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BRIEF REPORT

The protective role of social support against dissociative symptoms: Longitudinal findings from two international survey projects

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Abstract

Background Dissociative symptoms are prevalent and disabling, but little is known about what factors can longitudinally predict dissociative symptoms. This study examined the protective role of perceived social support against dissociative symptoms.

Methods We analyzed data from the International Dissociative Depression Survey Project ($N=152$) and the International Female Mental Health Survey Project ($N=293$). In both samples, participants completed validated measures of dissociative symptoms and perceived social support at baseline, and then reported their dissociative symptoms after approximately 6 to 12 months. We tested the hypothesis that perceived social support would predict subsequent dissociative symptoms in each sample and see whether the results could be replicated across different samples.

Results After controlling for demographic variables, childhood trauma, and baseline dissociative symptoms, baseline perceived social support was significantly associated with fewer dissociative symptoms at follow-up ($\beta = -0.129$ to -0.198, $p = .001$). The results were replicated across the two samples.

Conclusion This study contributes to the very limited literature on the longitudinal predictors of dissociative symptoms. Our results point to the critical role of social-interpersonal and family interventions in preventing and treating dissociative symptoms.

Keywords Dissociation · Dissociative disorders · Social support · Family support · Social psychiatry

Dissociation refers to failures in the process of integrating one's own psychophysiological experiences (e.g., memories, emotions, behaviors, identities; [30, 35]) and is recognized in both ICD-11 [36] and DSM-5-TR (American Psychiatric Association [1]), . The clinical manifestations of dissociation include but are not limited to amnesia, depersonalization, derealization, dissociative intrusions and flashbacks, and dissociative identities [8]. Dissociation is the core feature of Dissociative Disorders while it is also a transdiagnostic symptom that affects people with different psychiatric diagnoses [25]. Dissociative symptoms are prevalent (e.g., 11.4% of college students meet the diagnostic criteria for a Dissociative Disorder) [17], persistent (e.g., 63.6% in a 9-month follow-up study) [11], and disabling, causing considerable individual suffering and social-medical costs [14]. Dissociative symptoms are associated with poorer responses to psychiatric treatments across diagnoses [2, 32]. In addition, the impairment scores were 50% higher among patients with Dissociative Disorders than those with the other psychiatric diagnoses and that patients with Dissociative Disorders typically have lower global assessment of functioning scores [3]. Therefore, it is crucial to identify modifiable predictors of dissociation in order to inform prevention and early intervention strategies.

Currently, many factors have been proposed to be associated with dissociation, such as trauma, poor sleep, lack of

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emotional regulation capabilities, dysfunctional coping, the tendency for fantasy, and the ability to get into a hypnotic status [9, 20, 24]. However, most studies exploring these factors relied on cross-sectional data. Without longitudinal data, our understanding of the predictive strength of these hypothesized factors remains limited. Beyond childhood adversities [27] and coping (e.g., dysfunctional coping predicted subsequent levels of dissociative symptoms) [19], very little is known about other factors that can longitudinally predict dissociative symptoms.

In this study, we examined whether perceived social support would be a significant predictor of subsequent levels of dissociative symptoms. Dissociation is often conceptualized as a (mal)adaptive coping mechanism for trauma and stress, particularly interpersonal in nature, serving as a mental escape when physical escape is not feasible [10]. According to social support theory [21], social support is beneficial to well-being in multiple ways: for instance emotional support offers empathy and care, and thus provides comfort. In addition, social support can help the individual to better cope with stressors and difficulties (e.g., by providing a role model, or offering more tangible resources), which in turn may reduce emotional problems [37]. If a supportive person is present, providing emotional support and a safe space for the individual to express and process emotions through conversation and seek comfort, dissociation may no longer be necessary even under trauma and stress. It has been found that perceived support from an informal caregiver (e.g., a family member or a loved one) is associated with better outcomes in people with trauma-related symptoms [12]. Social support is also a strong protective factor for other mental health problems, such as post-traumatic stress disorder and depression [33, 34], but its protective role against dissociative symptoms has not been examined in any longitudinal study. Therefore, the present study tested the hypothesis that baseline perceived social support would predict fewer dissociative symptoms at follow-up, after controlling for confounding variables and baseline levels of dissociative symptoms.

Methods

Participants

To answer the research question, we analyzed the data available from two international survey projects.

Sample 1 was recruited in the International Dissociative Depression Survey Project, which was launched in 2021. Ethical approval was obtained from the Chinese University of Hong Kong. Snowballing technique and online social media advertising were used to recruit potential participants to complete an online survey. Participants should be aged 18 to 64, agree to provide online written informed consent, be able to read and write in English, and self-report having any depressive symptoms. Participants who self-reported having immediate need for professional help, diagnosed reading disorder, dementia or intellectual disabilities, or recurrent suicidal ideation, suicidal attempts or homicidal plans in the past 2 weeks were excluded.

A total of 152 participants provided informed consent and valid responses to the survey at Time 1 (T1) and Time (T2). Most participants reported living in Canada (25.0%), Singapore (19.7%), the United States (15.8%) and United Kingdom (15.1%). At baseline, 50.7% scored 67 or above on the Multiscale Dissociation Inventory (MDI), indicating elevated clinically significant levels of dissociative symptoms [4, 5].

Sample 2 was recruited in the International Female Mental Health Survey. Launched in 2024, this project obtained ethical approval at the Leshan Normal University. In this collaborative project, our research team members from around the world recruited potential participants in clinics and affiliated community centers and through online social media advertising. To meet the inclusion criteria, participants should identify as a woman aged 18 or above, provide online written informed consent, be able to read and write in English, self-report receiving any kind of mental health services in the past 12 months, and have not been officially diagnosed with reading disorders, or any cognitive or intellectual impairments. The methodology and part of the data have been reported elsewhere [22].

A total of 293 female participants provided informed consent and valid responses to the survey at T1 and T2. Most participants reported living in Malaysia (20.1%), North America (19.8%), the Philippines (16.4%), and the United Kingdom (14.7%). More than half of participants (57.0%) reported seeing a psychiatrist in the past 12 months. At baseline, 39.9% scored 67 or above on the MDI, indicating elevated clinically significant levels of dissociative symptoms ([4]; [5]).

The sample characteristics are reported in Table 1.

Measures

In both samples, participants completed self-report measures of dissociative symptoms and perceived social support at T1 and reported their dissociative symptoms again at T2.

Dissociative symptoms were assessed using the Multiscale Dissociation Inventory (MDI), which is a standardized, normed self-report measure of six different facets of dissociation (e.g., amnesia, depersonalization, identity dissociation; [4, 5]). Participants in both samples completed the MDI, and the total score was used. A total score of 67

Table 1 Sample characteristics

Variables	Sample 1 (N=152)	Sample 2 (N=293)
Age (range)	18 to 62	18 to 64
Age (mean and SD)	M=26.18; SD=8.78	M=26.63; SD=7.21
Gender (women)	94.1%	100%
Education (bachelor's degree)	46.7%	68.9%
Use of psychiatric services	61.2% reported having received psychiatric services	57.0% reported seeing a psychiatrist in the past 12 months
Elevated (clinically significant) levels of dissociative symptoms	50.7%	39.9%

or above indicates indicating elevated clinically significant levels of dissociative symptoms [4, 5]. Higher scores indicate higher levels of overall dissociative symptoms.

Perceived social support was measured differently in the two samples. In Sample 1, the 4-item Family Support Subscale of the Multidimensional Scale of Perceived Social Support (MSPSS-FS; [6, 38] was used to assess the level of perceived social support from family members. For each item, the response options range from 1 (very strongly disagree) to 7 (very strongly agree). The mean score was calculated based on the four items. In Sample 2, seven items with highest factor loadings from the Perceived Informal Support Questionnaire (PISQ; [12] were used to assess the level of perceived social support from an informal caregiver. In particular, the instruction was as follows: "This questionnaire focuses on the support you receive from people in your social circle, such as family members, friends, partners, or peers. When answering the questions, please do not include individuals with whom you have a professional relationship, such as social workers, therapists, or doctors." For each item, the response options range from 0 (never) to 4 (always). The summed score was calculated based on the seven items. For both measures, higher scores indicate higher levels of perceived social support.

Childhood trauma was assessed using the 12-item Childhood Trauma Section of the Brief Betrayal Trauma Survey (BBTS). This is a checklist that assesses 12 different types of potentially traumatic events before the age of 18. The BBTS is a reliable and valid measure [13].

Data analysis

SPSS 22.0 was used for statistical analysis. To answer the research question, hierarchical linear regression analysis was conducted in each sample. In Step 1, we entered the possible confounding variables, including demographic variables and childhood trauma as well as T1 MDI scores to control for their effects. After that, we entered the perceived social support variable in Step 2. We examined whether the addition of perceived social support to the prediction of T2 MDI scores led to a statistically significant increase in R^2. Childhood trauma was included as a controlled variable because it is a well-known risk factor for dissociative symptoms [7, 18, 31].

Results

We first examined the predictive effects of perceived family support in Sample (1) In the hierarchical linear regression analysis, after controlling for age, gender (woman), education level (having a bachelor's degree), childhood trauma, and T1 dissociative symptoms in Step 1, we entered the MSPSS-FS score as the predictor in Step (2) We found that perceived family support was a significant predictor of T2 dissociative symptoms ($\beta = -0.198$, $p = .001$; $\Delta R^2 = 0.036$, $\Delta F = 10.526$, $p = .001$). In other words, higher levels of perceived family support at baseline were associated with lower levels of dissociative symptoms at follow-up.

We conducted the same analysis in Sample 2. In the first step, we controlled for age, education level (having a bachelor's degree), childhood trauma, and T1 dissociative symptoms, and then entered the PISQ score in Step 2. We found that perceived informal support was a significant predictor of T2 dissociative symptoms ($\beta = -0.129$, $p = .001$; $\Delta R^2 = 0.016$, $\Delta F = 11.005$, $p = .001$). In other words, higher levels of perceived informal support at baseline were associated with lower levels of dissociative symptoms at follow-up.

The results are summarized in Table 2, demonstrating that the results could be replicated across two different samples.

Discussion

Although dissociation is a significant public health concern because of its prevalence, persistence, and association with social and medical consequences, very little is known about what factors could longitudinally predict the levels of dissociative symptoms. This research gap limits our ability to develop targeted prevention and early interventions. In this study, we examined the predictive role of perceived social support against dissociative symptoms. Analyzing longitudinal data from two international survey projects, we found that baseline perceived family and social support

Table 2 Variables predicting dissociative symptoms at Time 2 (T2) across two international samples

Variables	Sample 1 (N=152)				Sample 2 (N=293)			
	Step 1		Step 2		Step 1		Step 2	
	β	p	β	p	β	p	β	p
Age	0.127	0.050	0.145	0.021	0.011	0.800	0.009	0.831
Gender (woman)	0.049	0.420	0.059	0.325	/	/	/	/
Education level (bachelor's degree)	−0.044	0.499	−0.026	0.684	−0.017	0.687	−0.017	0.679
Childhood trauma	0.147	0.026	0.108	0.096	−0.033	0.456	−0.037	0.390
T1 Dissociative symptoms	0.618	<0.001	0.617	<0.001	0.756	<0.001	0.741	<0.001
T1 Perceived social support			−0.198	0.001			−0.129	0.001
R^2	0.464		0.500		0.554		0.570	
Adjust R^2	0.446		0.480		0.547		0.563	
F	25.301***		24.215***		89.315***		76.135***	
ΔR^2	0.464		0.036		0.554		0.016	
ΔF	25.301***		10.526**		89.315***		11.005**	

Notes. ** $p < .01$, *** $p < .001$

was associated with fewer dissociative symptoms at follow-up, above and beyond the effects of childhood trauma and baseline dissociative symptoms. The results are consistent across the two different samples.

This study has significant contributions to the field of study focused on dissociation because the results point to the critical role of social-interpersonal and family interventions in preventing and treating dissociative symptoms. While trauma-and dissociation-focused individual psychotherapy is the first-line treatment for post-traumatic and dissociative disorders [15, 23, 29], future studies should develop and evaluate interventions that focus on promoting social-emotional support for people with dissociative symptoms. For example, informal caregivers can be trained in skills to manage their loved ones' symptoms and foster emotional processing through active, nonjudgmental listening, thus reducing their dissociative symptoms.

This study has the strengths of replicating the findings across two independent samples, having a longitudinal design, and utilizing well-validated measures. However, this study also has some limitations. First, our samples were not representative of the clinical population; most participants were women.In addition, while our samples included participants from around the world, we only included participants who could read and write English. Therefore, the results may not be fully generalizable to other populations. We suggest that future studies should try to replicate our results in more diverse and representative samples. Second, we relied on self-reported measures. Although these measures are reliable and valid and are commonly used in epidemiological studies [16, 28], structured interviews should be added to verify the clinical status and confirm the diagnosis of the participants in future studies. Third, in this study, we measured perceived social support instead of actual social support. Perceived social support is widely measured and considered in the field, but it may be different from actual social support because the former is more subjective. A previous studies found that perceived support, instead of actual support, was associated with better mental health [26]. Future studies are needed to replicate our findings using more representative samples with data collected from different sources (e.g., interviews and information from other stakeholders). Finally, there are other possible confounding variables (e.g., socioeconomic status) we did not control for, although we controlled for childhood trauma, which is the most well-documented factor of dissociation. Despite the limitations, the present study provides important insights into the protective role of perceived social support against dissociation. We call for more social-interpersonal interventions for people with dissociative symptoms and disorders.

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Author contributions Authors' contributions: GFY and HWF contributed to the design of the International Female Mental Health Survey Project. HWF and WTC contributed to the design of the International Dissociative Depression Survey Project. HWF contributed to the conceptualization of this study, conducted data analysis, and prepared the first draft. HWF, GFY, MESR, ESJ, FM, AEZL, GD, PDB, GKK, KU, SH, NID, RN, SKKL collected data for this study. All authors critically reviewed the manuscript and contributed to the final draft of the manuscript. All authors read and approved the final manuscript.

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Data availability Data that supports the findings of this study is available from the corresponding author upon reasonable request.

Declarations

Competing interests The authors declare no competing interests.

Declarations of interest None.

Ethical statements All participants provided online written informed

consent before participation. The two studies reported in this study obtained ethical approval from the institutional review board at the Chinese University of Hong Kong and the Leshan Normal University, respectively.

Authors' contributions GFY and HWF contributed to the design of the International Female Mental Health Survey Project. HWF and WTC contributed to the design of the International Dissociative Depression Survey Project. HWF contributed to the conceptualization of this study, conducted data analysis, and prepared the first draft. HWF, GFY, MESR, ESJ, FM, AEZL, GD, PDB, GKK, KU, SH, NID, RN, SKKL collected data for this study. All authors critically reviewed the manuscript and contributed to the final draft of the manuscript. All authors read and approved the final manuscript.

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