



Peritraumatic dissociation as a predictor of post-traumatic stress disorder symptom severity: mediating roles of psychological inflexibility and emotional dysregulation

Lubna Kanwal Dar ¹, Shazia Hasan ¹

ABSTRACT

Objectives: To investigate the association between peritraumatic dissociation and post-traumatic stress disorder (PTSD) symptom severity and to examine the mediating roles of psychological inflexibility and emotional dysregulation.

Methods: This cross-sectional study was conducted from February to December 2024 in psychiatric departments of public and private tertiary care hospitals and outpatient mental health facilities in Punjab, Pakistan. A total of 206 trauma-exposed adults aged 20-40 years with PTSD symptoms were recruited through purposive sampling. Data were collected using the Peritraumatic Dissociative Experiences Questionnaire (PDEQ), Acceptance and Action Questionnaire-II (AAQ-II), Difficulties in Emotion Regulation Scale-Short Form (DERS-SF), and PTSD Checklist for DSM-5 (PCL-5). Pearson correlation, regression, and mediation analyses using the PROCESS macro with bootstrapping were performed.

Results: Peritraumatic dissociation showed a moderate positive correlation with PTSD symptom severity ($r=0.547$, $p<0.001$), emotional dysregulation ($r=0.408$, $p<0.001$), and psychological inflexibility ($r=0.405$, $p<0.001$). Peritraumatic dissociation significantly predicted emotional dysregulation ($\beta=0.407$, $p<0.001$), psychological inflexibility ($\beta=0.404$, $p<0.001$), and PTSD symptoms ($\beta=0.315$, $p<0.001$). Emotional dysregulation ($\beta=0.570$, $p<0.001$) and psychological inflexibility ($\beta=0.605$, $p<0.001$) were independent predictors of PTSD symptom severity. Mediation analyses demonstrated significant partial mediation by emotional dysregulation (indirect effect=0.651, 95% CI: 0.428-0.892) and psychological inflexibility (indirect effect=0.686), while the direct effect of peritraumatic dissociation on PTSD symptoms remained significant.

Conclusion: Peritraumatic dissociation is significantly associated with greater PTSD symptom severity through both direct and indirect pathways. Psychological inflexibility and emotional dysregulation partially mediate this relationship, highlighting potential therapeutic targets for improving outcomes in trauma-exposed individuals.

Keywords: Emotion Regulation (MeSH); Peritraumatic Dissociation (MeSH); Peritraumatic Dissociation (MeSH); Psychological flexibility (Non-MeSH); Stress Disorders, Trauma (MeSH); Post-Traumatic (MeSH); Trauma and Stressor Related Disorders (MeSH).

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I: Department of Psychology, University of Central Punjab, Lahore, Pakistan

Cell #: +92-335-4048160

Email ✉: lubna_kanwal_dar@yahoo.com

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violence.^{5,6} In Pakistan, studies conducted after the 2010 floods reported PTSD symptoms in 59% of survivors, highlighting the substantial psychological burden of trauma in the local population.⁷

Increasing evidence has highlighted the psychological processes involved in the development and maintenance of PTSD. Among these, peritraumatic dissociation (PD), characterized by depersonalization, derealization, emotional numbing and altered awareness during or immediately after a traumatic event, has consistently been identified as an important predictor of subsequent PTSD symptoms.⁸ However, the strength of this association remains inconsistent, with some studies demonstrating strong predictive effects, whereas others have reported weak or non-significant associations after controlling for potential confounding factors. Contemporary cognitive models of PTSD suggest that the relationship between PD and PTSD is not solely direct but may be mediated through maladaptive psychological processes that develop following trauma. This indicates that there is a need to explore mediating mechanisms instead of considering PD as a linear predictor.⁸

Among the proposed mediating mechanisms, psychological inflexibility has received increasing empirical attention. Psychological inflexibility refers to a rigid pattern of responding in which behavior is governed by internal psychological experiences rather than

INTRODUCTION

Post-traumatic stress disorder (PTSD) is a trauma- and stressor-related disorder characterized by intrusive re-experiencing, avoidance, negative alterations in cognition and mood, and hyperarousal following exposure to actual or threatened death,

serious injury, or sexual violence resulting from events such as accidents, natural disasters, armed conflict, or interpersonal violence.¹⁻⁴ PTSD has a lifetime prevalence of approximately 5-6% among trauma-exposed individuals and represents a major global public health challenge, particularly in settings affected by war, natural disasters, and

personally held values and adaptive goals. Evidence indicates that psychological inflexibility is independently associated with greater PTSD symptom severity, even after adjustment for established risk factors, including trauma severity, peritraumatic dissociation, perceived threat, personality traits and social support.^{9,10} Psychological inflexibility among United States war veterans has been shown to predict unique variance in clinician-rated PTSD symptom severity at one-year follow-up, with a medium effect size, even after controlling for shared variance with neuroticism and avoidance symptoms.¹¹ Evidence from cross-sectional studies also indicates that psychological inflexibility, along with related constructs such as reduced mindfulness and self-compassion, is strongly associated with PTSD symptom severity in clinical populations.¹² Furthermore, psychological inflexibility has been reported to mediate the relationship between trauma-related guilt and PTSD symptoms¹³ as well as the association between adverse childhood experiences and dissociation,¹⁴ suggesting that it may represent a transdiagnostic vulnerability process.⁸

Second, emotion dysregulation has emerged as a central feature of PTSD psychopathology. Individuals with PTSD commonly experience difficulties in emotional clarity, limited access to effective emotion regulation strategies, and greater reliance on maladaptive coping strategies such as rumination and suppression.¹⁵ Rumination has been shown to mediate the relationship between emotion regulation difficulties and PTSD symptom severity.¹⁶ Emotion dysregulation and psychological inflexibility are closely related processes, with cognitive fusion, a core component of psychological inflexibility, being strongly associated with emotion dysregulation and deficits in cognitive reappraisal in both clinical and non-clinical populations.¹⁷ Furthermore, studies conducted during the COVID-19 pandemic suggest that emotion dysregulation and dissociation jointly mediate the relationship between fear of COVID-19 and PTSD symptoms, particularly among individuals with pathological personality traits.^{18,19}

Despite these advances, important gaps remain in literature. Although previous studies have examined the associations between peritraumatic dissociation, psychological inflexibility, emotion dysregulation, and PTSD symptom severity, the mechanisms linking these variables remain incompletely understood. In particular, the mediating roles of psychological inflexibility and emotion dysregulation in the relationship between peritraumatic dissociation and PTSD symptom severity have received limited empirical attention. Most previous studies have examined these constructs independently or through simple bivariate associations, providing limited insight into the psychological mechanisms through which peritraumatic responses contribute to persistent PTSD symptoms. Furthermore, most available evidence has been generated from Western populations or in the context of the COVID-19 pandemic, limiting its generalizability to trauma-exposed populations in low- and middle-income countries, including Pakistan.

Therefore, the present study aimed to investigate the role of peritraumatic dissociation in PTSD symptom severity by examining both its direct and indirect relationships with psychological inflexibility and emotion dysregulation. Specifically, the study sought to:

- (1) examine the association between peritraumatic dissociation and PTSD symptom severity, including the symptom domains of re-experiencing, avoidance, and hyperarousal;
- (2) assess the associations of peritraumatic dissociation with psycho-logical inflexibility and emotional dysregulation;
- (3) determine whether psychological inflexibility and emotional dysregulation predict PTSD symptom severity; and
- (4) evaluate the mediating roles of psychological inflexibility and emotional dysregulation in the relationship between peritraumatic dissociation and PTSD symptom severity.

Hypotheses

H1: Peritraumatic dissociation will be positively associated with PTSD symptom severity and its subscales (re-experiencing, avoidance and hyperarousal).

H2: Peritraumatic dissociation will be positively associated with psychological inflexibility.

H3: Peritraumatic dissociation will be positively associated with emotional dysregulation and its subcomponents.

H4: Psychological inflexibility will significantly predict PTSD symptom severity.

H5: Emotional dysregulation will significantly predict PTSD symptom severity.

H6: Psychological inflexibility will mediate the relationship between peritraumatic dissociation and PTSD symptom severity.

METHODS

This cross-sectional study was conducted over an 11-month period, from February to December 2024, in the psychiatric departments of public and private tertiary care hospitals and outpatient mental health facilities in major cities of Punjab, Pakistan.

A total of 206 patients aged 20-40 years with a clinical diagnosis of post-traumatic stress disorder (PTSD) and at least an intermediate level of education were recruited using purposive sampling. Both male and female participants were included.

The inclusion criteria comprised individuals aged 20-40 years with a confirmed diagnosis of PTSD and a minimum educational qualification of intermediate level. Participants with comorbid psychiatric or neurological disorders, including brain lesions, a history of intracranial surgery, or any condition that could impair their ability to provide informed consent, were excluded.

Ethical approval was obtained from the Institutional Review Board (IRB) of the University of Central Punjab. Written informed consent was obtained from all participants before enrollment, and the

study was conducted in accordance with established ethical principles.

Mediation analyses were performed using the PROCESS macro developed by Andrew F. Hayes. Based on the recommendations of MacKinnon and Fritz,²⁰ who suggested that a sample size of 150–200 participants provides approximately 80% statistical power to detect indirect effects using bootstrapping methods, the sample of 206 participants was considered adequate for the present study.

Prior to conducting the mediation analysis, the assumptions for regression analysis were evaluated. Linearity, independence of observations, and multicollinearity were assessed and found to be satisfactory. The normality of residuals was also examined; however, because the mediation analysis was performed using the PROCESS macro with bootstrapping, the analysis is considered robust to violations of the normality assumption. Furthermore, no evidence of problematic multicollinearity or influential outliers was detected.

Standardized, valid and reliable research instruments were used to collect data with the help of a demographic information sheet. Peritraumatic dissociative experiences questionnaire (PDEQ) was employed to determine dissociative experiences in the traumatic events.²¹ It is an 8-item self-report scale which is used to assess depersonalization, derealization, amnesia, out-of-body experiences, and distorted time perception in trauma. The answers are noted in a 5-point Likert scale where higher scores reflect a more dissociated person. Past studies have indicated acceptable internal consistency of Cronbachs alpha of 0.74 as well as satisfactory convergent and divergent validity.²²

The acceptance and action questionnaire-II (AAQ-II) was used to measure psychological inflexibility. This scale is a 7-item scale that measures experiential avoidance and psychological inflexibility originally created by Hayes SC, et al.,²³ and then updated by Bond FW, et al.,²⁴ Increased score signifies increased psychological inflexibility, which is linked to increased psychological distress and

avoidance behaviors.¹⁹

The PTSD checklist that was used to assess the presence of post-traumatic stress symptoms was the PTSD Checklist of DSM-5 (PCL-5) which comprised 20 items rated on a 5-point Likert scale (0=not at all, 5=extremely).²⁵ The scale measures symptoms on four dimensions; re-experiencing, avoidance, negative changes in cognitions and mood, and hyperarousal. All subscales have been shown to have a strong level of internal consistency in validation studies.

The difficulties in emotion regulation scale short form (DERS-SF), which was created by Victor and Klonsky,²⁶ was used to measure emotion dysregulation. This is an 18-item scale that

measures six variables of emotional dysregulation: awareness, non-acceptance, goals, impulse, clarity, and strategies. The increased the scale score, the more is the difficulty in regulation of emotion. High score indicates high emotional dysregulation. Data were analyzed using IBM SPSS Statistics version 25. Descriptive statistics were computed for all study variables. The data were approximately normally distributed and therefore suitable for parametric analyses

RESULTS

Demographic Characteristics:

Table I show the demographic characteristics of the study participants. Most participants were

Table I: Demographic characteristics of the sample (n=206)

Variables		Frequency	Percentage
Age (years)	20-25	145	70.4
	26-30	35	17.0
	31-35	17	8.3
	36-40	9	4.4
Gender	Male	83	40.3
	Female	123	59.7
Education	Matric-Intermediate	18	8.7
	Bachelor-Master	132	64.1
	M.Phil.-PhD.	56	27.2
Occupation	Student	94	45.6
	Unemployed	33	16.0
	Employed	79	38.3
Marital Status	Married	32	15.5
	Unmarried	174	84.5
Family system	Nuclear	112	54.4
	Joint	94	45.6
Threatening Death of loved ones	Yes	95	46.1
	No	111	53.9
Near death experiences	Yes	94	45.6
	No	112	54.4
Serious Injury	Yes	124	60.2
	No	82	39.8
Witness of Traumatic event	Yes	97	47.1
	No	109	52.9
Emotional Abuse	Yes	122	59.7
	No	84	40.8
Physical Abuse	Yes	143	69.4
	No	63	30.6
Sexual Abuse	Yes	122	59.2
	No	84	40.8

Table IIa: Correlations matrix amidst main study variables (PDEQ, PCL-5, DERS-SF and AAQ-II)

S. No.	Variables	1	2	3	4
1	Peritraumatic Dissociation (PDEQ)	—	—	—	—
2	Post-traumatic stress disorder (PCL-5)	.547**	—	—	—
3	Emotion Dysregulation (DERS-SF)	.408**	.698**	—	—
4	Psychological Inflexibility (AAQ-II)	.405**	.728**	.712**	—

p<0.05*, p<0.01**, p<0.001***

Table IIb: Correlations among post-traumatic stress disorder and emotion dysregulation subscales

Variable	1	2	3	4	5	6	7	8	9	10
1. Re-experiencing	—	—	—	—	—	—	—	—	—	—
2. Avoidance	.545**	—	—	—	—	—	—	—	—	—
3. Cognitive/Mood	.689**	.574**	—	—	—	—	—	—	—	—
4. Hyperarousal	.619**	.431**	.768**	—	—	—	—	—	—	—
5. Awareness	-.181*	-.146*	-.088*	-.107*	—	—	—	—	—	—
6. Clarity	.445*	.320*	.557*	.574*	-.020	—	—	—	—	—
7. Non-acceptance	.531*	.345*	.664*	.622*	-.116	.690**	—	—	—	—
8. Goals	.472**	.324**	.516**	.519**	-.225**	.470**	.676**	—	—	—
9. Impulse	.507**	.298**	.549**	.577**	-.068	.523**	.700**	.659**	—	—
10. Strategies	.576**	.334**	.628**	.613**	-.138*	.595**	.750**	.716**	.770**	—

p<0.05*, p<0.01**, p<0.001***

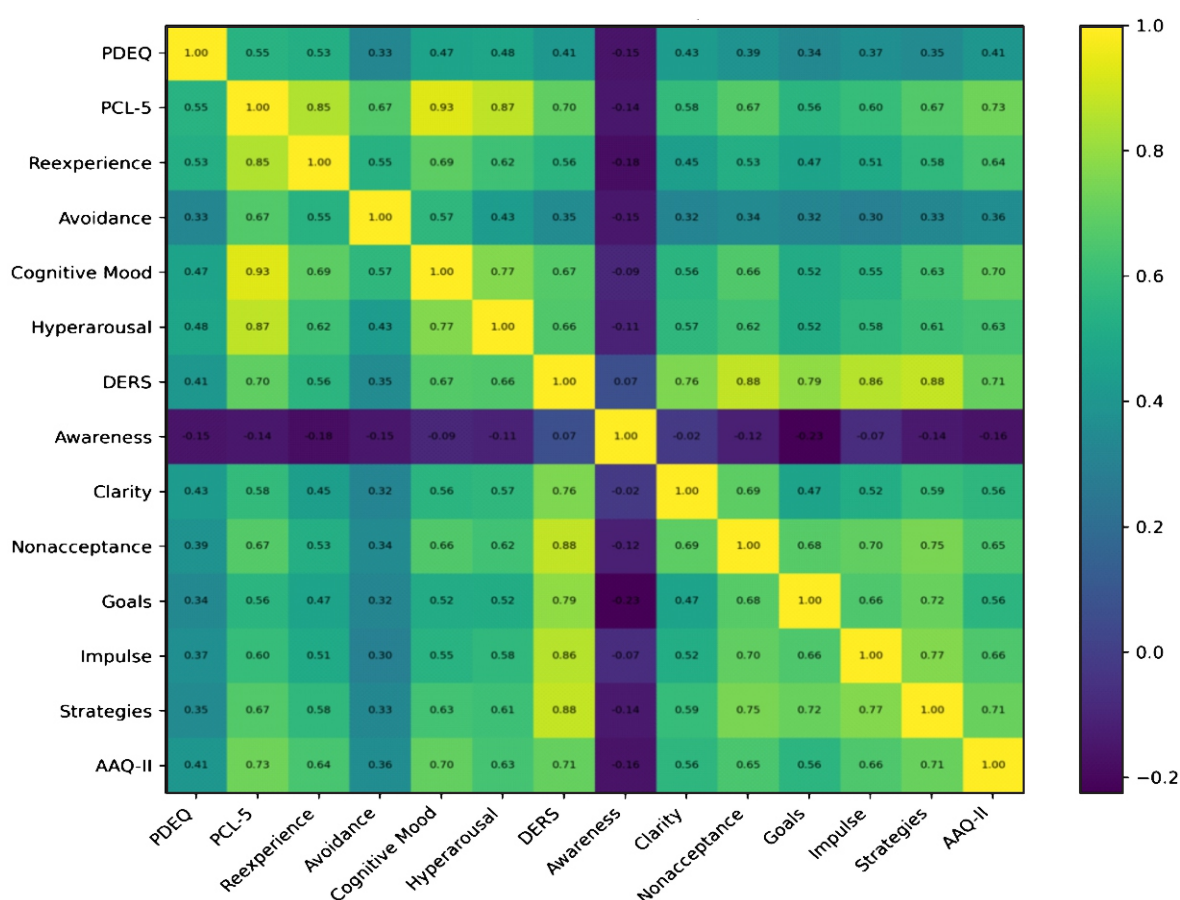


Figure 1: Correlation heat map of study variables. The color intensity represents the strength of correlations, while numerical values indicate Pearson correlation coefficients among all study variables

Table III a: Mediation analysis of emotional dysregulation in the association between peritraumatic dissociation and post-traumatic stress disorder symptoms

Variable	Predictor	B	SE	t	P	β	95% CI (LL)	95% CI (UL)
Emotional Dysregulation	Emotional Dysregulation	.857	.134	6.38	.000	.407	.592	1.12
PTSD Symptoms (PCL-5)	PTSD Symptoms (PCL-5)	.881	.141	6.25	.000	.315	.603	1.16
PTSD Symptoms (PCL-5)	PTSD Symptoms (PCL-5)	.759	.067	11.31	.000	.570	.627	.891

PTSD: post-traumatic stress disorder; PCL-5=post-traumatic stress disorder Checklist for DSM-5

Table III b: Effects of peritraumatic dissociation on emotion dysregulation subscales

Outcome Variable	B	SE	t	P	β	95% CI (LL)	95% CI (UL)
Awareness	-.066	.029	-2.23	.026	-.154	-.125	-.008
Lack of Awareness	.186	.028	6.75	.000	.427	.132	.241
Lack of Emotional Clarity	.191	.032	5.97	.000	.385	.128	.255
Non-acceptance	.171	.033	5.14	.000	.338	.105	.236
Goal-directed Difficulties	.198	.034	5.67	.000	.369	.129	.267
Impulse Control Difficulties	.175	.033	5.32	.000	.349	.110	.240
Regulation Strategies Difficulties	.857	.147	5.80	.000	.306	.566	1.14

Table IV a: Direct, indirect and total effects of peritraumatic dissociation on post-traumatic stress disorder symptoms mediated by emotional dysregulation

Effect Type	Pathway	B	SE	β	95% CI (LL)	95% CI (UL)
Total Effect	PDEQ → PCL-5	1.53	.164	.547	1.20	1.85
Direct Effect	PDEQ → PCL-5	.811	.143	.289	.528	1.09
Indirect Effect	PDEQ → DERS → PCL-5	.651	.118	.232	.428	.892

Note: PDEQ= peritraumatic dissociation; DERS=emotional dysregulation; PCL-5 = PTSD symptoms

Table IV b: Effects of emotion dysregulation subscales on post-traumatic stress disorder symptoms

Predictor	B	SE	t	P	β	95% CI (LL)	95% CI (UL)
Lack of Awareness	-.265	.310	-.854	.393	-.040	-.877	.346
Lack of Emotional Clarity	.899	.429	2.09	.037	.140	.052	1.74
Non-acceptance	2.54	.370	6.88	.000	.452	1.81	3.28
Goal-directed Difficulties	.458	.381	1.20	.231	.082	-.294	1.21
Impulse Control Difficulties	.536	.395	1.35	.176	.102	-.242	1.31
Regulation Strategies Difficulties	2.28	.450	5.07	.000	.410	1.39	3.17

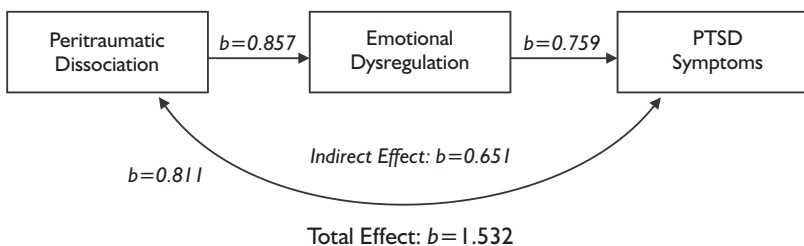


Figure 2. Mediation model showing emotional dysregulation as a mediator in the relationship between peritraumatic dissociation and PTSD symptoms. The total effect of peritraumatic dissociation on PTSD symptoms was significant ($b=1.532$), with a significant direct effect ($b=0.811$) and a significant indirect effect through emotional dysregulation ($b=0.651$), indicating partial mediation.

aged 20–25 years (70.4%), followed by those aged 26–30 years (17.0%). Females constituted 59.7% of the

sample. Most participants were unmarried (84.5%). Regarding educational attainment, 64.1% were

graduates, while 27.2% had postgraduate or doctoral qualifications. In terms of occupation, 45.6% were students and 38.3% were employed.

With respect to trauma exposure, 47.1% of participants reported witnessing a traumatic event, and 46.1% had experienced a life-threatening event involving a loved one. Histories of emotional, physical, and sexual abuse were reported by 59.7%, 69.4%, and 59.2% of participants, respectively.

Correlation Findings: Pearson's correlation analysis (Tables IIa and IIb)

Table V a: Mediation analysis of the relationship between peritraumatic dissociative experiences and post-traumatic stress disorder symptoms with psychological inflexibility

Outcome Variable	Predictor Variable	B	SE	t	P	β	95% CI (LL)	95% CI (UL)
Psychological Inflexibility	Peritraumatic dissociation	0.662	0.104	6.32	.000	0.404	0.456	0.869
PCL-5 (PTSD Symptoms)	Peritraumatic dissociation	0.846	0.134	6.27	.000	0.302	0.580	1.11
PCL-5 (PTSD Symptoms)	Psychological Inflexibility	1.03	0.082	12.50	.000	0.605	0.872	1.19

Table V b: Indirect effects of emotional dysregulation subscales on the association between peritraumatic dissociation and PTSD symptoms (bootstrapping analysis)

Indirect Path	B	SE	β	95% CI (LL)	95% CI (UL)
PDEQ → Awareness → PCL-5	.010	.025	.003	-.034	.070
PDEQ → Clarity → PCL-5	.118	.086	.042	-.043	.300
PDEQ → Non-acceptance → PCL-5	.255	.108	.091	.068	.481
PDEQ → Goals → PCL-5	.020	.067	.007	-.111	.158
PDEQ → Impulse → PCL-5	.048	.088	.017	-.135	.224
PDEQ → Strategies → PCL-5	.269	.101	.096	.091	.493

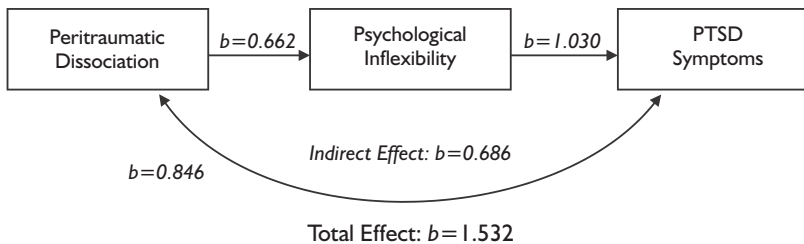


Figure 3: Mediation model showing psychological inflexibility as a mediator in the relationship between peritraumatic dissociation and PTSD symptoms. The total effect was significant ($b=1.532$), with a significant direct effect ($b=0.846$) and a significant indirect effect ($b=0.686$), indicating partial mediation.

demonstrated significant positive associations among the main study variables. Peritraumatic dissociation was moderately correlated with PTSD symptom severity ($r=0.547$, $p<0.001$) and showed moderate positive correlations with emotional dysregulation ($r=0.408$, $p<0.001$) and psychological inflexibility ($r=0.405$, $p<0.001$). PTSD symptom severity exhibited strong positive correlations with emotional dysregulation ($r=0.698$, $p<0.001$) and psychological inflexibility ($r=0.728$, $p<0.001$). Emotional dysregulation was also strongly associated with psychological inflexibility ($r=0.712$, $p<0.001$).

At the subscale level (Table IIb), all PTSD symptom domains (re-experiencing, avoidance, cognitive/mood alterations, and hyperarousal) showed significant positive correlations with most domains of emotional dysre-

gulation. The strongest associations were observed for non-acceptance of emotional responses, limited access to emotion regulation strategies, impulse control difficulties, and difficulties engaging in goal-directed behavior. In contrast, the awareness subscale demonstrated weak negative or non-significant correlations with the PTSD symptom domains and other emotional dysregulation subscales.

Mediation: Emotional Dysregulation Model: The mediating role of emotional dysregulation in the relationship between peritraumatic dissociation and PTSD symptoms was examined using PROCESS macro with bootstrapping. As shown in Table IIIa, peritraumatic dissociation significantly predicted emotional dysregulation ($B=0.857$, $\beta=0.407$, $p<0.001$). Furthermore, both peritraumatic dissociation ($B=0.881$, $\beta=0.315$,

$p<0.001$) and emotional dysregulation ($B=0.759$, $\beta=0.570$, $p<0.001$) were significant predictors of PTSD symptoms.

The associations between peritraumatic dissociation and the emotional dysregulation subdomains are presented in Table IIIb. Peritraumatic dissociation showed significant positive associations with lack of emotional awareness, lack of emotional clarity, non-acceptance, goal-directed difficulties, impulse control difficulties, and limited access to emotion regulation strategies, whereas emotional awareness demonstrated a weak negative association.

The associations between peritraumatic dissociation and the emotional dysregulation subdomains are presented in Table IIIb. Peritraumatic dissociation negatively influenced awareness ($B=-0.06$, $\beta=-0.15$, $p<0.26$) and positively influenced the lack of emotional clarity, non-acceptance, difficulties in goal directed behavior, difficulties in impulse control and difficulties in emotional regulation strategies. The results of the direct effect of peritraumatic dissociation on PTSD symptoms, controlling for emotional dysregulation shows a significant relationship with a coefficient ($B=0.81$, $\beta=0.289$, $p<0.001$). And in contrast, indirect effect shows that emotional dysregulation significantly mediate the

relationship between peritraumatic dissociation and PTSD symptoms ($B=0.651$, $\beta=0.23$, $p<.001$). Results suggest that emotional dysregulation explained 23% of relationship between peritraumatic dissociation and PTSD symptoms.

On sub-scales levels, it revealed significant mediation between non-acceptance and difficulties in emotional regulation strategies but in contrast didn't show significant mediation at lack of awareness, lack of emotional clarity, difficulties in goals and difficulties in impulse control. Overall, the total effect which includes both direct and indirect effects was also significant with a coefficient ($B=1.533$, $\beta=0.54$, $p<.001$).

Mediation: Psychological Inflexibility Model: Mediation analysis was conducted to investigate the mediating role of psychological inflexibility in the relationship between PD and PTSD symptoms. The results of the direct effect of PD on PTSD symptoms, controlling psychological inflexibility showed a significant relationship with a coefficient ($B=0.84$, $\beta=0.30$, $p<.001$). Indirect effect also showed that psychological inflexibility effect is significant and support the mediation hypothesis ($B=0.68$, $\beta=0.24$). Overall, the total effect which includes both direct and indirect effects was also significant with a coefficient ($B=1.53$, $\beta=0.54$, $p<.001$). Hence, it is proved that psychological inflexibility is a significant mediator as it accounted for 24% variance between the relationship of peritraumatic dissociation and PTSD symptom.

DISCUSSION

The current research investigated the association between PD, symptom severity of PTSD, psychological inflexibility, and emotional dysregulation. The results proved that all the subscales of PTSD symptoms such as re-experiencing, avoidance, and hyperarousal were significantly related to peritraumatic dissociation. Among them, PD accounted for a significant percentage of variance in re-experiencing symptoms (28%),

meaning that it plays a strong role in intrusive trauma-related memories. Conversely, there was a less significant yet significant correlation with avoidance symptoms (10% variance explained). In addition, PD became an important predictor of psychological inflexibility and emotional dysregulation with 17% and 24% of the variance, respectively. Mediation analysis also showed that psychological inflexibility was partially in between the relationship between PD and the severity of PTSD symptoms indicating that there is an indirect route through which the trauma related dissociation leads to the outcomes of PTSD.

Such results are in line with the current literature that highlights the key role of peritraumatic dissociation in the genesis and persistence of PTSD symptoms. According to Hagenaars MA, et al., (2008), the problem of dissociation during a traumatic event disrupts the encoding of traumatic memories, therefore, enhancing the intrusive recollections.²⁷ This memory-processing disruption model is supported by the strong association that was found between PD and re-experiencing symptoms in the current study.

Equally, the lesser correlation between PD and avoidance symptoms is consistent with previous studies indicating that avoidance behaviors are affected by a number of cognitive and emotional factors, other than dissociation. Nevertheless, avoidance is clinical because it helps to perpetuate PTSD due to the inability to process trauma emotionally.

The current results also build on past studies by showing that PD is highly linked with psychological inflexibility. Similar results were also obtained by Tull M, et al., (2007),²⁸ who realized that people with PTSD tend to develop inflexible cognitive and emotional behaviors, which perpetuate the severity of symptoms. Psychological inflexibility seems to serve as an important process that inhibits adaptive emotional trauma processing.

In addition, PD was strongly correlated with emotional dysregulation in this

research, which is consistent with the evidence provided by Cloitre M, et al., (2005),²⁹ who emphasized that victims of traumas tend to have a problem with recognizing, perceiving, and regulating emotions. The negative correlation between PD and emotional awareness is also observed, which is an additional indication that dissociation can lead to dysregulation as it may result in impaired emotional recognition.

The findings of this study have important clinical implications. First, they emphasize the importance of peritraumatic dissociation as one of the main risk factors of the severity of PTSD in early life, indicating that early recognition of dissociative experiences following trauma might help in screening high-risk groups.

Second, psychological inflexibility is strong, meaning that such interventions as acceptance and commitment therapy (ACT), which address cognitive rigidity and encourage psychological flexibility, could be especially effective in the trauma-focused therapy. Enhancing emotional awareness and emotional regulation skills can also help to decrease the severity of symptoms and increase recovery outcomes.

Lastly, the mediation effect indicates that psychological inflexibility could be minimized to lessen the effects of peritraumatic dissociation on PTSD symptoms, which is a potential therapeutic direction of intervention.

This study has several limitations. First, its cross-sectional design precludes establishing causal relationships among peritraumatic dissociation, psychological inflexibility, emotional dysregulation, and PTSD symptoms. Longitudinal studies are needed to clarify the temporal sequence of these associations. Second, the use of self-report instruments may have introduced recall and response biases, particularly in the assessment of traumatic experiences and psychological symptoms. Future studies should incorporate clinician-administered diagnostic interviews and objective behavioral measures to improve diagnostic accuracy. Third, the study

sample may not be representative of all trauma-exposed populations, limiting the generalizability of the findings. Future research employing longitudinal designs, multimethod assessments, and more diverse and representative samples is recommended to validate and extend these findings.

CONCLUSION

To sum up, the current research proves that peritraumatic dissociation is an important predictor of the severity of symptoms of PTSD and is closely linked with psychological inflexibility and emotional dysregulation. Notably, psychological inflexibility partially mediates this relationship, which implies that cognitive inflexibility is a prominent factor in sustaining distress associated with trauma. The results of this research can be used to understand the cognitive-emotional mechanisms of PTSD better and point out possible areas of focus in psychological intervention.

IMPLICATIONS

- This research provides guidelines for psychologists to develop and implement treatment plan with integrated therapies (e.g., ACT, CBT, DBT) that simultaneously address dissociation, emotional dysregulation, and inflexibility.
- This research is also useful for the psychiatrists in such a way that medications to stabilize emotions and reduce dissociative symptoms, enhancing the effectiveness of psychotherapy.
- This research has the potential to educate and empower patients to understand their symptoms and engage in skill-based therapies to build emotional and cognitive resilience.

Future directions

Further studies are needed that are longitudinal in nature to study how peritraumatic dissociation changes over time and adds to the development of chronic PTSD. Moreover, there is a need to conduct experimental and intervention-based research to test the

hypothesis of whether psychological flexibility can be increased to minimize symptoms of the PTSD in highly dissociative individuals.

More mediators and moderators (resilience, coping strategies and social support) should also be investigated to create a more detailed model of PTSD development. Increasing the research to clinical and culturally diverse groups will also make the results more general and applicable.

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AUTHORS' CONTRIBUTION

The following authors have made substantial contributions to the manuscript as under:

LKD & HS: Conception and study design, acquisition, analysis and interpretation of data, drafting the manuscript, critical review, approval of the final version to be published

Authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

CONFLICT OF INTEREST

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KMUJ web address: www.kmuj.kmu.edu.pk
Email address: kmuj@kmuj.kmu.edu.pk