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# Childhood Trauma and Dissociative Experiences: Moderating Role of Perceived Social Support among Adults

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## ABSTRACT

**Purpose:** Childhood trauma or adverse childhood experiences including physical, emotional, and sexual abuse, neglect, and witnessing violence, often evokes fear and disrupts a child's sense of safety. These experiences can have long-lasting effects on behavior and lifestyle, leading to mental health challenges such as dissociation. As a coping mechanism, dissociation helps individuals detach from overwhelming emotions but can impair daily functioning and quality of life. Despite extensive research on childhood trauma and dissociation, there is limited understanding of how perceived social support may aggravate these effects. Therefore, the present research aims to fill this gap by investigating whether perceived social support moderate the relationship between childhood trauma and dissociative experiences among adults.

**Material and Methods:** The study hypothesized that higher levels of perceived social support will weaken the relationship between childhood trauma and dissociative experiences and vice versa. Using cross-sectional study design and convenience sampling, the data for the study was collected from adults of twin cities using self-report measures. The participants (N=262) were asked to fill Childhood Trauma Questionnaire-Short Form (Bernstein et al., 2003), Dissociative Experiences Scale-II (Carlson & Putnam, 1993) and Multidimensional Scale of Perceived Social Support (Zimet et al., 1988).

**Findings:** The data analysis revealed satisfactory reliability for all scales and subscales used in the study. It showed a positive correlation between childhood trauma and dissociative experiences, indicating that trauma exposure leads to dissociation. Multiple regression analysis identified emotional abuse and physical neglect as key predictors of dissociative experiences. Males from nuclear families reported higher neglect and abuse. Social support, especially from friends and significant others, was found to reduce the impact of trauma on dissociation, while family support had no effect. These findings emphasize the protective role of social support and will inform therapeutic interventions to address the long-term effects of childhood trauma and reduce dissociative symptoms, enhancing mental health and quality of life.

**Implications to Theory, Practice and Policy:** The study contributes to theory by highlighting the moderating role of social support and emotional regulation in the relationship between childhood trauma and dissociation. It informs practice by suggesting targeted therapeutic interventions that enhance social support and emotional regulation to reduce dissociative symptoms. Additionally, the study has policy implications, emphasizing the integration of emotional regulation and support systems into mental health strategies to address the long-term effects of childhood trauma.

**Keywords:** *Abuse; Childhood Trauma; Dissociative Experiences; Neglect; Social Support*

**JEL Classification:** *I12, I14, I31, J12, J13*

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## INTRODUCTION

Childhood trauma is an early life event that can cause long lasting negative effects on an individual`s` life. These early life events affect individuals worldwide, making a person more conscious in their later life and thus leads to emotional, behavioral and psychological issues (Bellis & Zisk, 2014). The early years of development serve as a critical period for the development of stress response system, and exposure to trauma during this phase can lead to increased perceptions of stress (Loman & Gunnar, 2010). Ultimately, to cope up with the stress level, some individuals develop dissociative tendencies to distance themselves from overwhelming experiences which persist in adulthood. Dissociative experiences are a psychological phenomenon where individuals experience a disconnection from their thoughts, feelings, and sense of identity (Boyer et al., 2022). Dissociative experiences not only serve as a psychological defense mechanism but also underscore the enduring nature of trauma's impact on cognitive and emotional functioning. In the complex landscape of trauma outcomes, perceived social support emerges as potential moderator, influencing the relationship between childhood trauma and dissociative experiences. However, there is scarcity of literature regarding its moderating role in relationship between childhood trauma and dissociative experiences. Therefore, the present research aims to understand the complex interaction between childhood trauma and dissociative experiences, thereby focusing on the moderating role of perceived social support. By investigating the extent to which perceived social support can mitigate the severity of dissociative experiences, this research aims to provide valuable insights into culturally specific challenges faced by trauma survivors. The primary objective of the study is to explore the protecting effects of perceived social support in moderating the impact of childhood trauma on dissociative experiences. This objective aligns with the broader goal of informing evidence-based interventions to support trauma survivors and enhance mental health services in Pakistan.

While individual relationships between childhood trauma, dissociative tendencies and perceived stress have been extensively studied, there is a notable gap in the literature concerning the simultaneous examination of these variables and the mediating influence of perceived social support (Betz et al., 2020). Dissociative disorders, often rooted in childhood trauma, are among the many psychological conditions that can develop as a result of such experiences (Boyer et al., 2022). Dissociative disorders have been attributed to the abnormalities within the integration of consciousness, memory, emotion, perception, body representation, motor control, and behavior (Bravo et al., 2023). Dissociative identity disorder and related disorders is a subclass including depersonalization/ derealization disorder, dissociative amnesia, and possession disorders. The dissociative disorders have long been understood to represent reactions to extreme misery, which is often the result of repeated trauma, most readily occurring when traumatizing events occur during a time of developmental vulnerability (Bistas et al., 2024). Dissociative symptoms have been considered defense mechanisms or coping behaviors that arise when distress is overwhelming and usually linked with repeated traumas at a developmentally vulnerable stage (Sar et al., 2017). For instance, childhood trauma, especially when linked to attachment and developmental stressful events, represents an important etiological factor in the development of dissociative disorders. Decades of empirically supported study of the dissociative disorders have underscored an etiology that is specific but complex, one that principally points to events involving attachment and development-that is, traumatic stress occurring in childhood (Farina et al., 2019).

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The experiences of dissociation are significantly influenced by perceived social support. In instances of re-experiencing trauma, supportive, non-threatening, and reciprocal relationships with trustworthy individuals can promote emotional communication and mentalization, helping to reduce the adverse effects of dissociative symptoms (Boyer et al., 2022). Childhood trauma, a phenomenon affecting millions each year both in Pakistan and globally, plays a central role in the development of dissociative experiences. According to a study conducted in a trauma-exposed rural population in Pakistan, 90.5% of children experienced at least one trauma (Frost et al., 2024). The findings also revealed a higher prevalence of childhood abuse and neglect among males compared to females, with males scoring significantly higher on sexual abuse and emotional neglect. Additionally, a large number of adolescents reported experiencing all five subtypes of childhood trauma sexual abuse, emotional abuse, physical abuse, and emotional and physical neglect (Fatima et al., 2024).

Statistics from the Sahil report further highlight the alarming situation, with 2,960 child abuse cases reported in 2020, showing a 4% increase from 2019. On average, more than eight children were abused daily in Pakistan during 2020. Moreover, 41% of respondents in a retrospective study on child abuse reported experiencing at least one form of sexual abuse during childhood, with males (44%) reporting higher rates than females (39%) (Abbas & Jabeen, 2020). Neglect (19.7%) and being sworn at or insulted (16.9%) were identified as the most prevalent adverse childhood experiences (ACEs) in Pakistan, with an overall prevalence of exposure to at least one ACE of 40.7% (Shakeel et al., 2024). Other ACEs reported included living with a depressed parent (7.2%), experiencing physical harm (9.2%), and living with someone who beats you (8.4%). Additionally, 63.6% of participants in another study reported experiencing trauma before the age of 18, with the most common types being physical or verbal abuse (81%), unlawful touch or sexual abuse (45%), and parental separation or divorce (31%) (Bari et al., 2024). Globally, adverse childhood experiences are recognized as major contributors to the development of anxiety, depression, and post-traumatic stress disorder. These experiences not only cause immediate harm but also contribute to dissociative experiences during traumatic events, which act as a psychological defense mechanism to manage overwhelming distress.

Due to the stigma and general lack of awareness in Pakistan, dissociative disorders are often undiagnosed, despite international literature highlighting a strong correlation between childhood traumatic events and the development of dissociative symptoms. These symptoms act as defense mechanisms, helping individuals distance themselves from traumatic memories and overwhelming emotions. A study from Nepal defines dissociative disorder as the partial or complete loss of normal integration between memories of the past, awareness of identity, immediate sensations, and control of bodily movements. The study also elicited that dissociative disorders are more prevalent in developing countries than in developed ones, with an estimated prevalence of 5% in general hospital settings and 2.6% among general medicine inpatients. Specifically, 2.08% of inpatients in Nepal were diagnosed with dissociative disorders (Khattri et al., 2019). Reducing the impact of dissociative experiences and early trauma relies significantly on perceived social support. Social support, encompassing emotional, practical, and informational assistance from friends, family, and the community, can play a critical role in alleviating trauma. In Pakistan's cultural context, where family and community support hold immense value, understanding the role of social support in mental health becomes particularly important (Shafiq, 2020). Globally, research has demonstrated that

strong social support networks are associated with better mental health outcomes and a significant reduction in the severity of dissociative symptoms.

Traumatic experiences during childhood are alarmingly common, and individuals with dissociative disorders often endure worse environmental circumstances than those with other forms of psychopathology (Dutra et al., 2009). Evidence suggests that childhood abuse is more prevalent among patients with dissociative disorders compared to those who have experienced abuse but do not develop dissociative symptoms. Adverse childhood experiences (ACEs) are associated with a wide range of symptoms and diagnoses beyond PTSD, including the effects of neglect in addition to sexual, physical, and emotional abuse (Tzouvara et al., 2023). Studies examining the relationship between different types of childhood trauma and disorders in adult survivors have shown that experiences of sexual, physical, and emotional abuse significantly intensify dissociative-psychotic symptoms (Downey & Crummy, 2021). Notably, beyond disorders like schizotypy and post-traumatic depersonalization, functional dissociative disorders often manifest as depression. The intricate relationship between childhood trauma and dissociation highlights the potential variations in mechanisms linking the two. Factors such as perceived threat, social support inadequacy, and individual meaning-making processes play critical roles in shaping this association. Social support, in particular, can serve as a powerful protective factor, mitigating the adverse effects of childhood trauma on dissociation. By addressing this relationship, early interventions can focus on preventing or reducing dissociative symptoms (Calhoun et al., 2022).

Social support has a foundational and moderating role in the impact of childhood trauma on the development and severity of dissociative disorders. Research shows that individuals with high levels of social support are less likely to experience severe dissociative symptoms, even when exposed to childhood trauma (Charuvastra & Cloitre, 2008). Social support provides emotional comfort, practical assistance, and companionship, which can alleviate feelings of isolation and helplessness that trauma survivors often face (Ozbay et al., 2007). This protective factor fosters resilience and facilitates recovery, moderating the negative psychological consequences of trauma. Given its vital role, strengthening social support networks is a critical component of therapeutic interventions for individuals with a history of childhood trauma and dissociative disorders. By building these networks, interventions can promote emotional healing and reduce the intensity of dissociative symptoms, offering survivors a pathway toward recovery and improved mental health outcomes (Woolard et al., 2024; Şar, 2020).

In the context of Pakistan, where collectivist cultural values dominate, social support takes on unique dynamics. Collectivism emphasizes interdependence, familial obligations, and close-knit community ties, which shape how individuals perceive and receive social support. Family and extended kinship networks play a central role in providing emotional and practical support. For instance, caregivers and family elders often act as primary sources of comfort and decision-making, which can significantly influence how survivors of childhood trauma experience and process their emotions. Community involvement, such as support from religious or social groups, also adds to the fabric of perceived social support, offering survivors a sense of belonging and shared responsibility (Zhao et al., 2022). However, the collectivist culture can also impose challenges, such as stigma associated with mental health issues or a reliance on traditional coping mechanisms that may not address the complex needs of trauma survivors. Gender roles further complicate this dynamic; for example, women may have greater access to informal support within the home but face restrictions in seeking professional help or support outside the family. On the other hand, men may encounter barriers to expressing vulnerability

due to societal expectations of emotional stoicism. These cultural nuances underscore the importance of tailoring interventions to align with the collectivist ethos, ensuring that social support systems are both accessible and effective.

For children, social support in collectivist cultures such as Pakistan's encompasses individual developmental processes and environmental influences. Processes include interpretive patterns for assessing relationships, self-regulation strategies, security attachment, and a positive worldview. Environmental influences include general support from family members, the role of authoritative caregiving institutions, and support styles rooted in traditional family structures (Calhoun, 2022). These culturally embedded practices shape how children interpret and utilize social support, influencing their capacity to build resilience against trauma.

Although social support plays a significant role in moderating the relationship between risk factors and symptom expression, it does not completely buffer all negative effects. Instead, it moderates the transition between risk factors and the manifestation of symptoms. The current study aims to explore the threshold at which risk factors can be moderated within the context of collectivist cultural dynamics. By examining the essential threshold hypothesis, the research seeks to deepen our understanding of how culturally specific forms of social support, including those found in collectivist societies like Pakistan, influence the conversion of risk into symptoms.

## Theoretical Review

### Psychodynamic Theory and Childhood Trauma

Psychodynamic theories provide a valuable framework for understanding the impact of childhood trauma on psychological development, particularly in relation to dissociative disorders. These theories emphasize how early experiences and unconscious processes shape an individual's mental health (Traylor et al., 2022). Childhood trauma, according to psychodynamic perspectives, often leads to the use of defense mechanisms, such as repression and projection**,** which are directly implicated in the development of dissociative symptoms.

Repression, a central concept in psychodynamic theory, involves unconsciously blocking distressing memories and emotions from conscious awareness to protect the individual from overwhelming emotional pain. This process is particularly relevant to dissociative amnesia, where traumatic memories are inaccessible, resulting in gaps in memory that align with the traumatic event (Fang et al., 2020). Similarly, projection, another defense mechanism, involves attributing one's internal conflicts or unacceptable emotions to external sources. In individuals with dissociative disorders, projection may manifest as fragmented perceptions of the self or others, contributing to identity disturbances.

The psychodynamic approach posits that these maladaptive defense mechanisms emerge as unconscious strategies to manage the intense emotional turmoil caused by trauma. Over time, however, these mechanisms may contribute to dissociative symptoms such as depersonalization and identity fragmentation. Therapeutic interventions grounded in psychodynamic principles aim to bring these unconscious conflicts into conscious awareness, enabling individuals to process and integrate their traumatic experiences. This process fosters emotional healing and a more cohesive sense of self, underscoring the importance of addressing the unconscious dynamics underlying dissociation (Gatta et al., 2019).

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## Attachment Theory and Dissociative Disorders

Attachment theory provides a very important framework for understanding how dissociative disorders develop, particularly in relation to childhood trauma. According to the theoretical framework, the kind of relationship one has with a caregiver in childhood dictates the way an individual will function emotionally and psychologically in the future (Liotti, 2013). For example, a child whose caregiver alternates between moments of affection and sudden outbursts of anger may experience profound confusion and fear. This inconsistency prevents the child from developing a stable sense of trust and safety, leading to contradictory internal working models**.** The child may simultaneously view the caregiver as a source of comfort and as a threat, creating an internal conflict that cannot be resolved. To cope, the child may compartmentalize these conflicting experiences, resulting in fragmented mental states.

Consider a hypothetical case of a child who grows up with a caregiver struggling with unresolved trauma. The caregiver may exhibit unpredictable behaviors, such as withdrawing emotionally or reacting aggressively during times of stress. In response, the child might develop dissociative symptoms like amnesia**,** where memories of the caregiver's frightening behaviors are blocked, or depersonalization, where the child feels detached from their own emotions and body during moments of distress. Over time, these symptoms become ingrained as coping mechanisms, eventually contributing to the development of dissociative disorders.

Furthermore, in cases of severe neglect, where a caregiver fails to provide consistent emotional support, the child may experience a profound sense of abandonment. This lack of a secure base can lead to identity disturbances, as the child struggles to form a coherent sense of self. For instance, the child may develop dissociative identity traits, characterized by shifting self-perceptions, as a way to adapt to the emotional void created by the caregiver's neglect.

The role of attachment in dissociation underscores the importance of addressing early relational experiences in therapeutic interventions. By helping individuals reconstruct a sense of safety and trust, therapy can facilitate the integration of fragmented mental states and reduce dissociative symptoms. These examples illustrate how disorganized attachment, shaped by inconsistent caregiving, directly contributes to the development of dissociative disorders (Degnan et al., 2022).

## Literature Review

Benjet & Bromet (2016) investigated the prevalence of trauma worldwide using data from the World Health Organization's World Mental Health Surveys. Their findings revealed that 70% of people globally reported experiencing at least one traumatic event. However, the study relied on self-reported data, which may have introduced bias. This highlights the need for research that uses more objective measures to corroborate self-reported trauma exposure. Trauma, as a pervasive public health issue, can take various forms, including single events involving significant injury or death, sexual assault, or prolonged experiences of marginalization, abuse, neglect, and damaged attachment bonds. These findings underscore the widespread impact of trauma but fail to address the role of protective factors, such as social support, in mitigating its effects.

Gilmore et al. (2017) estimated the prevalence of trauma exposure among children in the United States, finding that one in four adults reported three or more adverse childhood experiences, and three in five reported at least one. While the study used a large representative sample, it did not account for cultural differences in the perception of trauma. Furthermore,

their findings suggested a higher prevalence of trauma in the U.S. compared to the global average. This emphasizes the importance of examining how social and cultural contexts influence trauma outcomes, an area requiring further exploration.

Petruccelli et al. (2019) examined the relationship between childhood trauma exposure and negative life outcomes, including chronic illnesses, mental illness, and substance abuse. While the study found a positive correlation between trauma and these outcomes, it did not investigate potential moderators, such as social support, that could mitigate these effects. This omission highlights the importance of understanding how factors like perceived social support may buffer the adverse effects of childhood trauma, a gap this study aims to address.

Kratzer et al. (2018) focused on trauma-related dissociation as a mediator between trauma exposure, PTSD, and other health and social hazards. Their findings emphasized the ubiquity of dissociative symptoms following trauma but noted that these symptoms are often under-researched. However, due to the study's cross-sectional design, causal relationships could not be established. This limitation reinforces the need for longitudinal research to clarify the mechanisms underlying dissociation and the role of social support in alleviating dissociative symptoms.

Xiang et al. (2024) explored the long-term psychological consequences of childhood trauma and the protective role of social support. Their longitudinal study revealed that high perceived social support significantly reduced the negative impact of childhood trauma on adult mental health. However, the study did not examine the quality or specific sources of social support, leaving a critical gap in understanding how different forms of support contribute to resilience. This study seeks to build on these findings by examining how perceived social support, in its various forms, moderates the relationship between childhood trauma and dissociative symptoms.

Su et al. (2022) also highlighted the moderating effects of social support and effective coping mechanisms on the mental health consequences of childhood maltreatment. While their findings confirmed that social support significantly reduces the impact of childhood trauma, the study's limited population restricts its generalizability. By addressing this limitation, the current study aims to provide a broader understanding of how perceived social support functions across diverse populations.

**Problem Statement**

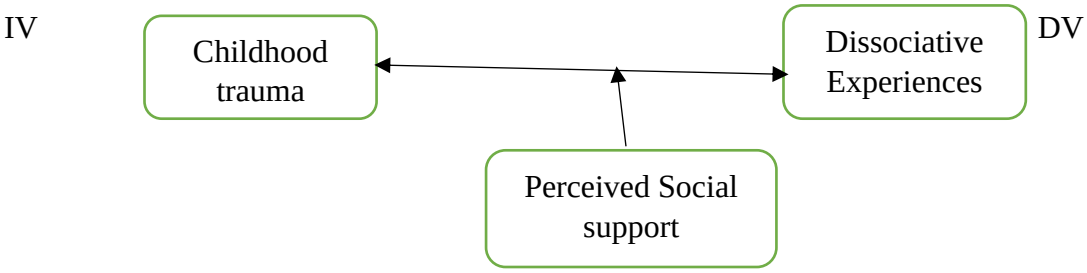
Most of the psychological impacts of childhood trauma emerge during adulthood, including dissociative experiences that cause disruption to the continuity of reality and identity. However, less is known about how perceived social support from adults may moderate the connection between childhood trauma and dissociative experiences (Sar, 2020) The development of this moderation might contribute to explaining some protective factors against the noxious psychological consequences of traumatic experiences during childhood (Barlow, 2014).

**Rationale**

Childhood trauma is a pervasive issue with profound and long-lasting psychological consequences, often leading to dissociative experiences characterized by disruptions in memory, identity, and consciousness. These experiences, while initially functioning as coping mechanisms for overwhelming trauma, can significantly impair an individual's functioning and quality of life. Research has established the role of childhood trauma as an antecedent factor in dissociative experiences (Manna, 2022); however, there is a critical gap in understanding how

perceived social support functions as a protective factor in this context (Chi & Jiang, 2023). While studies like Benjet & Bromet (2016) highlight the prevalence of trauma and its global implications, they fail to address the role of protective factors, such as social support, in attenuating trauma's effects. Similarly, Petruccelli et al. (2019) and Xiang et al. (2024) acknowledged the connection between trauma and adverse life outcomes but do not explore the moderating role of specific forms of social support. Moreover, Kratzer et al. (2018) emphasized the prevalence of dissociative symptoms but highlight the need for longitudinal research to establish causal relationships and to examine how social support may alleviate these symptoms. Su et al. (2022) underscored the protective role of social support but point to limitations in generalizability due to restricted populations. These gaps collectively underscore the need for research that examines how perceived social support moderates the relationship between childhood trauma and dissociative experiences across diverse populations. This study directly addresses these gaps by investigating the moderating role of perceived social support in the relationship between childhood trauma and dissociative experiences. By focusing on the quality and specific sources of perceived social support, the research aims to provide a more in-depth understanding of how different forms of support contribute to resilience. These findings will contribute to developing practical strategies and targeted interventions that emphasize the importance of social support systems in fostering recovery and reducing the long-term psychological effects of childhood trauma.

**Conceptual Framework**




## MATERIALS AND METHODS

### Study Setting

The study was conducted in various cities across Pakistan, targeting participants from the general population. The setting encompassed diverse urban and rural areas to ensure representativeness.

### Study Design

This study employed a cross-sectional research design to investigate the relationship between childhood trauma, dissociative experiences, and the moderating role of perceived social support.

### Sample and Sampling Technique

The sample consisted of 262 participants, including 206 females and 56 males, aged between 19 and 39 years. A non-probability convenience sampling technique was used to recruit participants from different regions in Pakistan.

## Instruments

### Demographic Sheet

A pre-designed questionnaire was used to collect data on the socio–demographic variables (name, age, gender, education, school, family system, residence, father`s education, father`s occupation, family income and a few questions about experiencing trauma directly or witnessing it.

### Multidimensional Scale of Perceived Social Support (MSPSS)

The Multidimensional Scale of Perceived Social Support was developed by Zimet et al. (1988) to assess perceptions of support from three sources (family, friends, and a significant other). It is 7-point likert scale that consisted of 12 items. In reliability analysis, the Cronbach's alpha reliability for the scale is reported to be α=.78. The Cronbach's alpha values for perceived social support from family, friends and significant others were α=.82, friends α=.90 and α=.78 respectively.

### Dissociative Experience – Scale (DES-II)

The dissociative experiences scale (DES) was developed by Bernstein & Putnam (1986). According to Ross (1997), this is the most widely used self-administered scale and has undergone the most methodological scrutiny. In several studies, the DES has been found to yield high internal reliability i.e; α=.90. It has 28 items. These items were based mainly on experiences of people who have dissociative disorders and discussions with clinical experts in the field of dissociative disorders. Carlson et al. (1991) explored the internal structure of the DES with clinical and nonclinical samples and found three subscales: amnesia factor, absorption factor and depersonalization/derealization factor. These subscales also yield high internal reliability (Dubester & Braun, 1995).

### Childhood Trauma Questionnaire –SF

The Childhood Trauma Questionnaire-Short Form (CTQ-SF), developed by Bernstein et al. (2003), is a 28-item retrospective self-report instrument designed to assess childhood maltreatment. It evaluates five dimensions: physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect. The original CTQ consisted of 70 items, but the short form includes five items per subscale, along with three additional items to assess minimization and denial. Each item is rated on a 5-point Likert scale, ranging from 1 (never true) to 5 (very often true), with higher scores indicating greater severity of maltreatment. The CTQ-SF demonstrates strong internal consistency, with an average Cronbach's alpha coefficient of α=.89 for the total score. The subscale reliability ranges from α=.66 for physical neglect to α=.92 for sexual abuse, making it a valid and reliable tool for assessing childhood trauma.

## Statistical Analysis

The collected data were analyzed using the Statistical Package for Social Sciences (SPSS Version 20). Descriptive statistics were used to summarize the demographic characteristics and study variables. Reliability analysis was conducted to assess the internal consistency of the scales used in the study. Correlation analysis was applied to determine the relationships between the key study variables, while the Independent Samples t-Test was employed to compare the mean differences between groups. Additionally, Multiple Regression Analysis was used to identify significant predictors of dissociative experiences. Finally, moderation

analysis was performed to test the moderating role of perceived social support in the relationship between childhood trauma and dissociative experiences.

### Ethical Approval

Participants were fully informed about the study's purpose, procedures, and potential risks. Written consent was obtained, and participants were made aware of their right to withdraw from the study at any time without penalty. To ensure confidentiality, all collected data were anonymized, and secure storage methods were implemented to protect participant information. The study also took steps to minimize any potential distress by ensuring participants' comfort during data collection. Ethical principles, including respect for participants' autonomy, beneficence, and justice, were upheld throughout the research process.

## FINDINGS

### Frequency and Percentage

The sample comprised of 56 males (21%) and 206 females (78%) university students. 10% of intermediate student, 68% from graduate, while 21% were from post graduate. 60% students had residence of Urban and 40% had residence of Rural. Keeping in view the family system, 60% were from the nuclear family and 40% were from the joint family. Furthermore, it involve statement of have you ever experienced childhood trauma so, 63% students response No, 10% didn’t answer it and 26% response Yes to that statement. Moreover, other statement involve that do you know anyone who have experiences childhood trauma. So, 53% response Yes and 46% response No on that statement.

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**Table 1 Psychometrics Properties of the Study Variables/Scales (N=262)**

| Variables | *k* | *a* | *M(SD)* | Range | | Skewness | Kurtosis |
|---|---|---|---|---|---|---|---|
| | | | | Potential | Actual | | |
| Depersonalization factor | 6 | .95 | 30.58 | 0-36 | 0-97 | .42 | -.60 |
| Amnesia factor | 6 | .96 | 23.88 | 0-36 | 0-83 | .64 | -.66 |
| Absorption factor | 6 | .96 | 32.38 | 0-36 | 0-90 | .23 | -.73 |
| **Dissociative experiences total** | 28 | .94 | 29.57 | 0-280 | 0-84 | .33 | -.85 |
| Family dimension | 4 | .84 | 19.46 | 4-28 | 4-28 | -.44 | -.39 |
| Friends dimension | 4 | .82 | 19.41 | 4-28 | 4-28 | -.66 | .08 |
| Significant others dimension | 4 | .78 | 18.98 | 4-28 | 4-28 | -.51 | -.46 |
| **MSPSS (Total)** | 12 | .88 | 48.07 | 12-84 | 15-70 | -.34 | -.25 |
| Emotional abuse | 5 | .70 | 11.16 | 5-25 | 5-25 | .49 | -.56 |
| Physical abuse | 5 | .69 | 9.62 | 5-25 | 5-22 | .67 | -.70 |
| Sexual abuse | 5 | .73 | 9.18 | 5-25 | 5-25 | 1.0 | .04 |
| Emotional neglect | 5 | .81 | 13.08 | 5-25 | 5-25 | .33 | -.16 |
| Physical neglect | 5 | .78 | 10.20 | 5-25 | 5-20 | .41 | -.88 |
| **Childhood trauma** | 28 | .84 | 62.84 | 28-140 | 37-108 | .50 | -.72 |

Table 1 shows the psychometric properties of the scale. The Cronbach alpha value for Depersonalization factor (.95), amnesia factor (.96), Absorption factor (.96), Dissociative Experiences Total (.94). The Cronbach alpha for perceived social support (.88), subscales include Family dimension (.88), Friends dimension (.87), Significant Others dimension (.78), and Emotional Abuse (.70), Physical abuse (.69), Sexual abuse (.73), Emotional Neglect (.81), Physical Neglect (.78), Total Childhood trauma questionnaire (.84). which shows high internal consistency. Values of skewness were between -1 to +1 which were acceptable values.

**Table 2 Pearson Correlation among Study Variables (N=262)**

| | Variables | 1 | 2 |
|---|---|---|---|
| 1 | CT | - | .48** |
| 2 | DE | | - |

*Note: *p<.05, **p<.01, DE=(Dissociative Experiences), CT=(Childhood Trauma)*

Table 2 demonstrates that Childhood Trauma has a significant moderate positive correlation with Dissociative Experiences (r=.484**, p<0.01).

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**Table 3 Multiple Linear Regression Showing Childhood as Predictors of Depersonalization among University Students (N=262)**

| | | | | | | 95%CI | |
|---|---|---|---|---|---|---|---|
| ***Predictors*** | ***B*** | ***β*** | ***SE*** | ***t*** | ***P*** | ***LL*** | ***UL*** |
| (Constant) | 2.78 | | 3.85 | .72 | .47 | -4.80 | 10.38 |
| Emotional abuse | .75 | .18 | .31 | 2.39 | .01 | .13 | 1.38 |
| Physical abuse | .58 | .13 | .36 | 1.62 | .10 | -.12 | 1.30 |
| Sexual abuse | .30 | .08 | .25 | 1.17 | .24 | -.20 | .80 |
| Emotional neglect | -.03 | -.00 | .26 | -.12 | .90 | -.56 | .49 |
| Physical neglect | 1.00 | .21 | .33 | 3.04 | .00 | .35 | 1.66 |

Dependent Variable= Depersonalization

*Note: R=.484, $R^2$=.23;* CT=Childhood Trauma

Multiple Regression analysis was used to test if Childhood Trauma significantly predict Depersonalization. The result indicated that $R^2$ value of .23 indicated that 23% variance in the dependent variable can be accounted for by the predictor variable of Emotional abuse and Physical Neglect. While Sexual Abuse, Emotional Neglect and Physical abuse are non-significant predictors of depersonalization. Emotional abuse ($p<0.05$, $\beta=.18$) and physical neglect significantly predicts with depersonalization ($p<0.01$, $\beta=.21$)

**Table 4 Multiple Linear Regression Showing Childhood Trauma as Predictors of Amnesia Factor among University Students(N=262)**

| | | | | | | 95%CI | |
|---|---|---|---|---|---|---|---|
| ***Predictors*** | ***B*** | ***β*** | ***SEB*** | ***t*** | ***P*** | ***LL*** | ***UL*** |
| (Constant) | -6.09 | | 4.09 | -1.48 | .13 | -14.16 | 1.97 |
| Emotional abuse | .39 | .09 | .33 | 1.18 | .23 | -.26 | 1.06 |
| Physical abuse | .77 | .16 | .38 | 2.01 | .04 | .01 | 1.53 |
| Sexual abuse | .27 | .06 | .27 | 1.00 | .31 | -.26 | .81 |
| Emotional neglect | -.09 | -.01 | .28 | -.32 | .74 | -.65 | .46 |
| Physical neglect | 1.64 | .32 | .35 | 4.66 | .00 | .94 | 2.33 |

Dependent Variable= Amnesia Factor

*Note: R=.529, $R^2$=.28;* CT=Childhood Trauma

Multiple Regression analysis was used to test if Childhood Trauma significantly predict Amnesia. The result indicated that $R^2$ value of 0.28 indicated that 28% variance in the dependent variable can be accounted for by the predictor variable of Physical Neglect and Physical abuse. While Emotional Abuse, Sexual Abuse, and Emotional Neglect are non-significant predictors of amnesia. Physical abuse significantly predicts amnesia ($p<0.05$, $\beta=.16$) and Physical neglect significantly predicts amnesia ($p<0.001$, $\beta=.32$) While Emotional abuse, Sexual abuse and Emotional Neglect are a non-significant predictor of Amnesia.

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**Table 5 Multiple Linear Regression Showing Childhood as Predictors of Absorption Factor among University Students (N=262)**

| | | | | | | 95%CI | |
|---|---|---|---|---|---|---|---|
| ***Predictors*** | ***B*** | ***β*** | ***SEB*** | ***t*** | ***P*** | ***LL*** | ***UL*** |
| (Constant) | 8.98 | | 4.12 | 2.17 | .03 | .85 | 17.11 |
| Emotional abuse | .83 | .20 | .33 | 2.45 | .01 | .16 | 1.50 |
| Physical abuse | .54 | .12 | .38 | 1.41 | .15 | -.21 | 1.31 |
| Sexual abuse | .29 | .07 | .27 | 1.08 | .28 | -.24 | .83 |
| Emotional neglect | .00 | .00 | .28 | .00 | .99 | -.56 | .56 |
| Physical neglect | .59 | .12 | .35 | 1.67 | .09 | -.10 | 1.29 |

Dependent Variable= Absorption Factor

*Note: R=.429, R2=.18;* CT=Childhood Trauma

Multiple Regression analysis was used to test if Childhood Trauma significantly predict Absorption. The result indicated that $R^2$ value of 0.18 indicated that 18% variance in the dependent variable can be accounted for by the predictor variable of Emotional abuse. While Emotional Abuse, Sexual Abuse, Emotional Neglect and Physical Neglect are non-significant predictors of amnesia. However, emotional abuse significantly predicts amnesia ($p<0.05$, $\beta=.20$).

**Table 6 The Moderating Role of Perceived Social Support in Relationship between Childhood Trauma and Dissociative Experiences among University Students (N=262)**

| **Moderator Model 1** | | | | | **95%Cl** | |
|---|---|---|---|---|---|---|
| **Predictors** | **β** | ***SEB*** | ***t*** | ***p*** | ***LL*** | ***UL*** |
| Constant | -60.35 | 18.75 | -3.21 | .001 | -97.2 | -23.41 |
| CT | 1.4 | .29 | 4.95 | .000 | .88 | 2.05 |
| PSS | 1.1 | .37 | 2.96 | .003 | .37 | 1.84 |
| X*M | -.01 | .00 | -3.07 | .002 | -.03 | .006 |
| $R^2$ | .26 | | | | | |
| F | 30.2 | | | | | |
| $\Delta R^2$ | .027 | | | | | |
| ΔF | 9.44 | | | | | |

*Note.* CT= Childhood Trauma; PSS=perceived social support; DE= Dissociative Experience

Table 6 shows the moderating effect of perceived social support on the relationship between Childhood Trauma and Dissociative Experience. The interaction term (X*M) has a significant negative effect on Dissociative Experience ($\beta = -0.01$, $p = .002$), indicating that Perceived Social Support significantly moderates this relationship. Specifically, the negative interaction term suggests that higher levels of Perceived Social Support weaken the positive relationship between Childhood Trauma and Dissociative Experience. The overall model explains 26% of the variance in Dissociative Experience ($R^2 = .26$), and the addition of the interaction term contributes a significant incremental change to the explained variance ($\Delta R^2 = .027$, $\Delta F = 9.44$, $p < .01$).

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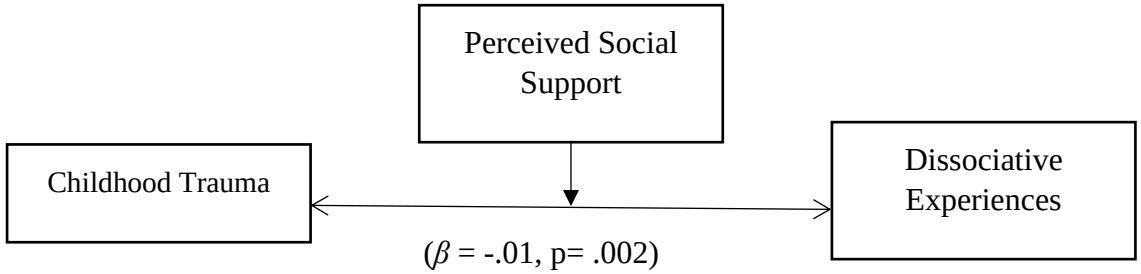


*Figure 1 Impact of Perceived Social Support on Dissociative Experiences through Childhood Trauma*

This graphical presentation showed that PSS significantly moderated the relationship between Childhood Trauma and Dissociative Experiences. The indirect effect ($\beta$ = -.01; *S.E* = .00, LL=-.03, UL=.006) indicated that Perceived Social Support significantly weakens the relationship of Childhood Trauma and Dissociative Experiences.

**Table 7 The Moderating Role of Perceived Social Support in Relationship between Relationship of Childhood Trauma and Dissociative Experiences among University Students (N=262)**

| | | | M | | | |
|---|---|---|---|---|---|---|
| | **Model 1** | | | | **95%Cl** | |
| **Predictors** | **β** | ***SEB*** | ***t*** | ***p*** | ***LL*** | ***UL*** |
| Constant | -28.63 | 17.18 | -1.66 | .09 | -62.47 | 5.20 |
| CT | .86 | .24 | 3.51 | .000 | .38 | 1.34 |
| FD | 1.02 | .82 | 1.24 | .215 | -.59 | 2.64 |
| X*M | -.01 | .01 | -1.08 | .277 | -.03 | .011 |
| $R^2$ | .23 | | | | | |
| F | 26.8 | | | | | |
| $\Delta R^2$ | .003 | | | | | |
| ΔF | 1.18 | | | | | |

*Note*.CT= Childhood Trauma; FD= Family Dimension; DE= Dissociative Experience

Table 7 shows that moderating effect of Family Dimension on the relationship between Childhood Trauma and Dissociative Experience. The interaction effect value shows that moderation is non-significant (b= -.01, p=.277). Finding shows that Family Dimension shows non-significant moderation between Childhood Trauma and Dissociative Experience.

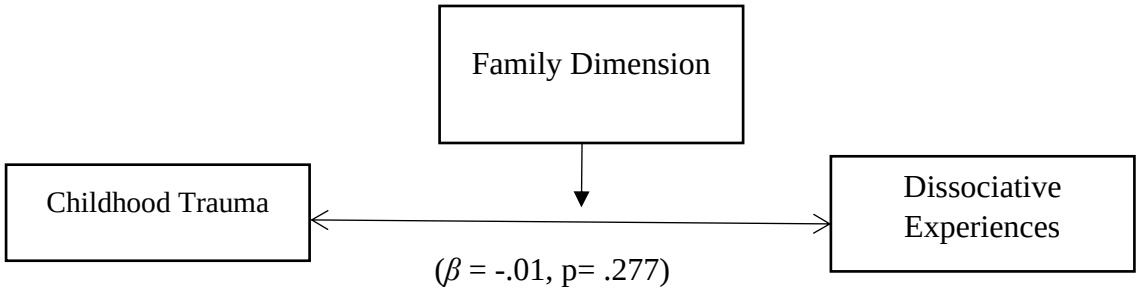


*Figure 2 Impact of Family Dimension on Dissociative Experiences through Childhood Trauma*

This graphical presentation showed that Family Dimension non-significantly moderated the relationship between Childhood Trauma and Dissociative Experiences.

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**Table 8 The Moderating Role of Friend Dimension in Relationship between Childhood Trauma and Dissociative Experiences among University Students (N=262)**

| | M | | | | | |
|---|---|---|---|---|---|---|
| | **Model 1** | | | | **95%Cl** | |
| **Predictors** | **β** | ***SEB*** | ***t*** | ***p*** | ***LL*** | ***UL*** |
| Constant | -44.61 | 15.48 | -2.88 | .004 | -75.10 | 14.11 |
| CT | 1.25 | .24 | 5.06 | .000 | .76 | 1.73 |
| FD | 1.94 | .76 | 2.55 | .01 | .44 | 3.44 |
| X*M | -.03 | .01 | -2.82 | .005 | -.05 | -.01 |
| $R^2$ | .25 | | | | | |
| F | 29.8 | | | | | |
| $\Delta R^2$ | .023 | | | | | |
| ΔF | 7.97 | | | | | |

*Note.*CT= Childhood Trauma; FD= Friends Dimension; DE= Dissociative Experience

Table 8 shows that moderating effect of Friends Dimension on the relationship between Childhood Trauma and Dissociative Experience. The interaction effect value shows that moderation is significant negative (b= -.03, p=.005). Finding shows that Friends Dimension shows significant moderation between Childhood Trauma and Dissociative Experience.

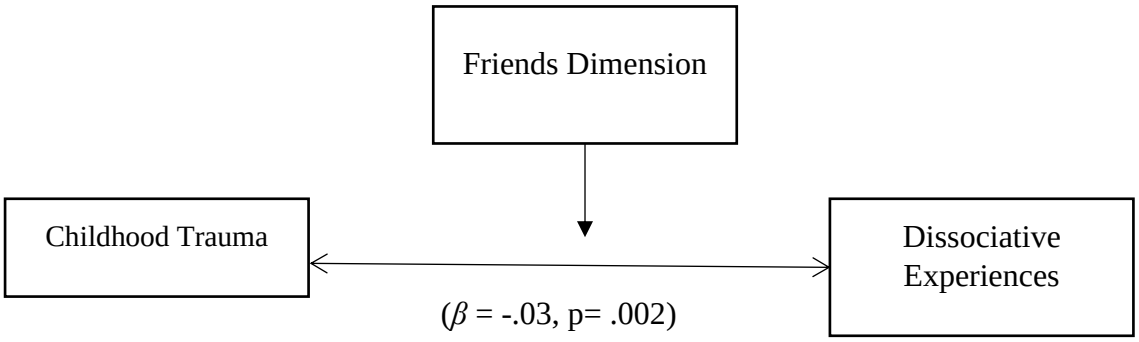


*Figure 3 Impact of Friend Dimension on Dissociative Experiences through Childhood Trauma*

This graphical presentation showed that Friend Dimension significantly moderated the relationship between Childhood Trauma and Dissociative Experiences. The indirect effect (*β* = -.03; *S.E* = .01, LL=-.05, UL=-.01) Friends Dimension significantly weakens the relationship of Childhood Trauma and Dissociative Experiences.

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**Table 9 The Moderating Role of Significant Others in Relationship between Childhood Trauma and Dissociative Experiences among University Students (N=262)**

| | M | | | | | |
|---|---|---|---|---|---|---|
| | **Model 1** | | | | **95%Cl** | |
| **Predictors** | **β** | ***SEB*** | ***t*** | ***p*** | ***LL*** | ***UL*** |
| Constant | -45.93 | 14.21 | -3.23 | .001 | -73.92 | 17.94 |
| CT | 1.21 | .21 | 5.58 | .000 | .78 | 1.64 |
| SO | 1.97 | .68 | 2.90 | .004 | .63 | 3.32 |
| X*M | -.03 | .01 | -3.06 | .002 | -.05 | -.01 |
| R2 | .26 | | | | | |
| F | 30.2 | | | | | |
| ΔR2 | .02 | | | | | |
| ΔF | 9.38 | | | | | |

*Note*.CT= Childhood Trauma; SO=Significant Others; DE= Dissociative Experience

Table 9 shows that moderating effect of Significant Others on the relationship between Childhood Trauma and Dissociative Experience. The interaction effect value shows that moderation is significant negative (b= -.03, p=.002). Finding shows that Significant Others shows significant moderation between Childhood Trauma and Dissociative Experience.

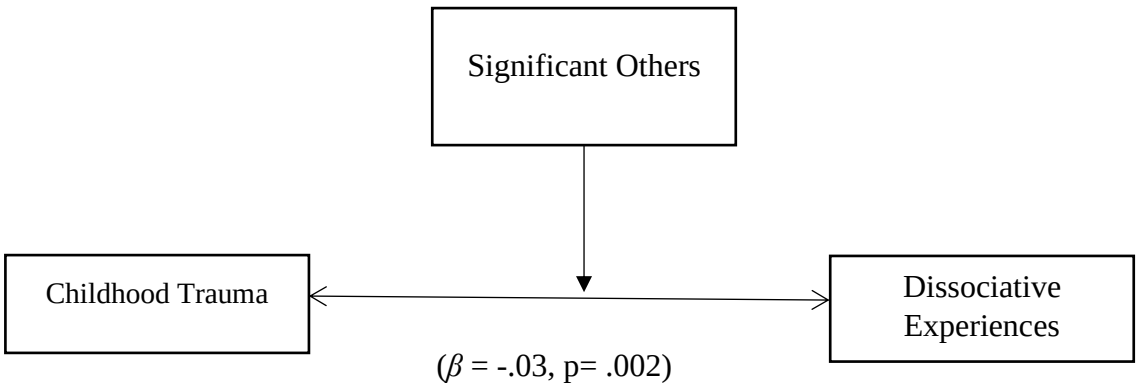


*Figure 4 Impact of Significant Others on Dissociative Experiences through Childhood Trauma*

This graphical presentation showed that Significant Others significantly moderated the relationship between Childhood Trauma and Dissociative Experiences. The indirect effect (*β* = -.03; *S.E* = .01, LL=-.05, UL=-.01) Significant Others significantly weak the relationship of Childhood Trauma and Dissociative Experiences.

**Table 10 Mean Difference in A Study Variables on the Basis of Gender (N=260)**

| | **Male** | | **Female** | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **M** | **SD** | **M** | **SD** | **F** | ***p*** | **N2** | **Post hoc** |
| Emotional abuse | 10.6 | 4.29 | 11.3 | 4.9 | 1.01 | .34 | | |
| Physical abuse | 10.9 | 4.57 | 9.5 | 4.6 | .19 | .39 | | |
| Sexual abuse | 9.18 | 4.96 | 9.1. | 5.3 | 1.92 | .99 | | |
| Emotional neglect | 14.0 | 4.5 | 12.8 | 4.3 | .38 | .05 | 0.02 | 2<1 |
| Physical neglect | 11.5 | 4.0 | 9.8 | 4.0 | .09 | .005 | 0.04 | 2<1 |

**Note:** **p<.05, **p<.01,*

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Table 10 Shows mean, SD, and f values for Emotional Abuse, Physical Abuse, Sexual Abuse, Emotional Abuse, Physical Abuse across Gender. Results indicate significant differences across Gender on emotional Neglect (f=.38, p=0.05) and Physical Neglect (f=.09, p=0.005). The finding reveals that Male experienced high level of Emotional Neglect and Physical Neglect as compared to Females. It also shows a non-significant difference with other variables across gender because its p-value is greater than 0.05

**Table 11 Mean Difference in a Study Variables on the Basis of Family Type (N=260)**

| | Nuclear | | Joint | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **M** | **SD** | **M** | **SD** | **F** | **p** | **N2** | **Post hoc** |
| **Emotional abuse** | 11.6 | 4.9 | 10.4 | 4.5 | .53 | .04 | 0.02 | 2<1 |
| **Physical abuse** | 9.8 | 4.7 | 9.2 | 4.4 | .35 | .30 | | |
| **Sexual abuse** | 9.6 | 5.4 | 8.5 | 5.0 | 3.7 | .10 | | |
| **Emotional neglect** | 13.6 | 4.4 | 12.2 | 4.2 | .09 | .01 | 0.03 | 2<1 |
| **Physical neglect** | 10.5 | 4.0 | 9.7 | 4.2 | .33 | .11 | | |

**N0te:** **p<.05, **p<.01,*

Table 11 Shows mean, SD, and f values for Emotional Abuse, Physical Abuse, Sexual Abuse, Emotional Abuse, Physical Abuse across Family Type. Results indicate significant differences across Family Type on emotional Abuse (f=.53, p=0.04) and Emotional Neglect (f=.09, p=0.01). The finding reveals that Nuclear Family experienced high level of Emotional Abuse and Emotional Neglect as compared to Joint Family. It also shows a non-significant difference with other variables across Family Type because its p-value is greater than 0.05

**Summary of the Findings**

The present study aimed to explore the relationship between childhood trauma, dissociative experiences, and the moderating role of perceived social support among university students. The findings provide significant insights into the nature of these associations, supporting and extending prior research in the field.

The results demonstrated a significant positive correlation between childhood trauma and dissociative experiences ($r = .48$, $p < 0.01$), aligning with previous research indicating that childhood trauma is a key predictor of dissociative experiences in adulthood (Sar et al., 2004; Steele et al., 2006). Dissociative symptoms such as depersonalization, amnesia, and absorption were significantly associated with various forms of childhood trauma, including emotional abuse and physical neglect, confirming that adverse childhood experiences can disrupt emotional and cognitive processes, leading to dissociative tendencies (Dorahy et al., 2017).

The findings from the regression analyses showed that childhood trauma significantly predicted dissociative experiences. Emotional abuse and physical neglect accounted for 23% of the variance in depersonalization, while physical neglect and physical abuse accounted for 28% of the variance in amnesia. Additionally, emotional abuse was a significant predictor of absorption, explaining 18% of the variance. These results are consistent with earlier studies suggesting that specific types of traumas, such as neglect and abuse, have distinct impacts on

dissociative subtypes (Briere & Rickards, 2007; Steele et al., 2001). The differential impact of abuse types underscores the importance of addressing specific traumatic experiences in therapeutic interventions.

The results confirmed the moderating effect of perceived social support on the relationship between childhood trauma and dissociative experiences. Higher levels of perceived social support significantly weakened the positive relationship between childhood trauma and dissociative experiences ($\beta$ = -0.01, p = 0.002). Notably, the Friends Dimension of social support emerged as a significant moderator ($\beta$ = -0.03, p = 0.005), whereas the Family Dimension did not show a significant effect. This finding is consistent with prior research suggesting that supportive friendships can mitigate the psychological consequences of childhood trauma by providing emotional stability and a sense of belonging (Cohen & Wills, 1985; Turner & Lloyd, 1995). The absence of a significant moderating role for family support may reflect complexities in familial relationships, particularly in cases where the family is a source of trauma.

The results indicated significant gender differences in emotional and physical neglect, with males reporting higher levels of neglect than females. This finding corroborates previous studies highlighting gender-specific experiences and responses to trauma, where males often report higher neglect and females report higher emotional abuse (Powers et al., 2009). Additionally, participants from nuclear families reported higher levels of emotional abuse and neglect compared to those from joint families, suggesting that family structure may influence the prevalence or reporting of childhood trauma. This aligns with research indicating that joint family systems often provide broader social and emotional support, which may buffer against neglect and abuse (Kumar et al., 2012).

## IMPLICATIONS TO THEORY, PRACTICE AND POLICY

The study findings have several implications for clinical practice and research;

### Theoretical Implications

The study provides evidence of the critical role of childhood trauma in the development of dissociative disorders. This strengthens existing theories that dissociative symptoms arise as a defense mechanism against overwhelming distress. The findings highlight the need for a nuanced understanding of how specific types of traumas (e.g., emotional abuse, physical neglect) contribute to distinct dissociative subtypes, supporting the differentiation of dissociative experiences in theoretical models.

The moderating role of perceived social support highlights its importance in mitigating the adverse effects of trauma. The differentiation between the impact of support from friends versus family underlines the complexity of social dynamics, suggesting that non-familial relationships may play a more critical role in recovery. Theoretically, this calls for an expansion of attachment and social buffering models to include nuanced relationships outside of the family unit. Therapeutic interventions should focus on enhancing patients' access to supportive friendships and community networks. For example, peer-support programs and group therapies can foster emotional stability and reduce feelings of isolation. Additionally, interventions should educate patients on identifying and cultivating healthy relationships outside the family system, particularly if familial relationships are a source of trauma.

The study's findings on gender differences in trauma exposure and dissociative outcomes offer a theoretical basis for exploring how societal and cultural norms shape gendered responses to

trauma. This expands existing frameworks on trauma and psychopathology by emphasizing the role of cultural and gender dynamics. The findings underscore the significance of cultural factors, particularly in regions like Pakistan, where family and community support are integral. This aligns with cross-cultural psychology theories, suggesting that cultural contexts heavily influence the perception and impact of social support on mental health outcomes.

**Practical Implications**

Clinicians could design interventions that specifically address the types of traumas (e.g., emotional abuse, physical neglect) most strongly associated with dissociative symptoms. Therapeutic approaches such as trauma-focused cognitive-behavioral therapy (TF-CBT) and eye movement desensitization and reprocessing (EMDR) should incorporate tailored strategies for different trauma subtypes. The findings indicate that males and individuals from nuclear families may experience higher levels of neglect. Community outreach programs can focus on these demographics to provide psychoeducation, early trauma screening, and access to support networks. This is particularly relevant in cultural contexts where nuclear families may lack the broader emotional safety nets provided by joint family systems.

Additionally, mental health practitioners should receive specialized training to identify and treat dissociative symptoms, especially in regions where under-diagnosis is prevalent. Training should also emphasize cultural competence, ensuring that interventions are sensitive to local norms and values. At a systemic level, public health initiatives should aim to reduce the stigma surrounding dissociative disorders and childhood trauma. Campaigns can emphasize the importance of social support and educate communities about recognizing and addressing childhood trauma. Schools, workplaces, and community centers should be included in these awareness efforts.

**Limitations**

While the study provides valuable insights, several limitations warrant consideration.

- The study's cross-sectional design limits the ability to establish causality between childhood trauma, dissociative experiences, and the moderating role of perceived social support. Longitudinal studies would be more effective in understanding the progression of dissociative symptoms over time.
- While the study emphasizes the cultural context of Pakistan, it does not account for potential variability in the understanding and experience of trauma and social support across different regions within the country. This limits the applicability of findings to more diverse cultural or regional settings.
- Although the study highlights the role of friends' support, it does not adequately explore the complexities of family dynamics, especially in cases where family relationships are the source of trauma. This restricts the understanding of how familial relationships influence dissociative symptoms.
- The study does not examine the potential impact of trauma experienced in adolescence or adulthood, which could also contribute to dissociative experiences. This narrows the scope of the research and its applicability to broader trauma-related disorders.
- The findings on gender differences may reflect reporting biases, as cultural norms in Pakistan might discourage males from reporting emotional or physical abuse, leading to under-representation of these experiences.

- The study primarily emphasizes severe trauma such as abuse and neglect but does not consider the potential effects of less severe yet chronic stressors, such as bullying or family conflict, which might also contribute to dissociative symptoms.
- Additionally, the reliance on self-reported data may introduce bias.

**Recommendation**

Future research should adopt longitudinal designs to track the long-term impact of childhood trauma on dissociative symptoms and the buffering role of social support. This will help establish causality and identify critical intervention windows. Given the differential impact of friends versus family support, further studies should explore how various types of relationships (e.g., peer, romantic, community) contribute to trauma recovery. This will inform more targeted support strategies. Research should explore how cultural values influence the perception and effectiveness of social support. Interventions should be tailored to align with these values, such as leveraging the extended family and community structures in collectivist cultures like Pakistan. Digital platforms and telehealth services can be used to provide support, especially for individuals with limited access to traditional social networks. Online support groups and virtual therapy sessions can play a critical role in trauma recovery. Schools can implement trauma-sensitive programs to identify and support children experiencing neglect or abuse. Training teachers to recognize early signs of trauma and refer students to appropriate services can prevent the escalation of dissociative symptoms. By applying these theoretical and practical implications, professionals can better address the complex relationship between childhood trauma, dissociation, and social support, ultimately improving outcomes for affected individuals.

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