that when escape is not an option in face of a traumatic experience (e.g. that by a primary caregiver) the aforementioned ability may be withheld in order to survive [4]. The breaking of the toxic relationship would otherwise mean the lack of vital resources, primary support, care and protection. Betrayal trauma can, in that manner, be told to describe the conceptualization of the dissociative amnestic experiences which function not only as the guarantors of survival but also the blockers of traumatic experiences that would prevent one's psychological integrity. The best-documented type of betrayal trauma is most probably child sexual abuse, while other types can be counted as institutional and romantic betrayal. Due to the fact that it refers to negative experiences perpetrated by those for whom one relies upon, the most common perpetrators of betrayal trauma tends to be one's own family, or rather more precisely, one's own dysfunctional family.

The negative or positive child-rearing styles of the dominant family structure in a certain time period determine both the prevalent social structure and the direction of the transformation. Such a

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social structure and transformation towards either development or regression can be told to be shaped in accordance with the leading practices of child-rearing styles. Parents with the same or related child-rearing styles tend to raise new generations as similarly traumatized and pathologized as not only themselves but also their own parents. This intergenerational transmission of trauma is well documented especially by numerous studies on the Holocaust. In her case history of a female patient who was suffering from parental traumas even though she was born after the Nazi genocide of the Jews, Wilgowicz conceptualizes the incarceration of children that have already been traumatized by wars and other combats in their very own parents' traumas as a "vampiric" form of identification [5]. Prager also focused on the fact that even generations that have not witnessed the traumatic turning point themselves are most likely to be subjects of the victimization due to this collective memory [6]. Öztürk, on the other hand, promotes the suggestion by underlining the fact that a traumatized individual has two life periods around the traumatic turning point: one period before the traumatic experience and the one afterwards. The traumatic turning point does not refer to the first trauma which the subject had experienced, remembers, or realizes in time, but rather the most upsetting experience that most likely to have happened in childhood. The traumatic turning point refers to the most upsetting traumatic experience which takes a major role in the development of trauma schemata. After the traumatic turning point, the individual is most likely to continue their life with a psychiatric diagnosis and as a case that possesses a "trauma self" characterized by dissociative reactions associated with this diagnosis. According to Öztürk, flashbacks appear suddenly and rapidly after this traumatic turning point. The frequency, severity and duration of traumatic experiences are directly related to these flashbacks. After the traumatic turning point, the negative life experiences of the individual in their actual life will continue to be repeated in their inner world, almost like a traumatic obsession. These repetitions, on the other hand, constitute the main reason for self-harming behaviors and suicide attempts, which are accompanied by feelings of shame and anger in the traumatic case [7,8]. Parents with the same negative child-rearing styles, thus, tend to raise a dysfunctional generation that is characterized by the aforementioned negative feelings and similar levels of traumatic and dissociative experiences [9]. It is of high importance to refer to child-rearing styles in families -with varying levels of functionality within a spectrum differing from normality to psychopathology- as a medium of this transmission in order to be able to operationally define this intergenerational traumatization. This review, thus, aims to evaluate the concepts of betrayal trauma, dissociative experiences and dysfunctional family dynamics as well as related flashbacks, self-harming behaviors and suicide attempts in trauma-related psychiatric disorders, namely post-traumatic stress disorder and dissociative disorders within a psychotraumatological frame.

Family dynamics, which can be seen almost identical to the notion of child-rearing styles, thus, gain vital significance in evaluating the characteristics of values, emotions, memories, behaviors and experiences that are intergenerationally transmitted. In order to comprehend these relationship dynamics varying from normal to psychopathological within families, Öztürk underlines three different family models: (i) "normal", (ii) "psychopathological" and (iii) "apparently normal" or in other terms, "dysfunctional" families [9,10]. A "normal" family model refers to the involvement of individuals without any psychiatric diagnoses; which is also the only possible model to raise psychologically integrated generations without psychopathologies. A "psychopathological" model consists of members that are diagnosed with at least one psychiatric disorder. An equally important model in-between is called the "apparently normal" or "dysfunctional" family which refers to children that are diagnosed with at least one psychiatric disorder and parents with usually only subclinical diagnoses. Dysfunctional family dynamics that are present in this last model can be defined as pathologically-structured patterns of thoughts, emotions and behaviors, which function as violence-oriented negative child-rearing styles and generate childhood traumas. These notions, i.e. childhood traumas as well as negative child-rearing styles within dysfunctional families which not only traumatize their own children but also fail to protect them from external traumatic and/or negative life experiences, are among the most significant means of "intergenerational transmission of trauma" and "intergenerational transmission of psychopathology". This intergenerational existence of traumatic experiences and psychopathological processes bring dissociative disorders and post-traumatic stress reactions into view [9].

Generating from chronical childhood traumas and dysfunctional family dynamics, dissociative disorders are characterized by suicide attempts, self-harming behaviors, dissociative amnesias, bursts of anger and ambiguities in identity or identity confusions; most commonly comorbid with post-traumatic stress disorder (PTSD), somatoform disorders and borderline personality disorder [11]. Research shows a wide range of the age of starting to self-harming behaviors in dissociative disorders, varying from 5 to 14 with focus on the ages between 10 and 15 as the most common period [9]. The etiology of deliberate self-harming behaviors is likely to be multilayered, alluding to factors such as moments of disappointment, physiological excitation, low tolerance, self-punishment and problematic interpersonal relationships [12,13]. Apart from these, psychological traumas, precisely chronic childhood traumas are likely to explain both self-harming behaviors and suicide attempts. Dissociative experiences play a mediating role in terms of the frequency, severity and duration of self-harm behaviors and suicidality or suicide attempts related to preceding childhood traumas [14,15]. Self-harming behaviors, which are closely related to dissociation, are done in order to control the negative effects of childhood traumas on emotion, thought and behavior [16]. Under these circumstances, it is literally of vital importance to scrutinize the effects of dysfunctional family dynamics and betrayal trauma on deliberate self-harming behaviors and suicide attempts especially in PTSD and dissociative disorders, two of the most common psychiatric diagnoses related to suicidal attempts.

Dysfunctional Families as a Dissociogenic Agent in Betrayal Trauma

Bowlby, in his Attachment theory of which the most fundamental tenet is that children in their early years need to form a relationship with at least one primary caregiver for a healthy development both socially and psychologically, was the first author to emphasize the fact that traumatizing experiences with one's primary caregiver impacts a child's attachment security, stress, coping strategies, and

the sense of self [17]. He mentions three types of internal working models, i.e. internal representations with which individuals can recognize which inner content is dominant. Bowlby defines "securely organized internal working models", "insecurely organized internal working models" and "disorganized internal working models" among which the latter two refer to possible early childhood traumas. The last one, however, alludes directly to unprocessed or unmetabolized negative life experiences of the caregiver themself, which then affect the subsequent attachment style with their own children. Hesse and Main [18] suggest that disorganized attachment occurs when the caregiver is ambivalently both a source of the child's fright and solution, referring to a double bind. Individuals with this disorganized form of attachment happen to experience altered states of consciousness as well as dissociation more frequently. Insecure and disorganized attachments also happen to form one of the main characteristics of apparently normal families, namely the dysfunctional families as defined by Öztürk and Şar [9,10].

Dysfunctional families are characterized by non-empathetic violence-oriented child-rearing styles, inconsistent communication styles, constant conflicts, frequent child abuse and/or neglect, and probable history of traumatic experiences of at least one family member, resulting in dissociative defenses which is accompanied by a "pathological conformism", described as the adoption of psychopathological actions. These families manifest major impairments in the fulfillment of basic family functions and children that grown up in these families, with a psychopathological effort to adopt and/or a conformist attitude, perceive these dysfunctions in the family as a social norm [9]. There are certain common behavioral patterns that dysfunctional family models develop as a result of negative life experiences within an "internal social system" and that should be recognized in the psychotherapy process. These particular common behavioral patterns are instrumental in the emergence of dysfunctional family patterns by enabling inconsistent communication dynamics. Dysfunctional family dynamics are psychopathogenic dynamics that are learned from parents but can be unconsciously acted upon at certain rates. These psychopathogenic dynamics function as a means of controlling individuals and traumatize them. Some common characteristics of dysfunctional families are listed below [9]:

•Distortions, dissociative defenses as well as denial are prominent in dysfunctional families. Parents tend to reject the fact of abuse, or even legalize it by believing its normality and/or ordinariness.

•These families consist of inconsistent individuals and there are certain –mostly sub-threshold psychopathologies in family members.

•Parental favoritism is common. Besides, parents lack the necessary mutuality, or they may even manifest pseudomutuality. Some members of the family are approached by over empathetic attitudes while the others face the lack of empathy.

•Adjustment of personal spaces or interpersonal distances is often problematic.

•Manipulation, envy, jealousy and rudeness are present in both internal and external relationship dynamics of the family members.

•Bursts of anger, self-harming behaviors, inconsistent interpersonal relationships and suicide attempts as well as addictive behaviors are frequent.

•Family members frequently sabotage not only themselves but also others.

•"Intergenerational transmission of trauma" and "intergenerational transmission of psychopathology" is ubiquitous.

•Lack of privacy between the members is common.

•Children tend to experience processes of insecure attachment.

•A social isolation is mostly present.

•The members are controlled by traumatization, which continues in an intergenerational dimension.

•Womanhood and childhood are internalized as negative notions.

•Negative and psychopathological child-rearing styles are adopted.

•A criminogenic structure is observed.

•Continuity of a dysfunctional generation is provided.

Traumatic experiences and the negative child-rearing styles of dysfunctional families can cause adverse and permanent psychological effects on the whole life of people from childhood to old age. In a process characterized by normal and optimal functional dynamics, the family is the most important and most valuable agent of the society in which the strategies of knowledge, kindness, merit, loyalty and overcoming the maladaptive effects of negative life events are transmitted or taught to children from parents. Intergenerational experiences and psychosocial dynamics transmitted by parents can be both positive and negative. Children's ability to effectively use their coping styles in the face of negative life events in and outside the family, to provide empathic reciprocity, to construct trust-oriented communication styles, and to maintain the optimal stimulus level against excessive stimuli or lack of stimulus are positive dynamics. Negative dynamics are that violence-oriented negative child-rearing styles continue to exist between generations without much change, the asymmetrical internal system: polarization of the family structure, attachment to the abuser, identification with the abuser, experiencing dissociative chaos in close relationship patterns, and generally choosing children as victims in the family with a dysfunctional orientation [9,19]. Intergenerational transmission of trauma and intergenerational transmission of psychopathology, which are characterized by these negative dynamics, make it possible to experience many psychiatric diagnoses over generations, especially dissociative disorders and post-traumatic stress disorder, which show the closest relationship with chronic negative life events [7].

Although they were initially suggested to explain the etiology of schizophrenia decades ago, such characteristics which are now associated with apparently normal families still play a crucial role in the comprehension of childhood traumas. Apart from insecure and disorganized attachment among those characteristics, pseudomutuality refers to the apparently happy members who in fact restrain themselves excessively, which in turn generates a

mild psychological disturbance in at least one of the members due to the lack of a field of freedom in which individuals can be and manifest themselves. Another typical characteristic, double-bind, as mentioned before refers to multiple messages from parents which are reciprocally conflicting and visible in interpersonal relationships and communication [20]. Parental favoritism refers to an in-group schism or segregation and would most likely to end in a split in the psyche of the offspring. All these characteristics above can be told to be violating a child's feeling of safety, intimacy and trust, i.e. the betrayal trauma. Betrayal trauma, thus, functions as a dysfunctional family dynamic in most cases.

As mentioned before, dysfunctional and pathological family models serve the intergenerational transmission of psychopathology and trauma in a society. Dysfunctional families are characterized by the intergenerational transmission of contradictory and psychopathogenic dynamics that they learn from their parents and unwittingly apply to their own children. Dysfunctional families use violence-oriented and unempathetic negative child-rearing styles as a method of punishment for their own children, and in fact, the traumatized or even victimized individual is stigmatized as "sick" and easily controlled by both their own family and those outside the family. In the formation of psychopathology, dysfunctional family structure and dynamics come into play as the most destructive internal systems. The basic reality here is that both psychopathology disrupts the family structure and the family is in an existentially dysfunctional structure. The traumatic experiences of both the parents and children of individuals who adopt the same child-rearing styles are close to each other and in the same psychopathological pattern, and their revictimization experiences on the intergenerational axis also happen to show similarities in the same direction [9].

Negative life events that are repeated through the traumatizing and negative child-rearing styles of parents, and psychopathologies characterized by these negative life events show intergenerational transmission on a dissociative basis. The traumatic experiences of parents or caregivers are transmitted to their own children through the negative child-rearing styles they adopt. While some of the parents are active agents in dysfunctional communication dynamics characterized by violence-focused, trust-insecurity conflicts, and negative child-rearing styles far from empathy, some of the parents remain as recessive agents in the position of an inactive spectator, thus ensuring the continuity of abuse and neglect as well as ensuring the continuity of abuse and neglect within the family. It hides traumatic experiences and even makes it impossible for individuals outside the family to be noticed. Parents' adoption of their traumatic experiences in their own history to their own children through negative child-rearing styles may cause this maladaptive process of intergenerational transmission of trauma to be experienced by being preserved at certain or even major rates for generations [19,21].

Basic Etiological Factors of Psychopathology: Dysfunctional Family Dynamics and Betrayal Trauma

As a result of the increase in the number of studies conducted within the scope of childhood traumas, these negative life experiences and dysfunctional family dynamics have begun to be evaluated in a common context. The ambivalent and insecure relationship patterns that emerge between the parents, the inconsistent and double or mixed messages given to the children, and the poor communication skills constitute the basic elements of dysfunctional families. Child abuse and neglect, among the most visible forms of familial dysfunctionality, happen to be correlated with numerous psychopathologies including alcohol and/or substance abuse [22], as well as negative effects on the brain and the hypothalamic-pituitary-adrenal (HPA) system; resulting in psychiatric vulnerability in adulthood [23]. Dysfunctional attitudes and behaviors that arise in the family and are directed to children to a large extent can cause –mainly in guise of childhood traumas- the development of many psychopathologies, especially dissociative disorders, post-traumatic stress disorder, depression disorders and anxiety disorders [9,24,25].

Betrayal trauma is documented as a significant contributor to symptoms in many trauma-related psychiatric disorders including PTSD, personality disorders, dissociative disorders as well as schizophrenia spectrum and other psychotic disorders. Thus, when it comes to trauma-related psychopathologies, the presence of dysfunctional family dynamics should also be considered as the betrayal trauma functions as one. A traumatized individual may experience a very limited or an absolute nonexistent amount of awareness of the traumatic event. Especially early, chronic and cumulative childhood traumas can be manifested psychosomatic and psychological symptoms such as somatization, flashbacks, disorientation and psychological symptoms such as somatization, flashbacks, disorientation and dissociation. As dissociative defenses cease the awareness of the traumatic experiences, major negative life events such as childhood sexual abuse may well create the dissociative reactions. Dissociative identity disorder, likewise, is significantly related with chronic and overwhelming traumas such as childhood sexual abuse and/or neglect and similar interpersonal injuries. Another case that is commonly associated with dysfunctional families is alcohol and/or substance abuse disorder. Current research found that childhood neglect and abuse increase the risk for substance abuse [15,22,26]. Some authors suggest that due to the fact that betrayal trauma happen to generate a loss of control, this loss incorporates into the guise of substance abuse while others claim that it is a form of coping mechanism with post-traumatic negative affect traits such as avoidance, self-medication or tension reduction [27]. Even though the preeminent, long-standing and prominent way of treatment of hallucinations that are present in psychotic disorders has been pharmacotherapy; current research postulates that the treatment of betrayal trauma may also be beneficial in reducing hallucinations when accompanied with a history of sexual abuse in childhood [28]. When it comes to personality disorders, the most studied trauma-related case in literature happens to be the borderline personality disorder. It is a well-documented fact that borderline personality disorder has roots in early abuse, neglect, insecure attachment and other forms of traumas which may occur as a result of the emotional, physical and/or sexual abuse by caregivers [29]. Strikingly, self-harming behaviors and suicide attempts in guises of suicidal ideation; dissociative (deep) memory and dysfunctional family dynamics happen to be what all these trauma-related psychopathologies have in common [7,9]. In order to comprehend, explain and work on suicidal tendencies or suicide attempts, it is of vital importance to scrutinize early childhood traumas and related dysfunctional family dynamics that can most likely to be manifested as betrayal trauma.

Flashbacks, Self-Harming Behaviors and Suicide Attempts with Regard to Dysfunctional Family Dynamics

Flashbacks can be defined as intense revisualizations of traumatic experiences mostly reported by patients with PTSD [30]. Some authors prefer to conceptualize them as completely distinct type of memory [31,32] while some others tend to refer to a fragmented and disorganized form of the autobiographical memory [33,34]. They were also found to be among the most common types of dissociation [35]. While some studies tend to be skeptical about the frequency of flashbacks as they tend to handle this notion referring to comorbid substance abuse and related hallucinogenic effects [36], others claim that many trauma survivors suffer from autobiographical memory disturbances (such as psychogenic or dissociative amnesia) and intrusions (namely flashbacks and nightmares) that would manifest powerful sensory characteristics [37,38]. Another study focusing on forensic interviews with children that have an abuse history suggests that such interviews were a medium through which dissociative post-traumatic reactions were activated and frequently manifested in sensory flashbacks [39]. Apart from their characteristics and neuropsychological roots, flashbacks have been scrutinized in terms of their relationship with suicide attempts and deliberate self-harming behaviors. In a study conducted with suicidal women with borderline personality disorder, it was found that suicide attempts were more likely to be preceded by flashbacks or nightmares [40]. Some authors even prefer the term "flash-forwards" to describe the imagery about a future suicide attempt, risk-taking and/or self-harming behaviors rather than visualization of a past traumatic event [41]. Mainly focusing on war trauma that can have intergenerational effects, literature draws a parallelism between post-traumatic stress reactions, flashbacks as well as nightmares, self-harming behaviors and related suicide attempts [42].

As mentioned before, dysfunctional and pathological family models serve the intergenerational transmission of psychopathology and trauma in a society. Dysfunctional families are characterized by the intergenerational transmission of contradictory and psychopathogenic dynamics that they learn from their parents and unwittingly apply to their own children. Dissociative disorders, which are frequently seen in adolescents and young adults, on the other hand, are among the psychiatric diagnoses in which self-harming behaviors and suicide attempts are seen most frequently. Self-harming behaviors are one of the public health problems that have significant adverse psychological effects on all age groups in the world and in our country. Self-harming behaviors, which are characterized by decreasing the quality of life of individuals and having negative effects on their physical and psychological stability, are among the focus topics of clinical psychology and psychiatry disciplines [7,9,43].

Self-harming behavior is defined as the whole of behaviors that are mostly performed voluntarily, resulting in injury to at least one part of the body, and directly disrupting the integrity of it [44]. Current research stresses the fact that 87% of dissociative disorder cases manifest self-harming behaviors, while 78% of them report suicide attempts and 1 to 2% of the cases result in death by suicide [24]. Studies on self-harming behaviors emphasize that childhood traumas are major etiological factors of negative behaviors in psychiatric disorders associated with these traumatic experiences [45,46]. Self-harming behaviors, which are closely related to dissociation, are adopted to control the adverse psychological effects of childhood traumas on emotion, thought and behavior [16]. Connors described three basic functions of trauma-related self-harming behaviors: (i) re-enacting real or symbolic representations of the original trauma with self-harming behaviors, (ii) trying to express feelings and emotional problems that are difficult to share by self-harming, such as post-traumatic anger, regret and shame (iii) restoring the physiological and emotional balance, that is, homeostasis, by rearranging the self through self-harming behaviors [47]. Various mental health experts in the field of dissociative disorders underline the fact that childhood traumas are closely related to self-harming behaviors [7, 48-51]. Franzke, Wabnitz, and Catani state that solely dissociation plays a mediating role between childhood traumas and self-harming behaviors [45]. Brand, Loewenstein, and Lanius state that as a result of negative life events experienced by individuals, especially childhood traumas and that cannot be coped, self-harming behaviors occur on a wide scale ranging from careless driving to physiological self-neglect [52]. Brand et al. emphasize that 64-78% of dissociative identity disorder cases harm themselves, 61-72% have suicidal ideation, and 1-2% suicidal attempts result in death by suicide [53].

Conclusion

First introduced by Freyd, betrayal trauma is described as a type of trauma consisting of negative experiences in which the victims are close to the traumatizing people as well as institutions for which they rely upon protection, support, vital resources and/or even survival. Three distinct types were defined as: (i) child sexual abuse which shows a direct correlation with dysfunctional family dynamics, (ii) institutional betrayal trauma that can be observed in academic, military, legal and healthcare organizations in guises of mobbing, harassment, discrimination, sexual assault and brutality, and (iii) romantic betrayal trauma which refers to a wide spectrum of interpersonal relations varying from infidelity to domestic violence. In most cases, severe traumatic reactions are products of prolonged childhood traumas in the early years of life, stressing the fact that betrayal trauma happens to function as a dysfunctional family dynamic. The dysfunctionality of the family in terms of support, care, nutrition and protection of the child manifests itself as a traumatized child most likely to suffer from trauma-related psychopathologies as an adult. Dissociation was found to be a severe symptom of betrayal trauma; recent studies even underline that hallucinations are linked to extreme cases of this type of generalized trauma [28].

A grand majority of dissociative disorder cases states that they tried to harm themselves because they could not cope with their traumas in their first interview, their desire to live decreased almost to nothing and they were suicidal. In these cases, suicide attempts ranges from moderate to severe death wish, and a case without suicidal ideation is extremely rare to observe [7,24,54]. Öztürk refers to self-harming behaviors and suicide attempts as "individuals' last-ditch cry for help not only against themselves, but also their abusers due to the fact that they were unable to take traumas into consideration as a solid possibility and thus they were left in the lurch [55]. The elimination of self-harming behaviors and suicide attempts in cases of dissociative disorder is successfully achieved by the application of trauma-centered and

structured psychotherapies including crisis intervention treatment for this diagnosis group. It is a striking point that insecure attachment, childhood separation, emotional neglect, sexual abuse, and dissociation, all of which refer to betrayal trauma and related dysfunctional family dynamics, were found to be significant predictors of deliberate self-harming behaviors [56]. Öztürk, also suggests that traumatized individuals have a certain traumatic turning point and thus two periods of their lives, namely the one prior to the specific traumatic experience and the one afterwards. The traumatic turning point refers to the most upsetting traumatic experience which takes a major role in the development of trauma schemata. From the traumatic turning point on, individuals are most likely to continue their lives with a psychiatric diagnosis and a "trauma self" characterized by dissociative reactions associated with the diagnosis. According to Öztürk, flashbacks appear suddenly and rapidly after this traumatic turning point and the frequency, severity and duration of traumatic experiences are directly related to them. After this aforementioned turning point, the negative life experiences of individuals in their actual lives will continue to be repeated in their inner worlds, resembling to a so-called traumatic obsession. These repetitions can be told to constitute the basic triggers behind self-harming behaviors and suicide attempts accompanied by feelings of shame and anger in the traumatic individual [7,8].

In this respect, in all trauma-related psychiatric diagnosis groups, cases that continue psychotherapy should be supervised in recurrent crisis periods, crisis intervention psychotherapy approaches like Trauma Based Alliance Model Therapy developed by Öztürk should be used, and these cases should be admitted to a closed psychiatry service when necessary. Working effectively in the psychotherapy process with chronic dissociative disorder cases characterized by repetitive suicide attempts and self-harming behaviors require fundamental knowledge -focused on psychotraumatology and suicidology- specific to this field, cumulative professional experience and a novel perspective and scientific approach. Working with self-harming behaviors and suicide attempts of trauma cases is, in fact, a crisis intervention psychotherapy [7,55].

Being able to terminate self-harming behaviors and suicide attempts, which are the basic psychopathological and dissociative characteristics of all trauma-related psychiatric diagnosis groups, requires the development of short-term and trauma-centered psychotherapy methods, which will be structured within the framework of the paradigms of modern psychotraumatology. Since childhood traumas constitute an important factor in the etiology of self-harming behaviors and suicide attempts the prevention of them should be undoubtedly prioritized [57-60]. To conclude, we found the three quotes below from patients with dissociative disorder encountered by Öztürk during their psychotherapeutic processes very striking in terms of referring to their dysfunctional families, betrayal trauma and ideation of annihilation (self-annihilation) which would likely to be manifested as risk-taking, self-harming or suicidal behaviors:

“I can no longer live in this situation. I wish I just disappeared, I wish I became nothing, I wish I simply didn’t exist anymore.”

“They killed my emotions. Now I have so few emotions to give that I want to become numb, and I want them to feel that I became emotionless.”

“Not being able to feel even the numbness kills me inside every day. When my traumatic memories invade every moment like an obsession, I can only realize that I still exist by cutting my body. The pain of injuring my own body drives my planned suicide attempts away from me. The shame that my family inflicted and the anger I felt towards them distance me from all people and from myself. The only thing that consoles me is my own wounds, which are still bleeding, which I can endure as if I'm experiencing someone else's pain. The never-healing wounds that both others and the past inflicted and that surround my mind at every moment... I am now a different person watching the evil done to myself from afar and watching every scene of my sacrifice a thousand times in my mind.”

Conflict of interests
The authors declare that they have no competing interests.

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