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RESEARCH PAPER

Quality of Life and Somatoform Symptoms among Afghan Adults: Mediating role of Self-Compassion

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ABSTRACT

Research aimed to examine relationship among self-compassion, quality of life, and somatoform symptoms in individuals from Afghanistan and to find mediating role of self-compassion between quality of life and somatoform symptoms. Afghanistan has been facing political instability and violence, resulting in profound psychological distress among its population. Somatoform symptoms are prevalent among conflict-affected populations and severely effect ones' quality of life. 300 adults recruited from three universities. Self-Compassion Scale-Short Form (SCS-SF), the World Health Organization Quality of Life Scale-BREF (WHOQOL-BREF), and the Patient Health Questionnaire-15 (PHQ-15) were used for data collection. Results indicated self-compassion and quality of life had significant positive relationship. Furthermore, both self-compassion and quality of life were negatively associated with somatoform symptoms. Results showed relationship between quality of life and somatoform symptoms is partially mediated by self-compassion. The study offers practical implications for promoting well-being in individuals, particularly in contexts with unique socio-cultural challenges.

KEYWORDS Afghan Adults, Quality of Life, Self-Compassion, Somatoform Symptoms

Introduction

Afghanistan has been facing political instability, and violence, resulting in profound psychological and emotional distress among its population (Ayazi et al., 2014). The cumulative effects of these adversities often manifest in somatoform symptoms, which are physical manifestations of psychological distress in the absence of any organic pathology (Hausteiner-Wiehle & Henningsen, 2014). Somatoform symptoms are prevalent among conflict-affected populations and severely effect ones' QoL (Steel et al., 2009). Considering the difficult living conditions and traumatic experiences experienced by Afghan adults, understanding the interplay between self-compassion, quality of life, and somatoform symptoms becomes crucial. Self-compassion has been recognized as a protective element against mental health difficulties, fostering resilience and psychological well-being (Yarnell et al., 2015).

Self-Compassion

Self-compassion refers to the act of replacing our inner critic with a compassionate and supportive inner voice. As described by Neff (2003a), a prominent researcher in this area, it encompasses three key components. Firstly, self-kindness entails treating oneself with gentleness and understanding, rather than being excessively critical and judgmental. Additionally, when we recognize our shared humanity, we can cultivate a sense of connection with others, understanding that suffering is an intrinsic

aspect of the human condition rather than something that sets us apart and isolates us. Neff & McGeehee (2010) & Wei et al. (2011) suggests that individuals with lower levels of self-compassion often have critical mothers and encounter more family conflicts due to insecure attachment style. Conversely, individuals with higher self-compassion tend to have nurturing mothers, experience less family conflict, and have secure attachment style.

1.1.1 Somatoform Symptoms

Somatoform symptoms refer to physical symptoms that are experienced by individuals but do not have a clear medical or physiological explanation. American Psychiatric Association [APA] (2013) defined this disorder as symptoms that can manifest as pain, sensory disturbances, gastrointestinal issues, or other bodily complaints, without an identifiable organic cause. It is defined as presence of somatic symptoms without an adequate medical explanation by Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Quality of Life

It is a multidimensional concept considers both personal perceptions and objective indicators to evaluate the degree of fulfillment and happiness (WHOQOL Group, 1995). Quality of life entails assessing an individual's overall well-being and contentment in diverse areas. These areas encompass physical and physiological aspects, environmental conditions, mental and emotional state, personal growth and education, relationships with others and society, as well as opportunities for enjoyment and self-expression (Ruzevicius, 2014).

Literature Review

Abundant research consistently confirms the strong link between self-compassion and quality of life. For instance, Pinto-Gouveia et al. (2013) found that self-compassion significantly predicted an improved quality of life. Likewise, Neff (2003b) observed that individuals with elevated levels of self-compassion tended to experience higher psychological well-being and greater overall life satisfaction. Studies focusing on specific populations have further supported these findings. Kim and Ko (2018) conducted research on older adults and discovered that therapies promoting self-compassion can lead to improved QoL. Hlabangana and Hearn (2019) conducted research that also demonstrated a positive correlation between self-compassion and various dimensions of quality of life, except for physical well-being. MacBeth and Gumley (2012) emphasized how self-compassion acts as a protective factor, potentially enhancing psychological well-being, which is closely linked to overall quality of life.

Quality of Life of Afghans

It is crucial to acknowledge that the situation in Afghanistan is intricate and has undergone substantial changes and difficulties in recent times. Access to healthcare services remains a significant challenge in Afghanistan, particularly in remote and conflict-affected areas. The country has made progress in improving healthcare infrastructure, but the availability and quality of services vary across regions (WHO, 2021). Afghanistan has made substantial progress in improving access to education, particularly for girls, since the fall of the Taliban regime (UNESCO, 2020).

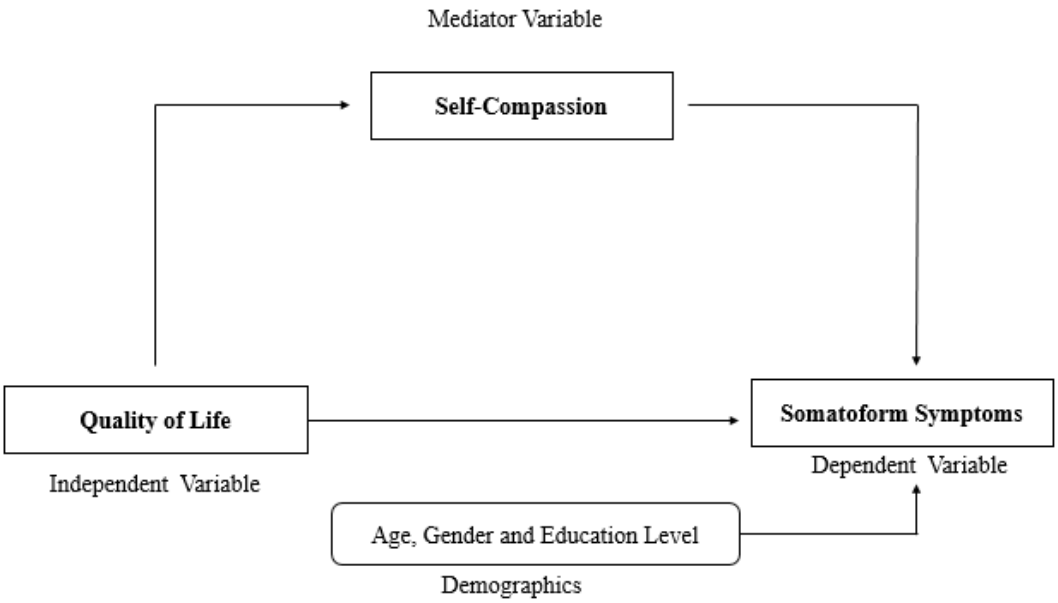

Figure 1. Conceptual Model of the Current Study

The suggested model ascertain how self-compassion mediates the relationship of quality of life and somatoform symptoms.

Hypotheses of the Study

1. Self-compassion has positive relationship with quality of life.
2. Both self-compassion and quality of life have negative relationship with somatoform symptoms.
3. Somatoform symptoms have positive relationship with age.
4. Self-compassion mediated the relationship of quality of life and somatoform symptoms.
5. Females have more somatoform symptoms than males.
6. Education level has negative association with somatoform symptoms.

Material and Methods

The current study employed cross sectional correlational research approach, which is a quantitative research design. It focuses on examining the relationship between variables and assessing the extent of their association.

Sample of the Study

Study sample comprised of 300 adults between age range18-45. Convenient sampling technique was used for selection of participants from three universities located in the war-affected province of Nangarhar, Afghanistan. The universities included in the sampling frame were Kabul University, University of Nangarhar, and Laghman University.

Table 1
Subjects Demographics Characteristics (N = 300)

Variable	Category	F	%
Age	18-45 years	300	100%
Gender	Male	245	81.66%
	Female	55	18.33%
Education Level	BS	295	98%
	M.Phil	5	2%

Note. Gender and educational level wise data of the selected sample.

Tools of Data Collection

Data were collect through structure questionnaire. In this study, three questionnaires were employed:

Self-Compassion Scale-Short Form (SCS-SF)

To assess the level of self-compassion SCS-SF was used. It is comprised of 12 items with 5 response options. Minimum score is 12 and maximum score is 60. The internal consistency of the scale used in the current study is .793, indicating satisfactory internal consistency. This finding aligns with Raes et al.'s (2010) original study, which reported a coefficient alpha of .86.

World Health Organization Quality of Life Scale-Brief (WHOQOL-BREF)

WHOQOL-BREF is a 26item measure with 5 response options. Three items (numbers 3, 4, and 26) are reverse-coded. Minimum score is 26 and maximum score is 130.In the current study, the alpha reliability coefficient for the WHOQOL-BREF scale was $\alpha = .881$. This finding aligns with the results reported by Almarabheh et al. (2021), who reported $\alpha = .91$ for the scale.

Patient Health Questionnaire-15 (PHQ-15)

To examine somatoform symptoms PHQ-15 was used. It has 15 items with 3 response options ranging from 0 to 2.Minimum score is 0 and maximum score is 30. In current study scale has $\alpha = .77$, indicating a satisfactory level of internal consistency. The alpha reliability coefficient for the scale was reported to be $\alpha = .771$ by Kroenke et al. (2002).

Ethical Considerations

Research thesis was initially approved by ASRB of Hazara University Mansehra. Permission to use scales in the study was taken from respective authors. Informed consent was obtained from the study sample. Participants were assured regarding anonymity and confidentiality about data collection. Participants were also given right to withdraw at any phase if they want to. Research was conducted in accordance with APA ethical standards.

Statistical Analyses and Interpretation

The statistical analyses in this study were conducted using SPSS-26 Version. Alpha reliability coefficients were calculated for each scale to measure internal consistency. Descriptive statistics were utilized to determine the mean psychometric

properties of all scales employed in the study. Correlational analyses were performed to examine the strength and direction of relationships between variables. T-test was employed to examine potential gender differences. Mediation analysis was conducted to explore the mediating role of self-compassion between quality of life and somatoform symptoms.

Results and Discussion

Table 2
Psychometric Properties of (SCS-SF), BREF (WHOQOL-BREF) & (PHQ-15; N = 300)

Variables	*M*	*SD*	Range	Cronbach's α
SCS-SF	36.80	8.41	20-60	.79
WHOQOL	76.58	11.64	67-130	.88
PHQ-SF	11.15	5.60	1-30	.77

Note. SCS-SF = Self-Compassion Scale-Short Form, WHOQOL-BREF = World Health Organization Quality of Life Scale-Brief, and PHQ-15 = Patient Health Questionnaire-15; *M* = Mean, *SD* = Standard Deviation.

The reliability coefficients (α) for the SCS-SF, WHOQOL-BREF, and PHQ-15 were found to be .80, .88 and .77, respectively, as reported in Table 2. These results indicated that all scales demonstrate high internal consistency and can be considered reliable measures for assessing the respective constructs.

Table 3
Correlations among (SCS-SF), (WHOQOL-BREF), (PHQ-15), Age & Education (N = 295)

Variables	N	M	SD	1	2	3	4	5
SCS-SF	12	36.78	8.42	-	.266**	-.400**	-	-
WHOQOL-BREF	26	76.58	11.64	-	-	-.406**	-	-
PHQ-15	15	11.15	5.60	-	-	-	-	-
Age	-	23.63	2.98	-	-	-	0.28	-
Education	-	53.21	6.10	-	-	-	-	.008

Note. SCS-SF = Self-Compassion Scale-Short Form, WHOQOL-BREF = World Health Organization Quality of Life Scale-Brief, and PHQ-15 = Patient Health Questionnaire-15; *N* = Number of Items; *M* = Mean, *SD* = Standard Deviation. $^{**}p < .01$, $p > .05$.

Table 3 reveals noteworthy associations: there are strong positive links between self-compassion and quality of life, while self-compassion is significantly inversely related to somatoform symptoms. Furthermore, quality of life demonstrates a significant negative correlation with somatoform symptoms. Notably, the data also indicates there is no significant relationship between age and somatoform symptoms as well as there is no significant relationship between education and somatoform symptoms.

Table 4
Mediation Results for Somatoform Symptoms with Self-Compassion (N = 295)

DV	M	Effect of IV on M	Effect of M on DV	Direct Effects	Indirect Effect	Total Effects
PHQ	SCS	.1255***	-.5374***	-.2602***	-.0674***	-.3276***

Note. QoL = Quality of Life; SC = Self-Compassion; SFS = Somatoform Symptoms; SE = Standard Error; CI = Confidence Interval. $^{***}p < .001$.

Table 4 reveals noteworthy discoveries concerning the mediating function of self-compassion in the relationship between quality of life and somatoform symptoms. The presence of a significant path coefficient highlights a meaningful association between

quality of life and somatoform symptoms. This coefficient signifies a statistical link between these two factors, indicating their tendency to co-vary.

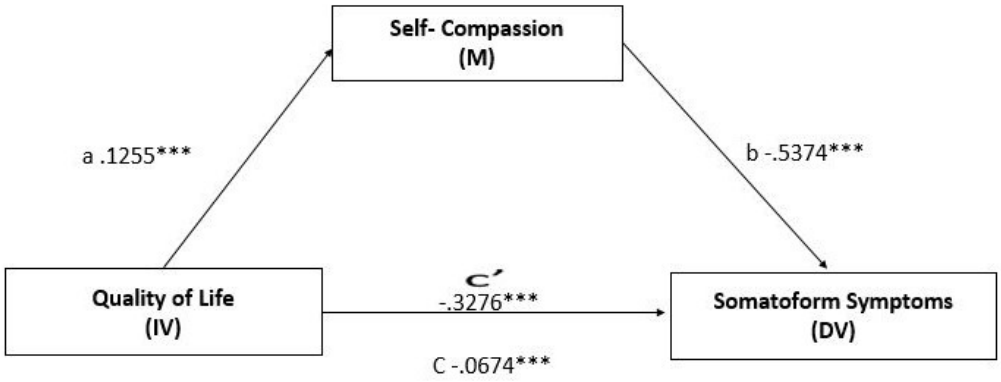

Figure 2. Mediation Analysis

The results of a simple mediation analysis, as illustrated in Figure 2, revealed that self-compassion partially mediates the relationship between quality of life and somatoform symptoms. The analysis demonstrated a significant positive association between quality of life and self-compassion (a = -.1255, *p* = .000), as well as a significant negative correlation between self-compassion and somatoform symptoms (b = -.5374, *p* = .000). The indirect effect, computed using 10,000 bootstrap samples and a 95% bias-corrected confidence interval, indicated that the indirect effect (ab = -.0674) was significantly different from zero (-.1089 to -.0327).

Moreover, even after accounting for the indirect effect of self-compassion on quality of life, there remained a significant direct effect on somatoform symptoms (C′ = -.3276, *p* = .000). These findings suggest that while self-compassion partially mediates the relationship between quality of life and somatoform symptoms, quality of life also exerts an independent direct influence on somatoform symptoms, irrespective of its mediating role through self-compassion.

Table 5
Mean Differences of Gender on (PHQ-15; N = 295)

	Males		Females				
Variable	**M**	**SD**	**M**	**SD**	**t(293)**	**P**	**Cohen's d**
PHQ-15	53.18	6.143	53.31	5.974	-.144	.886	0.02

Note. N = 295; n = 241 males, n = 54 females; PHQ-15 = Patient Health Questionnaire-15; *M* = Mean; *SD* = Standard Deviation. *p* > .05.

Table 5 indicated no significant gender differences in the scores of the Patient Health Questionnaire-15 (PHQ-15).

The primary goal of this research was to examine the relationship among self-compassion, quality of life, and somatoform symptoms in individuals from Afghanistan. Furthermore, the study aimed to examine the impact of socio-demographic factors like age, gender, and education on somatoform symptoms. The study encompassed 300 adult participants from three distinct universities. Study utilized three assessment scales: the SCS-SF, the WHOQOL-BREF, and the PHQ-15. To assess the reliability of the scales within the sample, the researcher calculated the alpha reliability coefficients. The SCS-SF, WHOQOL-BREF, and PHQ-15 demonstrated satisfactory levels of internal consistency, with alpha reliability coefficient values of .79, .88, and .77, respectively (as

shown in Table 2). Moreover, the significant item total correlations presented in Table 3, 4, and 5 indicate that these scales exhibit good construct validity.

The current study revealed significant positive correlation between self-compassion and quality of life. Furthermore, both self-compassion and quality of life exhibited significant negative relationship with somatoform symptoms, thereby confirming the first and second hypotheses of the study. These findings are aligned with prior research. For instance, Pinto-Gouveia et al. (2013) demonstrated that self-compassion substantially forecasted an enhancement in quality of life, while Neff (2003b) observed that individuals displaying higher levels of self-compassion tend to encounter improved psychological well-being and overall quality of life.

Houtveen et al. (2022) documented favorable transformations in individuals with somatoform disorders after undergoing self-compassion training. This implies that self-compassion could potentially exert a positive influence on somatoform symptoms, pointing to a negative relationship between the two. Other studies have also shown that somatoform disorder can significantly reduce quality of life, impair functioning, and increase healthcare utilization (Rief et al., 2010). Moreover, Rief et al. (2010) showed that somatoform symptoms are linked with diminished quality of life, heightened psychological distress, and lowered functioning.

The results displayed in table 3 of the present research also revealed there is a no connection between age and somatoform symptoms, which rejects the third hypothesis that somatoform symptoms tend to increase with age. The results of the current study are consistent with previous research, such as the study conducted by Hanel and Henningsen (2014), there is no association of age with somatoform symbols among individuals.

According to Waller et al. (2001), the connection between age and somatoform symptoms cannot be simply categorized as increasing with age because it is subject to variation and influenced by a multitude of factors, encompassing biological, psychological, and social elements. Significant life events, trauma, and stressors can act as triggers for somatoform symptoms at any stage of life. There is no association between age and somatoform symptoms among individuals it can happen any time and is not based on categorical fixation. Hiller (2003) conducted a study on the individuals with somatoform symptoms with different age groups and found, these symptoms often serve as a means for individuals to manage overwhelming emotions.

Furthermore, the presence of psychiatric disorders like somatic symptom disorder can result in the persistence of somatoform symptoms across different age groups. Such individuals may exhibit an enhanced sensitivity to physical sensations and interpret them as indicators of serious medical conditions, study concluded no association between somatoform symbols and age among different individuals. Bergander et al (2013) conducted research on younger and older chronic somatoform patients in psycho-diagnostics, physician-patient relationship, and treatment outcome after analyzing the correlational analysis of somatoform with age there was no significant relationship concluded resultantly. It's crucial to understand that somatoform disorders are intricate conditions influenced by a variety of factors, including psychological, genetic, and environmental elements. While age difference alone is improbable to be the primary cause of somatoform symptoms, it could conceivably contribute as one of several factors in particular circumstances. In such cases, it remains essential to comprehensively grasp and address the underlying psychological distress and the

dynamics within relationships as part of the holistic approach to understanding and managing these symptoms.

The findings presented also demonstrated that there is non-significant association of educational level with somatoform symptoms. These outcomes are not in the favor of the sixth hypothesis of the current study, which posited a negative correlation between education level and somatoform symptoms. These results align with prior research conducted by Cano-García et al. in 2020 and Zhou et al. in 2020, demonstrating that somatoform symptoms exhibit only limited invariance across various educational age groups. A study was conducted on students of different educational levels with somatoform symptoms and many other illnesses causes but as a result there was no association between somatoform symptoms and educational levels (Bach et al., 1994).

A study aimed to investigate how alexithymia relates to measures of psychopathology and illness severity in two distinct groups: patients with somatoform disorders and patients dealing with chronic medical illnesses, the sample was from different grades of education, there was no significant connection between the grades and somatoform symbols among individuals (Bach & Bach, 1996). The absence of a significant association between educational level and somatoform symptoms may be justified by recognizing the intricate and multifaceted nature of somatoform disorders. These conditions are influenced by a multitude of factors, and educational level may not be a primary determinant of their occurrence or severity in a given population.

The primary aim of the present research was to examine whether self-compassion functions as an intermediary in the connection between quality of life and somatoform symptoms in the context of individuals in Afghanistan. The outcomes derived from the mediation analysis showcased in Table 7 supported the fourth hypothesis of the study, indicating that self-compassion operates as an indirect channel through which quality of life impacts somatoform symptoms.

These results are consistent with prior investigations that consistently affirm the mediating role of self-compassion across diverse scenarios. For instance, Hilber et al. (2015) illustrated that self-compassion partially mediated the link between self-stigma and outcomes such as depression, somatic symptoms, and health status. Their study emphasized self-compassion's potential to ameliorate the influence of self-stigma on individuals' well-being. Similarly, Yu et al. (2018) established that self-compassion served as a mediator in the relationship between stress and psychosomatic symptoms. Collectively, these studies suggest that incorporating self-compassion practices into stress management interventions could yield advantageous effects on both psychological and physical well-being. The consistent findings across varied studies underscore the significance of self-compassion in bolstering individuals' overall health and functioning.

Furthermore, Dewsaran-Van et al. (2018) conducted multiple regression analyses and revealed that individuals with somatoform disorders and lower self-compassion levels experienced a higher incidence of symptoms and a diminished health-related quality of life. They highlighted the clinical relevance of self-compassion, proposing its potential to influence therapy outcomes and serve as a potential target for therapeutic interventions in individuals with somatoform disorders. These findings underscore self-compassion's importance in comprehending and addressing the interplay between quality of life, somatoform symptoms, and overall well-being. They suggest that interventions aimed at enhancing self-compassion may yield positive effects on symptom management and overall quality of life for individuals encountering somatoform symptoms.

The outcomes depicted in Table 5 revealed no significant gender disparities in the scores of the Patient Health Questionnaire-15 (PHQ-15). These findings do not support fifth hypothesis of the present study, which postulated that females would report a greater prevalence of somatoform symptoms compared to males. These results align with prior research, such as the study conducted by Hinz et al., (2022), observed that there is no difference between somatoform symptoms among males and females. It's important to note that gender differences, in themselves, are not typically considered a direct cause or conclusion for the development of somatoform symptoms. Somatoform symptoms are more closely associated with psychological factors, such as stress, anxiety, or emotional distress, rather than biological gender differences. Gender differences themselves are not a direct cause or conclusion for somatoform symptoms, they can interact with various sociocultural, psychological, and healthcare-related factors that may indirectly influence the development, expression, or management of these symptoms. It's important to consider the complex interplay of these factors when assessing and addressing somatoform disorders in individuals of different genders.

Conclusion

To conclude, this study aimed to find interconnections among self-compassion, quality of life, and somatoform symptoms in the Afghan population. The results indicated significant positive relationship between self-compassion and quality of life, understanding the link between higher self-compassion levels and improved overall well-being. Furthermore, both self-compassion and quality of life exhibited significant negative associations with somatoform symptoms, implying that individuals with high self-compassion and enhanced quality of life tend to experience fewer bodily concerns. The research also identified that there is no significant association of age with somatoform symbols among individuals. No education levels were found to be associated with somatoform symptoms, there was no difference between exhibiting different levels of symptomatology. No gender differences were observed. Furthermore, mediation analysis unveiled that self-compassion played a partial mediating role in the connection between quality of life and somatoform symptoms. This highlights self-compassion's crucial role in individual well-being and symptom manifestation. These findings suggest that interventions focused on nurturing self-compassion could yield positive outcomes by mitigating somatic complaints and enriching overall quality of life.

Recommendations

1) The study enriches the existing body of knowledge concerning self-compassion, QoL, and somatoform symptoms, offering valuable insights within the unique Afghan context. Grasping the interplay between somatoform symptoms and QoL among Afghan adults can illuminate the psychological distress faced by those with these symptoms and factors that might mitigate their effects.
2) Mental health challenges, including somatoform symptoms, frequently bear stigma and are misconceived in various societies, including Afghanistan. Therefore, awareness can be heightened regarding the tangible and substantial consequences of somatoform symptoms on individuals' QoL. This effort can help reduce stigma and foster more empathetic strategies for mental health support.
3) Analyzing the role of self-compassion as a potential mediator in the connection between QoL and somatoform symptoms can hold practical implications for interventions and therapy. Identifying self-compassion as a potential safeguarding element can guide the formulation of therapeutic approaches that foster self-compassion as a method for elevating QoL and reducing somatoform symptoms among Afghan adults.

4) Consequently, exploring the interrelation between QoL, somatoform symptoms, and self-compassion in the context of Afghan adults is pivotal for comprehending the mental health ramifications, cultural gap, and treatment insights related to somatoform symptoms. It can contribute to diminishing stigma, enhancing mental health care, and presenting specific valuable insights tailored to the Afghan population.

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