

Childhood Trauma and Emotional Dysregulation as Predictors of Borderline Personality Symptoms Among Undergraduate University Female Students

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The present study investigated the relationship between childhood trauma, emotional dysregulation, and borderline personality symptoms among a group of undergraduate female university students. A cross-sectional correlational research design was used with a sample of 200 female students aged 18-25 years from universities in Islamabad and Rawalpindi. Standardized tests were employed including the Childhood Trauma Questionnaire (CTQ), the Difficulties in Emotion Regulation Scale (DERS), and the Borderline Personality Questionnaire (BPQ). The Pearson correlation analysis revealed that there were significant positive correlations between childhood trauma, emotional dysregulation, and borderline personality symptoms ($r = .42$ to $.54$, $p < .001$). Regression analysis indicated that the most predictive variable in borderline personality symptoms was emotional dysregulation ($\beta = .54$, $p < .001$), whereas childhood trauma also turned out to be a significant predictor ($\beta = .22$, $p < .05$). Together, childhood trauma and emotional dysregulation explained 43.4% of the variance in borderline personality symptoms. The results emphasize the necessity of trauma-informed and emotion-based interventions in undergraduate female university students

Keywords. Childhood trauma, emotional dysregulation, borderline personality symptoms, undergraduate females

Borderline Personality Disorder (BPD) is an emergent mental issue because of the multifaceted emotional, behavioral, and interpersonal challenges ([American Psychiatric Association, 2022](#)). It is imperative to understand its underlying risk factors since BPD is commonly linked to the lifetime impairment, unstable relationships,

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and self-harming behavior (Lazarus et al., 2019). Among the possible factors, early negative childhood experience, especially childhood trauma, has become the primary determinant in the development of borderline characteristics (Porter et al., 2020). This vulnerability is further reinforced by emotional dysregulation, which is the inability to control and respond to intense emotional conditions and influences the development of borderline symptoms significantly (Carpenter & Trull, 2015; Velotti et al., 2017). Women are found to be diagnosed with BPD more than men and tend to show patterns individualized regarding emotional instability and interpersonal sensitivity (Grant et al., 2015). Consequently, childhood trauma and emotional dysregulation are important variables to study concurrently to understand the influence of these variables on the acquisition of borderline personality symptoms in female students at universities. The next section gives a comprehensive description of the main variables to be studied in the current study.

Childhood Trauma

Childhood trauma is defined as any physical, sexual, and emotional abuse that interferes with the life of an individual, and results in the adoption of a coping mechanism and behaviors because of the exposure to the adverse events (Downey & Crumphy, 2022). According to existing literature, childhood trauma is commonly comorbid with such psychological traits as neuroticism and impulsiveness, which in turn contributes to the development of the traits of the borderline personality disorder and emotion dysregulation (Cattane et al., 2017; Elices et al., 2015).

Childhood Trauma as a Contributing Factor to BPD

Childhood trauma is cited as a risk factor that forms the background of the progression of BPD. According to developmental theories, early trauma interferes with the security of attachment, which results in the internal working models of fear, mistrust, and instability (D'Agostino et al., 2017). The trauma victims tend to develop incoherent self- concepts, managing emotional states, or forming healthy interpersonal relationships, all of which are domains hard hit in BPD (Cattane et al., 2017).

The studies provide consistent evidence that core borderline symptoms like affective instability, impulsivity, self-harm, and disrupted relationships are predicted by early maltreatment, particularly, emotional abuse and neglect (Jia et al., 2022; Kim et al., 2019). Unsafe sexual practices, disordered eating, substance misuse, and self-injury are typically considered high-risk behaviors observed in

survivors of childhood trauma who are trying to manage the emotionally overwhelming states (Kim et al., 2019). Multiple studies have shown that between 30 and 90 percent of people diagnosed with BPD have been exposed to serious childhood trauma, which highlights the key role of childhood trauma in the development of the disease (Cattane et al., 2017). The neurodevelopmental changes and emotional processing in the case of trauma contribute to persistent impairments in emotion regulation, which, in turn, sustain borderline symptoms (Crowell et al, 2016).

The Pakistani context contributes to some extra vulnerability. Child maltreatment, particularly emotional neglect and cruel parenting behavior, is a generally ignored or normalized issue because of cultural norms that teach obedience, silence, and family honor (Crittenden et al., 2021). Young girls can be subjected to gender discrimination, emotional oppression, or limited freedom, which can lead to emotional hardships in the long-term. Because no one in the Pakistani culture is encouraged to report trauma, most Pakistani women experience unresolved emotional pain during childhood, which can lead to emotional dysregulation and borderline behavior as adults. Pakistani research has revealed that childhood emotional maltreatment is strongly correlated with emotional dysregulation, which requires the exploration of these pathways (Ali & Yousaf, 2022).

Emotional Dysregulation

Emotional dysregulation is the inability to recognize, to perceive, and to accept emotions, as well as to make appropriate use of adaptive strategies to alter the intensity and duration of emotions. It is also linked to problems of overcoming impulsivity and goal-oriented behavior under emotional distress (Weiss et al., 2021). In general, it is a manifestation of emotional experiences or expressions that disrupt productive activity (Beauchaine, 2015).

A study emphasizes that emotional dysregulation is a result of inadequate emotional reactions and unsynchronized emotional processes such as overpowering responses and lack of stability. Or chronic activation that eventually undermines the achievement of goals (Cole et al., 2017). In the same manner, another study defines it as an incapability to perform fundamental regulation functions to an extent that substantially alters general functioning (Bunford et al., 2015).

Emotional Dysregulation as Transdiagnostic Construct

Emotional dysregulation is commonly considered a trans diagnostic risk factor that is attributed to many psychological

conditions, especially to internalizing issues (Aldao et al., 2016; Cai et al., 2018). It is the dysfunctional processing of internal or external stimuli because of the disrupted processes of emotion regulation (Sebastian et al., 2019). It is known to manifest clinically as hyper arousal, emotional instability, impulsiveness, aggression, and temper outbursts (Tonacci et al., 2019) and is often accompanied by anxiety, self-harm, PTSD, BPD, and bipolar disorders (Gratz et al., 2017; Loevaas et al., 2018).

A study also confirms its trans diagnostic applicability by demonstrating that these patterns of mood instability which are a key characteristic of emotional dysregulation are similar among pregnant and non-pregnant women, despite the variation in daily mood fluctuations (Stevens et al., 2023). Emotion dysregulation is a set of maladaptive mechanisms to understand or respond to emotions (Gratz et al., 2017) and occurs across several disorders. A study established that women with ADHD, BPD, or both conditions were highly emotionally unstable than the healthy controls, with the latter exhibiting the worst disability (Moukhtarian et al., 2021).

Moreover, specific maladaptive patterns of rumination and catastrophizing (Van Rheenen et al., 2015), and increased impulsiveness and suicide vulnerability due to sleep disturbance (Palagini et al., 2019) are also used by the patients with bipolar disorder. Emotional uncontrollability is fundamental in PTSD, which contributes to long-term hypervigilance, emotional numbing, and irritability after trauma (Fitzgerald et al., 2018; Muñoz-Rivas et al., 2021).

Borderline Personality Disorder (BPD)

BPD is a pattern of behavior and emotion that is characterized by instability, a pattern of unstable and intense relationships, intense visceral affect, and self-destructive behaviors (American Psychiatric Association, 2022). BPD symptoms manifest themselves in the early stages of adulthood resulting in gross disabilities in social interactions and affecting occupational and academic performance. The studies indicate that BPD symptoms persist in adulthood since the emotional dysregulation and problems with others are likely to persist despite the alleviation of some of the symptoms (Lazarus et al., 2019). The disorder became part of DSM-III released in 1980 which was used as a reference point in classifying personality disorders.

Symptom Complexity and Expression of BPD

Borderline Personality Disorder (BPD) has a complex and fluctuating symptom pattern which affects emotional, behavioral, and interpersonal functioning. Among the most salient characteristics is labile interpersonal relationships that are characterized by severe oscillations between idealization and devaluation, popularly referred to as splitting (Lazarus et al., 2019). People with BPD tend to experience problems in the stability of relationships as little disagreements or perceived insults can provoke emotional outbursts and intense changes in their perception of other people.

Another symptom common to BPD is fear of being abandoned, where the individual is highly anxious and acutely disturbed due to fear of being left alone or rejected. This can result in excessive reassurance seeking, clinginess, or driving others to find out the stability of relationships (Lazarus et al., 2019).

Another fundamental area is impulsivity, which is often manifested in destructive behavior, including drug and alcohol abuse, driving under the influence, eating disorder, unsafe sex, and self-harm. Such actions alleviate emotional stress in the short term but lead to a more permanent state of instability and distress (Gunderson et al., 2018). To many people, self-harming behaviors are an effort to control overpowering emotions or to be able to control them again.

The existence of interpersonal stress or perceived rejection is also an additional cause of rapid and intense changes in emotion commonly experienced during BPD (Unoka et al., 2021). People complain about the persistent nature of emptiness and an unbalanced sense of self, being both worthless and momentarily grandiose, which interferes with the process of identity formation and the long-term planning of goals (Carpenter & Trull, 2015).

According to recent studies, BPD people might also show disturbed physiological reactions to stress, such as decreased parasympathetic activity during social rejection, which further leads to increased perceived threat and problems with emotional processing (Kulakova et al., 2023). Moreover, dissociation and temporary paranoid ideation usually manifest themselves during episodes of high emotional arousal and make it difficult to function in everyday life (American Psychiatric Association, 2022).

All in all, this cluster of symptoms has a strong influence on social, academic, and occupational functioning. The complexity and expression of BPD symptoms are crucial to understand and, thus, to create specific and culturally relevant interventions.

Gender Differences and Prevalence of BPD

Borderline personality disorder (BPD) is estimated in the range of 1.6%-5.9% of the world population (DSM-5-TR, 2022). The prevalence is a bit lower in community samples and a bit higher in clinical with 3%-5% of outpatient and 9%-15% of inpatient satisfying diagnostic criteria (Gunderson et al., 2018). There are prominent gender differences in BPD, and around 75% of cases that are identified are among women (Ellison et al., 2018). Some studies also suggest higher rates among vulnerable female populations; in China, 10.6% of incarcerated women had the criteria of BPD, and among the risk factors: younger age, higher education, substance use, and psychiatric comorbidity (Zhu et al., 2024). The symptom expression can also be a source of gender disparities as men with BPD express externalizing behaviors more often including aggression that may result in a different diagnosis, e.g., antisocial personality disorder (Pagura et al., 2016).

The empirical evidence in Pakistan is still limited. The highest reported prevalence among psychiatric patients was 30.8% in one outpatient study (Saleem et al., 2019), whereas university and community studies tend to measure borderline characteristics instead of complete diagnoses because they use screening tools (Zareen & Ashraf, 2021). Nevertheless, the prevalence of mental health stigma, low help-seeking and the lack of national epidemiological surveys imply that the actual prevalence of BPD in Pakistan remains unknown. This disparity highlights the importance of targeted study, particularly in the group of female university students who might have serious emotional problems but are not diagnosed and treated accordingly.

Indigenous Research

Research conducted in Pakistan indicates that borderline personality disorder (BPD) has emerged as a significant mental health concern among adolescents and young adults, particularly within educational and clinical settings.

A cross-sectional study was carried out among 700 undergraduate students at the private universities in Lahore, and the results revealed that 62% of students had symptoms of BPD, with a greater proportion of female students. They highlighted the importance of early screening and intervention in institutions of higher learning, especially because most of the affected students were 18-22 years and had middle socioeconomic statuses (Hayee et al., 2021).

A study analyzed a cohort of 300 adolescents (13-18 years) in Lahore and found out that the emotional dysregulation was closely

linked with childhood emotional abuse and neglect, which predisposed them to borderline traits. Their results also emphasize the significance of trauma-informed interventions done early to avoid emotional and personality challenges in the future.

Equally, a longitudinal study involving 200 adolescents attending psychiatric outpatient departments in Pakistan reported that exposure to early childhood trauma was associated with the development of significantly higher BPD symptoms than other adolescents who were not exposed. The paper highlights childhood trauma as one of the major risk factors of BPD and demands special trauma-oriented care in the clinical setting (Iqbal et al., 2023).

Conclusively, these findings collectively demonstrate that borderline personality disorder among Pakistani adolescents and young adults is strongly associated with emotional dysregulation and early childhood trauma, underscoring the urgent need for early screening, trauma-informed interventions, and targeted mental health services within educational and clinical settings.

Rationale

Pakistan is experiencing an increase in mental illnesses but personality disorders; especially BPD is underdiagnosed and under researched, especially in women. Many females cannot express distress or seek psychological help due to cultural stigma, poor awareness, and limited access to such services (Khan & Kamal, 2017; Mirza & Jenkins, 2004).

Childhood trauma is also strongly underreported because brutal parenting, emotional neglect, and discrimination based on gender tend to be normalized. These experiences put young women at risk of emotional dysregulation and subsequent emergence of borderline personality symptoms, yet little Pakistani research has examined this relationship (Crittenden et al., 2021).

Undergraduate female students present a vulnerable group that is neglected. Developing identity, academic demands, and growing autonomy may worsen the effects of early trauma and emotional issues at this stage of development (Bruffaerts et al., 2018). To make it worse, various universities do not offer sufficient mental health screening or counselling services, and young women must grapple with emotional instability and interpersonal issues without assistance (Otway et al., 2021).

With these loopholes, culturally based studies are needed because the findings in the West cannot be completely applied to Pakistan

because sociocultural and family factors are different. Thus, this paper intends to examine the role of childhood trauma and emotional dysregulation in causing BPD symptoms in Pakistani undergraduate women.

Hypotheses

1. There will be a positive relationship between childhood trauma, emotional dysregulation, and borderline personality symptoms.
2. Childhood trauma will have a positive association with borderline personality symptoms.
3. Emotional dysregulation will have a positive impact on borderline personality symptoms.
4. Childhood trauma and emotional dysregulation will have a positive impact on borderline personality symptoms.

Method

Research Design

The current study employed a quantitative correlational research design to examine the relationships between childhood trauma, emotional dysregulation, and borderline personality symptoms. Such design is consistent with the past research that examines the same variables in young adults (e.g., [Cattane et al., 2017](#); [Gratz & Roemer, 2004](#)), which will enable the ability to compare the findings with existing empirical patterns.

Participants

The sample size was 200 undergraduate students (female) who were aged between 18-25 years and purposely selected in both the public and the private universities at Islamabad and Rawalpindi.

The age group of 18-25 years was chosen because of two favorable reasons. First, this interval reflects the regular and typical age group of undergraduate students in Pakistan where most students join the university right after their intermediate level education (age 17-18) and usually complete their degrees between the ages of 22 and 24. Thus, selecting participants aged 18–25 allows the sample to accurately represent the undergraduate population in general.

Second, it is the time when late adolescence turns into a stage of emerging adulthood with a higher degree of emotional vulnerability,

identity formation, and sensitivity to the impact of childhood trauma. According to previous studies, emotional dysregulation symptoms and borderline personality characteristics tend to be increased or more noticeable in this age, that is why it is a suitable development stage to study psychological outcomes of traumas ([Bakermans-Kranenburg & Van Ijzendoorn, 2016](#); [Lazarus et al., 2019](#)).

Inclusion Criteria

1. The sample only comprised of female students who were pursuing undergraduate courses in universities within Islamabad and Rawalpindi.
2. The participants had to be within the age bracket of 18 to 25 years because it is the average age of undergraduate students in Pakistan.
3. Students that could read and comprehend questionnaire statements in English were incorporated as all the study tools were given in English.
4. Only participants who voluntarily agreed to take part in the study and provided informed consent were included.

Exclusion Criteria

1. Male students were not included in the research to ensure that the study was more specific on the psychological variables among the female undergraduate students.
2. Students who were above 25 years of age (female) were not included because this is not the normal age group of a student in Pakistan undergraduate.
3. People who claimed to have a diagnosed psychiatric disorder or severe physical/neurological disorder (is mentioned in the demographic form) were excluded, as they might affect the emotional functioning and confound the study results.

Measures

Childhood Trauma Questionnaire (CTQ)

CTQ was developed by [Bernstein et al. \(2003\)](#). This self-report scale, which consists of 28 items, measures 5 domains of childhood trauma, namely, emotional, physical, sexual abuse, emotional neglect,

and physical neglect. Questions will be rated as to a five-point Likert scale (1= *Never True* to 5 = *Very Often True*).

The CTQ has been widely applied in international and South Asian studies with a focus on assessing childhood trauma, such as studies where it was assessed in its relationship with emotional dysregulation, depression, PTSD, and personality disorders (Cattane et al., 2017). High internal consistency has always been reported by previous research, and the values of Cronbach's alpha have been between .79 to .94 among its subscales (Bernstein et al., 2003). Meta-analytic data also justifies this range of reliability (Karos et al., 2014).

Considering its validity and reliability and because it is repeatedly used in psychological research involving trauma, the CTQ was chosen as a suitable measure when it comes to measuring childhood trauma in the proposed study.

Difficulties in Emotion Regulation Scale (DERS)

DERS was developed by Gratz and Roemer (2004). This 36-item scale assesses six aspects of emotion dysregulation, including lack of clarity, lack of awareness, impulse control difficulties, difficulties in engaging in goal-directed behavior, non-acceptance of emotional responses, and a lack of access to strategies. The responses have a five-point Likert scale (1 = *Almost Never* to 5 = *Almost Always*).

The scale has been extensively applied to both clinical and non-clinical populations, with findings demonstrating emotional dysregulation as a transdiagnostic construct across PTSD, BPD, depression, and anxiety disorders (Aldao et al., 2016; Gratz et al., 2017).

The DERS has shown good levels of internal consistency, with Cronbach's alpha values typically ranging between $\alpha = .88$ and $.93$ in earlier studies (Fowler et al., 2014; Gratz & Roemer, 2004). The DERS was suitable for the present study due to its strong psychometric properties and its relevance to symptoms of borderline personality disorder.

Borderline Personality Questionnaire (BPQ)

BPQ was developed by Poreh et al. (2006). This 80-item self-report scale is used to measure nine areas of BPD symptoms, such as impulsivity, affective instability, abandonment fears, unstable relationships, low self-esteem, self-harm / suicidality, chronic emptiness, intense anger, and brief psychotic conditions. The BPQ has been applied in research studies in the international and South Asian

states to detect BPD characteristics among adolescents, university students, and clinical samples (Iqbal et al., 2023).

The high internal consistency is reported in studies carried out in the past and the average value of Cronbach alpha is between .86 to .89 (Poreh et al., 2006). Given its coverage of a wide range of BPD symptom domains, it is an appropriate instrument for assessing borderline personality symptoms in the current study.

Procedure

Participants were contacted in classes after receiving institutional approvals and informed consent was taken. The questionnaire booklets that were used to collect the data included demographic items and the three study instruments. The participants were required to be informed of their decision to take part in the research, and they were informed of their rights to withdraw from the research, and to receive the outline of the research process and its benefits and drawbacks, and give their consent towards it, which was ultimately respected by all ethical considerations such as obtaining the consent of the authors, to use their tools, and confidentiality of the participants, and briefing/debriefing of the participants, among other things, in the process of data collection process, as well as in other processes.

Ethical Considerations

Considerations of ethics were taken seriously during the gathering of information about people who had experienced childhood trauma. To achieve informed consent, the participants were given unambiguous and not complicated information regarding the purpose, procedures, risks, and benefits of the study. The participation was self-voluntary, and it was emphasized that at any point, individuals could drop off or skip questions with no negative consequences. Since the memory of traumatic experiences might lead to emotional distress or re-traumatization, they received a trigger warning prior to emotionally challenging parts. The participants of the study were noted to express any signs of being uncomfortable during the data collection procedure and were free to take a break or pull out as they like. Anonymity was practiced, and information was kept in a safe location so that the information could remain confidential. No force or manipulation was applied or promised, and the aim of the study was explained to the participants in a manner that he or she would know what he or she would be getting out of his or her data. The participants were also made aware of the counselling services and mental health services should they be in distress. Finally, the protocol adopted was endorsed by the

Institutional Review Board (IRB) of Riphah International University to ensure that every ethical consideration was taken care of.

Results

Table 1: *Socio-Demographic Characteristics of Study Participants (N = 200)*

<i>Demographic Variables</i>		<i>n</i>	<i>%</i>
Age	18-21	119	59.5
	22-25	81	40.5
Socioeconomic Status	Lower	6	3
	Middle	176	88
	Upper	18	9
Academic Year	First year	52	26
	Second year	41	20
	Third year	60	30
	Fourth year	47	23.5

Table 1 presents the socio-demographic characteristics of the participants ($N = 200$). All participants were females. The majority (59.5%) were aged 18–21 years, while (40.5%) were aged 22–25 years. Most belonged to the middle socioeconomic class (88%), followed by the upper class (9%) and lower class (3%). The distribution of participants across academic years showed that 52 participants (26%) were in their first year, 41 participants (20%) were in their second year, 60 participants (30%) were in their third year, and 47 participants (23.5%) were in their fourth year. This indicates that third-year students formed the largest proportion of the sample.

Table 2: *Psychometric properties of Childhood Trauma Questionnaire, Difficulties in Emotion Regulation Scale, Borderline Personality Questionnaire (N = 200)*

Scales	α	M	SD	Range		Skew	Kurtosis
				Potential	Actual		
CTQ	.74	68.3	13.84	28-140	45-99	.75	.02
DERS	.82	104.35	22.69	36-180	38-165	-.26	.02
BPQ	.89	40.45	13.35	0-80	1-75	-.32	.43

Note. M = Mean, SD = Standard Deviation, α = alpha coefficients, CTQ = Childhood Trauma Questionnaire, DERS = Difficulties in Emotion Regulation Scale, BPQ = Borderline Personality Questionnaire.

Table 2 presents the psychometric properties and distribution characteristics of the three scales used in the study ($N = 200$). Childhood Trauma Questionnaire (CTQ) was reported to have a mean (M) of 68.30 and standard deviation (SD) of 13.84 with the potential range of 28- 140, an actual range of 45-99 and Cronbach alpha (α) of 0.74 indicating acceptable internal consistency. The mean (M) of the Difficulties in Emotion Regulation Scale (DERS) was 104.35 and standard deviation (SD) 22.69, whereas its potential range was 36-180, actual range was 38- 165, and Cronbach alpha (α) was =.82, indicating high internal consistency. The Borderline Personality Questionnaire (BPQ) was found to have a mean (M) of 40.45 and standard deviation (SD) of 13.35, a possible range of 0-80, an actual range of 1-75, and Cronbach alpha (α) =.89, indicating a very high internal consistency.

Table 3: *Correlation between Childhood Trauma, Emotional Dysregulation, and Borderline Personality Symptoms (N = 200)*

Variables	1	2	3
1. Childhood trauma	-	.42**	.45**
2. Emotional Dysregulation		-	.54***
3. Borderline Personality Symptoms			-

** $p < .01$; *** $p < .001$

Table 3 presents the correlation analysis among the study variables. Emotional dysregulation showed a strong positive correlation with borderline personality symptoms ($p < .001$). Childhood trauma demonstrated a moderate positive association with emotional dysregulation ($p = .007$) and borderline personality symptoms ($p = .004$). All correlations were statistically significant.

Table 4: *Effect of Childhood Trauma on Borderline Personality Symptoms Among Undergraduate University Female Students (N = 200)*

Predictor	B	β	SE	R^2	F
Constant	3.62				
Childhood Trauma	.49	.44	.16	.198	.004

Note. B = Unstandardized coefficient, β = Standardized coefficient, SE = Standard Error, R^2 = Correlation Square.

$p < .001$ ***

Table 4 presents the results of regression analysis examining the predictive value of childhood trauma on borderline personality symptoms ($N = 200$). The R^2 value of 0.198 indicates that childhood trauma explains 19.8% of the variance in borderline personality symptoms, with an F value of ($p = 0.004$). The findings reveal that childhood trauma significantly affects borderline personality symptoms.

Table 5: *Effect of Emotional Dysregulation on Borderline Personality Symptoms among Undergraduate University Female Students ($N = 200$)*

Predictor	B	β	SE	R^2	F
Constant	7.13				
Emotional Dysregulation	.31	.54	.03	.294	.000

Note. B = unstandardized coefficient, β = standardized coefficient, SE = Standard Error, R^2 = Correlation Square.

$P < .001^{***}$

Table 5 presents the regression analysis examining the predictive value of emotional dysregulation on borderline personality symptoms ($N = 200$). The R^2 value of 0.294 indicates that emotional dysregulation explains 29.4% of the variance in borderline personality symptoms, with an F value of ($p < .001$). Emotional dysregulation was a significant predictor of borderline personality symptoms.

Table 6: *Effect of Childhood Trauma and Emotional Dysregulation on Borderline Personality Symptoms among Undergraduate University Female Students ($N = 200$)*

Predictor	B	β	SE	R^2	p
Constant	15.83				
Childhood Trauma	.24	.22	.15		
Emotional Dysregulation	.38	.53	.09	.434	.000

Note. B = unstandardized coefficient, β = standardized coefficient, SE = Standard Error, R^2 = Correlation Square.

$p < .001^{***}$

Discussion

This study examined the relationship between childhood trauma, emotional dysregulation, and borderline personality symptoms among female undergraduate students. A total of 200 female participants aged 18-25 years were sampled using purposive sampling in universities

located in Islamabad and Rawalpindi. The sampling took approximately one and a half months. The primary aim was to study the relationship between early trauma experiences and emotion regulation problems as the cause of borderline personality symptoms. This research will be elaborated in the further sections of this chapter.

Main Study Constructs

The initial hypothesis was that there was a significant positive correlation between childhood trauma, emotional dysregulation, and borderline personality symptoms. Correlation analysis confirmed this hypothesis, and it demonstrated that childhood trauma was positively correlated with both emotional dysregulation and borderline traits and that emotional dysregulation was also positively correlated with borderline symptoms. These results correspond to the previous studies that found that early traumatic experiences hamper emotional regulation, making a person more prone to borderline features (Gratz et al., 2017; Krause-Utz, 2019). Cultural norms, concerns over family reputation, and the lack of an opportunity to express emotions make this connection stronger in Pakistan and can lead to internalized distress and unhealthy coping behaviors (Crittenden et al., 2021; Khan & Kamal, 2017; Mirza & Jenkins, 2004)

The second hypothesis, which claimed that childhood trauma would be a significant predictor of borderline personality symptoms, was proved by regression analysis. The meaningful contribution of childhood trauma to the variance in borderline traits indicated that greater exposure to trauma is associated with higher levels of symptoms. These results align with past research that demonstrates the significant role of emotional, physical, and sexual abuse in childhood as making the development of borderline pathology more likely (Gunderson et al., 2018; Levy et al., 2020). Low awareness, social denial, and harsh gender expectations in Pakistan do not allow victims to seek help, which only exacerbates untreated emotional discomfort and makes them susceptible to the development of borderline traits (Crittenden et al., 2021; Mirza & Jenkins, 2004).

The third hypothesis was that emotional dysregulation has a significant predictive value of borderline personality symptoms. This was supported by the results of the regression, which showed that the inability to regulate emotions is closely associated with central borderline features, including impulsivity, unstable relationships, and affective instability. The studies affirm that emotional dysregulation is a developmental process and a sustaining process of borderline symptoms (Daros et al., 2021; Weiss et al., 2021). Emotional regulation

problems in culturally restrictive settings such as Pakistan, where women tend to be under pressure to suppress emotions, are expressed as impulsive behavior, self-harm, and chronic personality dysfunction (Khan & Kamal, 2017; Otway et al., 2021).

The fourth hypothesis, which implied that childhood trauma and emotional dysregulation were both significant predictors of borderline symptoms, was strongly supported. The joint model accounted for a larger proportion of variance than either of the two predictors acting alone, and emotional dysregulation had a more significant contribution. These results support the existing evidence showing that emotional instability is caused by childhood trauma, which subsequently fosters borderline characteristics (Crowell et al., 2016; Krause-Utz, 2019). The combination of cultural consent to adversity, emotional constraints, and lack of trauma-informed care contribute to the compound effects of trauma and emotional dysregulation, which explains the need of culturally sensitive early interventions focused on managing trauma history, alongside emotional regulation ability.

Limitations and Future Recommendations

There are various limitations that should be considered in this study. Firstly, the sample consisted of female university students exclusively and non-clinical population. Though it provides significant information as to the borderline personality symptoms in this group, the fact that no males and no one in clinical populations were used restricts the generalizability of the findings to other populations. Second, the study employed self-report scales which are prone to social desirability or memory effects, or subjective interpretation of the question by the participants. This type of biases may have affected the credibility and validity of the information. Third, although the research assessed childhood trauma, there was neither a measure of severity of childhood trauma nor distinction of types of childhood trauma experiences. This lack of screening could have overlooked such key characteristics as the severity, length, and context of traumatic events, which are potentially significant causes of the borderline personality symptoms. Future research should therefore attempt to employ more heterogeneous samples, to employ multi-method assessment techniques, and to consider the variation in the severity of the trauma to provide a finer image of these associations.

Implications

The findings of this paper demonstrate the extent to which childhood trauma and emotional distress can influence the mental

framework of young women in universities. Our study indicates the necessity of early support systems in campuses by demonstrating the significant role of both these factors in causing borderline personality symptoms. These results indicate that universities would need to think about the provision of trauma-informed counselling and emotional regulation interventions that can be adjusted to the needs of female students. In a larger perspective, the work contributes to the increased awareness that mental health treatment should be based on the cultural and social realities of the victims. It provides a valuable point of departure to future research and local policy initiatives to facilitate emotional health in such populations.

Conclusion

This research explored that childhood trauma and emotional dysregulation are strongly linked to the onset and intensity of BPD symptoms among undergraduate females. The results corroborate the existing body of literature that emphasizes the importance of unresolved trauma as a stimulus of emotional and personality disorders, as well as the necessity of culturally sensitive and trauma-informed interventions. Despite limitations such as a female-only, non-clinical sample and reliance on self-reports, the study provides valuable insight into trauma-BPD mechanisms and directions for future research.

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