AMERICAN UNIVERSITY OF BEIRUT

A PRELIMINARY INVESTIGATION OF CHILDHOOD MALTREATMENT AND DISSOCIATIVE PSYCHOPATHOLOGY IN LEBANON: EXAMINING THE ROLES OF MALTREATMENT-RELATED BETRAYAL, ANGER, AND SHAME

by
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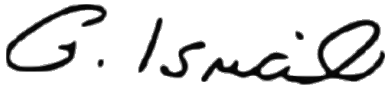

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ABSTRACT

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Title: A Preliminary Investigation of Childhood Maltreatment and Dissociative Psychopathology in Lebanon: Examining the Roles of Maltreatment-Related Betrayal, Anger, and Shame

Dissociation is an evolutionarily adaptive response that aims to protect individuals from the emotionally damaging effects of extremely distressing and inescapable experiences, such as those of childhood maltreatment (Lanius *et al.*, 2018; Levine *et al.*, 2018). The past three decades have witnessed various efforts to delineate the impact of specific maltreatment-related characteristics associated with childhood maltreatment and identify the roles of several cognitive, emotional, behavioural, and relational processes in predicting dissociative symptoms. In line with this, Dorahy (2017) proposed that in response to the betrayal trauma of childhood maltreatment, individuals may suppress their anger at the perpetrator, redirecting it into anger at the self and shame, which ultimately results in the activation of dissociative processes to preserve needed albeit threatening relationships such as those with abusive caregivers. As such, the purpose of the present study is to investigate the impact of five cognitive, emotional, and relational processes – namely, appraisals of betrayal, negative beliefs about anger, anger at the perpetrator, maltreatment-related shame, and anger at the self – over and above those of four maltreatment-related characteristics – namely, cumulative exposure to childhood maltreatment, age at onset of maltreatment, the total duration of maltreatment, and the severity of maltreatment – in the prediction of dissociative symptoms among a sample of adults who were maltreated in childhood and/or adolescence. In doing so, the present study seeks to validate Dorahy's (2017) conceptual framework on the roles of various psychological processes in the prediction of dissociative psychopathology.

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CHAPTER I

INTRODUCTION

Acts of omission of care and commission of violence against youth remain enduring issues worldwide, affecting close to 50% of children and adolescents annually across different cultures (Hillis *et al.*, 2016). In fact, a recent systematic review indicated that violence against youth is a pervasive issue across the Arab World (El-Ghossain *et al.*, 2019). In Lebanon alone, nearly two thousand suspected cases of childhood maltreatment are reported each year (himaya, 2015, 2016, 2017, 2018, 2019, 2020), although the true incidence is likely much larger than these estimates imply due to under-reporting. Childhood maltreatment has the potential to drastically alter a child's course of development, producing long-term disruptions in neurological (Hein & Monk, 2017; Paquola *et al.*, 2019), cognitive (Goodman *et al.*, 2019; Mercier *et al.*, 2018), emotional (Messman-Moore & Bhuptani, 2017; Seligowski *et al.*, 2015), physiological (Bunea *et al.*, 2017; Fogelman & Canli, 2018), medical (Baumeister *et al.*, 2016; Häuser *et al.*, 2011; Jakubowski *et al.*, 2018; Wegman & Stetler, 2009), behavioural (Angelakis *et al.*, 2019; J. Liu *et al.*, 2017; R. T. Liu, 2018, 2019; Wang *et al.*, 2019), and interpersonal functioning (Lo *et al.*, 2019). Additionally, childhood maltreatment has been consistently implicated in the development and exacerbation of various psychiatric conditions, including depressive and anxiety disorders (Gardner *et al.*, 2019; Li *et al.*, 2016), bipolar-related disorders (Agnew-Blais & Danese, 2016; Palmier-Claus *et al.*, 2016), psychotic disorders (Bailey *et al.*, 2018; Matheson *et al.*, 2013), post-traumatic stress disorder (Gardner *et al.*, 2019), eating disorders (Caslini *et al.*, 2016; Molendijk *et*

al., 2017), borderline personality disorder (Porter *et al.*, 2020), dissociative disorders (Rafiq *et al.*, 2018; Vonderlin *et al.*, 2018), and substance use disorders (Chwartzmann-Halpern *et al.*, 2018).

Early stressful life experiences can alter the epigenetic structures of specific neural circuitry underlying emotional, cognitive, and behavioural adaptation to stressful experiences later in life (Cicchetti & Rogosch, 2012; Daskalakis *et al.*, 2013). In the case of cumulative, repeated, and severe maltreatment, this adaptation may come in the form of dissociation (e.g., Dutra *et al.*, 2009; Lyons-Ruth *et al.*, 2006; Ogawa *et al.*, 1997). Dissociation is an evolutionarily adaptive response that affords humans (and other mammals) the ability to detach from extremely distressing and inescapable experiences (Lanius *et al.*, 2018; Levine *et al.*, 2018) and compartmentalise them away from conscious awareness (Freyd, 1994, 1996; Freyd & Birrell, 2013); thus, it aims to protect them from the potential emotionally damaging effects of extreme stress. Dissociation has been consistently reported among clinical (Lyssenko *et al.*, 2018) as well as non-clinical (Kate *et al.*, 2020) populations. When it is persistent, as in the case of dissociative psychopathology, it is thought to result in poorer treatment outcomes by thwarting the cognitive and emotional processing of post-traumatic reactions (Rafiq *et al.*, 2018; Schimmenti & Caretti, 2016).

While some post-traumatic sequalae arising from childhood maltreatment have been studied in Lebanon within the last decade (e.g., Naal *et al.*, 2018; Usta *et al.*, 2012), there is an evident absence of research on dissociative psychopathology within this cultural context. Dissociative psychopathology is an important post-traumatic outcome that is implicated in a broad range of disturbances in biopsychosocial functioning and further complicates the clinical presentation of an extensive array of

psychiatric conditions. Lack of awareness about the predictors and prevalence of dissociative psychopathology across different diagnostic categories may thus result in poorer responses to psychiatric medications and therapeutic interventions. For this reason, the central objective of this study is to explore the rate and predictors of dissociative psychopathology in a diverse sample of adults who were maltreated in childhood and/or adolescence.

Furthermore, since the relationship between severe childhood trauma and dissociative psychopathology was first noted by Pierre Janet and his contemporaries (van der Hart & Dorahy, 2009), a modest yet growing number of research studies have attempted to explore potential mechanisms for this relationship. For instance, one recent line of research has attempted to identify and understand the roles of cognitive, emotional, behavioural, and relational processes (e.g., trauma-related self-blame, shame, compliance, and bonding) in contributing to the prediction of dissociative psychopathology following childhood maltreatment (Feiring *et al.*, 2010; Platt *et al.*, 2017; Schimmenti, 2017). Correspondingly, another line of research has sought to delineate the roles of maltreatment-related characteristics (e.g., maltreatment source, type, timing, and impact) in predicting dissociative psychopathology (Krüger & Fletcher, 2017; Mueller-Pfeiffer *et al.*, 2013; Schalinski *et al.*, 2016; Schimmenti, 2018).

Considering the nascence of these lines of research, however, there remains a gap in the literature about the possible contributions of other clinically relevant emotional processes to the prediction of dissociation. For instance, in a recent theoretical paper that establishes the conceptual framework for this study, Dorahy (2017) theorised that reduced awareness of betrayal, reduced anger at the perpetrator, elevated anger at the self, and elevated shame all play important roles in the prediction

of dissociative psychopathology. However, no studies have, as of yet, investigated the joint contributions of these constructs over and above the contributions of maltreatment-related characteristics through a unified model comparison approach. Additionally, there appears to be an absence of research on the role of anger-related emotional processes in the prediction of dissociative psychopathology, such as negative beliefs about anger, as well as perpetrator-directed anger and self-directed anger. This is mainly due to the unsuitability of most current measures in adequately capturing these constructs.

To address these research gaps, the present study aims to situate itself amidst the two aforementioned lines of research by investigating the joint contributions of five cognitive, emotional, and relational processes (namely, appraisals of betrayal, negative beliefs about anger, anger at the perpetrator, maltreatment-related shame, and anger at the self) over and above those of four maltreatment-related characteristics (namely, cumulative exposure to childhood maltreatment, its age at onset, its average duration, and its impact) in the prediction of dissociative psychopathology among adults who were maltreated in childhood and/or adolescence.

CHAPTER II

LITERATURE REVIEW

The present chapter begins by offering an overview of dissociation followed by a review of the literature on the characteristics related to childhood maltreatment that are implicated in the prediction of dissociative psychopathology. This is then proceeded by a discussion on the roles of various psychological processes in the prediction of dissociative psychopathology, with a focus on the roles of betrayal trauma, anger, and shame.

A. Dissociation

While there is no clear consensus among researchers and clinicians on the range of phenomena that comprise the construct of "dissociation" (Cardeña, 1994; Kihlstrom, 1994), a team of British researchers (Holmes *et al.*, 2005; Brown, 2006) have proposed a coherent definition of dissociation based on their review of several prominent theories in the field (e.g., Allen, 2001; Brown, 2002; Cardeña, 1994; Putnam, 1997; van der Kolk & Fisler, 1995). They suggest that dissociation refers to a disruption of – or discontinuity in – one or more aspects of *typically integrated* neuropsychological functions associated with identity, memory, consciousness, motor control, and/or perception. According to them, this disruption consists of two qualitatively distinct yet partially interconnected forms: *detachment* and *compartmentalisation*.

Holmes *et al.* (2005), and then Brown (2006), conceptualised *detachment* as an experiential shift in awareness that represents a sense of estrangement (or disconnection) from various elements of one's emotions, sense of self, bodily

representation, and perception of the world. In particular, detachment may manifest itself in the form of commonly co-occurring symptoms of emotional numbing, depersonalisation, derealisation, and autoscopy (out-of-body experiences). Both Holmes and colleagues, as well as Brown, concur that experiences of detachment are the result of an evolutionary neurobiological *threat-response system* that aims to abate the unbearable effects of intense emotions arising in life-threatening situations. In such instances, peri-traumatic detachment is thought to lead to a deficit in integrative capacity that then fragments the encoding of trauma-related information into autobiographical memory, thus playing an important role in the development of compartmentalisation (Dorahy, 2006; Lensvelt-Mulders *et al.*, 2008).

Compartmentalisation, according to Holmes *et al.* (2005) and Brown (2006), is thus conceptualised as an experienced inability to retrieve information or control mental processes or behaviours that would typically be accessible to conscious awareness, attributable to the self, or intentionally controllable. As a result, compartmentalisation is characterised by a discontinuity in subjective experience, at times accompanied with involuntary and unsolicited intrusions into conscious awareness, as well as behaviours that are experienced as "automatic" or outside the realm of one's control. In particular, symptomatic manifestations of compartmentalisation include dissociative amnesia, identity confusion (as in dissociative fugue) and alterations (as in dissociative identity disorder [DID]), intrusions of thoughts, emotions, images, sounds, smells, tastes, and physical sensations (such as conversion symptoms, pseudo-neurological syndromes, and acute psychogenic pains, among other instances of somatoform dissociation), as well as unconscious automatic behaviours (otherwise known as automatisms).

It is suggested that compartmentalisation may be the result of a chronic dysregulation of two inter-dependent evolutionary neurobiological systems, namely the *threat-detection system* and the *psychological immune system*. The *threat-detection system* aims to monitor the environment for threat-related perceptual cues (Boyer & Bergstrom, 2011), whereas the *psychological immune system* aims to prevent exposure to these noxious stimuli through the activation of aversive emotions, cognitions, behavioural impulses, and somatic sensations (Kagan, 2006). When these systems become dysregulated, as in the case of chronic childhood maltreatment (e.g., McCrory *et al.*, 2011), they may lead to excessive monitoring of anticipated existential threat, along with radically contrasting fluctuations in the retrieval of autobiographical information, ranging from intrusive re-experiencing dissociative amnesia (for a more complete discussion on this, see Corrigan, 2014).

The above definition of dissociation builds on the concept of *désagrégation* (disintegration), first introduced by Pierre Janet near the end of the nineteenth century in his attempt to describe the disruption of the mind's integrative capacity that results in mental fragmentation across several levels of conscious awareness: from the deficit in the field of consciousness to the compromised unity of one's personality structure (van der Hart & Horst, 1989; van der Hart *et al.*, 2006). Indeed, Janet was among the first to recognise that this disruption in integrative capacity is induced by intense emotions, such as extreme terror, that are often experienced during overwhelming traumatic events (Nijenhuis, 2014; van der Hart & Rydberg, 2019). Despite having been buried by the advent of Freudian views on psychic defence in response to trauma, Janet's conception on the disintegrative effects of vehement emotions has seen an increasing resurgence over the past 50 years. This is especially evident in the American Psychiatric

Association's (APA) incorporation of his work in the revised classification of the dissociative disorders within the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM–5; APA, 2013). This is further emphasised through the APA's introduction of a *dissociative subtype* for Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD) within the DSM–5, comparable to the earlier inclusion of a dissociative symptoms criterion for Borderline Personality Disorder (BPD) within the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM–IV; APA, 1994).

While these improvements to the aforementioned diagnostic classifications are testimonial of Janet's important contributions, they do not reflect the transdiagnostic nature of dissociative experiences that occur across a wide variety of clinical presentations (e.g., see Lyssenko *et al.*, 2018; van IJzendoorn & Schuengel, 1996) and result in poorer responses to treatment (Rafiq *et al.*, 2018). To remedy this, a team of Italian researchers proposed a *Traumatic–Dissociative Dimension* (Farina & Liotti, 2013; Farina & Imperatori, 2017; Farina *et al.*, 2019) that aims to explain the relationship between childhood maltreatment and dissociative manifestations across different psychiatric disorders. In support of this dimension, Şar and Ross (2006), Şar (2014), and Soffer-Dudek (2014) have independently reviewed empirical evidence linking histories of childhood maltreatment and dissociative symptoms to various psychiatric diagnoses, and described possible mechanisms through which dissociative psychopathology may accompany a myriad of psychiatric conditions, potentially complicating diagnosis and treatment, as well as acting as a confound in neurobiological and psychopharmacological research. For these reasons, the present study seeks to

investigate dissociative psychopathology in a diverse sample of adults who may utilise mental health services for any of the DSM–5's diagnostic classifications.

B. The Role of Childhood Maltreatment Characteristics in the Prediction of Dissociative Psychopathology

Childhood maltreatment constitutes two inter-dependent dimensions of experience: *deprivation* and *threat* (McLaughlin *et al.*, 2014). McLaughlin *et al.* (2014, p. 578) define deprivation as "the absence of expected environmental inputs and complexity" and threat as "the presence of experiences that represent a threat to one's physical [and/or psychological] integrity." The World Health Organisation (WHO, 1999) further defines childhood maltreatment as the abuse and neglect of individuals under the age of eighteen, encompassing "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust, or power" (p. 16).

Several studies have sought to investigate the relationship between childhood maltreatment and dissociation as well as the specific characteristics associated with increased dissociative psychopathology. A recent review article by Vonderlin *et al.* (2018) sought to meta-analyse the results of 65 of these studies (involving a total of 7,352 traumatised individuals) that utilised the Dissociative Experiences Scale–II (DES–II; Carlson & Putnam, 1993), the most commonly used screening instrument for dissociative experiences. They found that individuals who experienced childhood maltreatment, overall, reported higher rates of dissociative experiences compared to those who did not experience childhood maltreatment. Among those who experienced

childhood emotional, physical or sexual abuse, the highest rates of dissociative experiences were reported by those who were physically and sexually abused in childhood. This is likely the result of cumulative effects of childhood maltreatment, where individuals who were physically and sexually abused in childhood also report experiencing other types of childhood maltreatment that overwhelm their self-regulatory capacities, culminating in an increasingly complex array of dissociative symptoms (e.g., Briere *et al.*, 2016; Chiu *et al.*, 2015; Steine *et al.*, 2017).

Vonderlin *et al.* (2018) also found that individuals who experienced childhood physical and emotional neglect reported higher rates of dissociative symptomatology compared to those who did not experience childhood physical and emotional neglect. This result highlights the prominent role of childhood neglect in the development and exacerbation of dissociative symptomatology (Korol, 2008; Pasquini *et al.*, 2002). Furthermore, they identified lower age of onset, longer duration, and greater frequency of all forms of childhood maltreatment by parental figures as significant predictors of higher rates of dissociative psychopathology. According to Vonderlin and colleagues, these results demonstrate the inter-related effects of a dysfunctional family environment on a child's developing brain. In particular, they suggest that chronic, repeated exposure to adverse childhood experiences by close others may lead to higher rates of functional impairment in adulthood (e.g., Maglione *et al.*, 2018; Nemeroff, 2016). However, it is worth noting that they did not include studies evaluating the impact of timing of childhood maltreatment and the victim's affiliation with the perpetrator on the pathogenesis of dissociative psychopathology.

For instance, Mueller-Pfeiffer *et al.* (2013) explored the impact of different trauma exposure characteristics (i.e., type, timing, and the victim's relationship to the

perpetrator) on dissociative experiences. Their results found that childhood maltreatment predicted an increase in dissociative symptoms over and above other forms of adverse childhood and adulthood experiences (such as family problems, loss of a family member, or serious bodily injury). More specifically, they found that dissociative experiences were significantly linked to the severity of emotional abuse and neglect as well as sexual abuse and harassment across all childhood developmental stages, irrespective of the perpetrator's relationship to the victim. Perhaps unexpectedly, Mueller-Pfeiffer *et al.* (2013) found that perifamilial- and extrafamilial-perpetrated sexual abuse (involving physical contact) predicted higher levels of dissociation than did intrafamilial-perpetrated sexual abuse. However, they postulated that an under-reporting of intrafamilial-perpetrated sexual abuse due to shame, fear, or even amnesia, otherwise referred to as *betrayal blindness* (as per Betrayal Trauma Theory, Freyd, 1994, 1996; Freyd & Birrell, 2013), may explain this result.

Schalinski *et al.* (2016) aimed to further elucidate the impact of the type and timing of adverse childhood experiences on the course and severity of dissociative symptoms. Indeed, their results indicated that earlier onset, continued recurrence, and longer duration of childhood maltreatment predicted more severe dissociative psychopathology. More so, Schalinski *et al.* (2016) found that emotional and physical neglect, as well as sexual abuse, during the pre-school and early adolescent years significantly predicted higher rates of dissociative psychopathology. They suggested that this is due to sensitive periods in the developing brain, where it is more susceptible to the presence of adverse childhood experiences. They further postulated that these windows of vulnerability overlap with critical periods of brain development involving the hippocampus, the amygdala, and the prefrontal cortex (Pechtel *et al.*, 2014; Teicher

et al., 2016; Teicher *et al.*, 2018). As such, subverting the development of these modulatory brain regions (e.g., through exposure to childhood maltreatment) during these two sensitive periods may result in the disruption of the mind's integrative capacities and retrieval processes.

Additionally, a more recent study by Schimmenti (2018) explored the role of attachment figures in the development of dissociative experiences in a non-clinical sample. His study found that adverse childhood experiences involving significant attachment figures were linked to a variety of traumatic experiences across the lifespan. More specifically, he found that childhood emotional neglect from parental figures appears to be at the core of complex traumatisation and acts as a gateway for other forms of trauma and a pathway in the development of dissociative psychopathology.

In the same study, Schimmenti (2018) also identified four classes of response severity to trauma exposure in childhood and/or adolescence. The first of which encompassed extremely traumatised individuals as it reflected the highest number of trauma exposure reported, especially beginning in early childhood, and corresponding to the highest levels of dissociative symptoms. The second class, thought to be a subset of the first, included individuals who were considered resilient to the impact of abuse as it reflected comparable levels of traumatisation yet with fewer dissociative symptoms reported. This is intriguing, especially since, much like in the first class, all participants in this class reported sexual abuse by relatives yet did not report any emotional neglect or abuse. This may suggest that the presence of emotional abuse and/or neglect may hinder resilience in the face of severe trauma and exacerbate distress. The third class found by Schimmenti (2018) constituted individuals who were exposed to impersonal and social trauma, encompassing a wide variety of extra-familial interpersonal trauma,

such as emotional neglect and emotional abuse by non-family members, as well as being a witness to trauma, and reported with mild to moderate dissociative psychopathology. Finally, the fourth class constituted non-traumatised or mildly traumatised individuals who reported a negligible or limited number of traumatic experiences coupled with the lowest number of dissociative symptoms.

Finally, to increase generalisability to the dissociative disorders, Krüger and Fletcher (2017) explored the different types of childhood maltreatment, combined with perpetrator–victim relational ties, that may be predictive of a dissociative disorder diagnosis. In their study, patients diagnosed with dissociative disorders reported a much higher incidence of childhood maltreatment compared to patients diagnosed with other psychiatric conditions, with intrafamilial-perpetrated emotional neglect presenting the strongest association with a dissociative disorder diagnosis, followed by intrafamilial-perpetrated emotional abuse, bodily threat, and sexual harassment. In addition, they reported higher frequencies of perifamilial-perpetrated emotional neglect, emotional abuse, and sexual harassment, as well as extrafamilial-perpetrated sexual harassment compared to their non-dissociative counterparts. According to Krüger and Fletcher (2017), these results provide further support for Betrayal Trauma Theory (Freyd, 1994, 1996; Freyd & Birrell, 2013), where the presence of *betrayal trauma* (i.e., the violation of an individual's trust by an indispensable caregiver) is considered pivotal in the pathogenesis of more severe dissociative psychopathology and provides an explanation to these findings.

Taken together, the findings from these studies indicate that there is an overall relationship between cumulative childhood maltreatment perpetrated by immediate

family members at different time periods, thus providing indirect support for Betrayal Trauma Theory (Freyd, 1994, 1996; Freyd & Birrell, 2013).

C. The Role of Maltreatment-Related Reactions in the Prediction of Dissociative Psychopathology

Perhaps Janet was the first among his contemporaries to theorise about the role of potentially traumatising events in evoking vehement (i.e., intense) emotions, which in their essence may induce dissociative symptoms (van der Hart & Horst, 1989; van der Hart & Dorahy, 2009). He also observed that the disorganising effects of these intense emotions are proportional to their intensity, duration, and repetition (van der Hart & Rydberg, 2019). He further noted that these emotions are not adaptive in the situations in which they occur in that they result in disruptions in a person's self-regulating capacities (van der Hart & Rydberg, 2019).

In congruence with Janet's theoretical stance and clinical observations, Dorahy (2017) put forth a conceptual framework that weaves together the various constructs under study herein and their relationships to dissociative psychopathology. More specifically, Dorahy's (2017) conceptual framework suggests that dissociation is invoked in an attempt to compartmentalise outside of conscious awareness the betrayal that is inherent in childhood maltreatment and to detach from intense emotional experiences that may be perceived as threatening to key attachment relationships in a child's life. Thus, according to Dorahy (2017), dissociation is perceived as a necessary mechanism to preserve positive mental representations of maltreating caregivers at the expense of the child's sense of self-worth. The various cognitive, emotional, and relational reactions to childhood maltreatment that were discussed by Dorahy's (2017)

conceptual framework are thus delineated in the following subsections, with a review of the literature pertaining to each of these reactions.

1. Betrayal Blindness

Betrayal trauma is a social dimension of childhood maltreatment that involves the violation of a child's *trust* within a caregiving relationship by someone who was supposed to protect the child from harm. It also involves the exploitation of a child's *dependence* on a caregiving relationship for the purpose of harming or silencing the child (Freyd, 1994, 1996; Freyd & Birrell, 2013). Under these circumstances, however, becoming fully cognisant of the betrayal that is inherent in being maltreated may be detrimental to the child's well-being. For instance, a child who recognises that his or her caregiver is being abusive or neglectful may thus be motivated to confront them or emotionally and physically distance him- or herself from them. However, both of these reactions are likely to incite a punitive response from the maltreating caregiver in an attempt to re-affirm power over the child (Johnson-Freyd & Freyd, 2013) and compromise the child's chances of survival. Since the child recognises that he or she may not have any tangible means for self-sustenance or self-defence in these likely scenarios, he or she must thus maintain the attachment with that caregiver through continued approach and engagement (Bernstein & Freyd, 2014; Gagnon *et al.*, 2017). To do this, the child must then *compartmentalise* these instances of maltreatment away from conscious awareness, causing him or her to become *blind to the betrayal* (Freyd, 1994, 1996; Freyd & Birrell, 2013).

To date, only one study explicitly explored the links between self-reported appraisals of betrayal and dissociative psychopathology. In that study, DePrince *et al.*

(2011) found that the appraisal of betrayal was a significant negative predictor of dissociative psychopathology among female survivors of intimate partner violence. In other words, they found that reduced awareness of betrayal predicted higher levels of dissociative symptomatology. This finding is consistent with previous research that found correlations between interpersonal trauma committed by close others (i.e., high-betrayal trauma) and dissociative psychopathology (e.g., Martin *et al.*, 2013; Freyd *et al.*, 2007). However, no study has, as of yet, investigated the relationship between self-reported appraisals of betrayal and dissociative psychopathology among survivors of childhood maltreatment more specifically. Additionally, none of the studies surveyed in the previous section directly measured self-reported appraisals of betrayal, instead opting to use proximal closeness (i.e., immediate family members, extended family members, and non-family members) as a proxy for betrayal trauma. To address this shortcoming and further validate the role of betrayal in predicting dissociative psychopathology among survivors of childhood maltreatment, the present study seeks to measure participants' self-reported appraisals of betrayal to more clearly delineate its role in predicting dissociative psychopathology.

2. Negative Beliefs about Anger

Anger is a self-affirming emotion that is evolutionarily necessary for survival and a natural response against perceived injustice and humiliation (F. C. Clark, 1995; Dorahy, 2017). It is provoked by anticipated or actual harm or threat to one's sense of self from another with the aim to preserve the self and defend it against such harm (Dorahy, 2017). According to Dorahy, when this harm or threat is perceived to be intentional, this contributes to the subjective experience of feeling demeaned or

violated. He further argues that the experience of anger follows the recognition that a transgressor had the capacity to refrain from causing harm or injury but chose not to exercise that capacity. While the discharge of this anger typically allows individuals to affirm their needs in the face of injustice, when its expression is perceived to pose a threat to the self (e.g., through the loss of relationships or potential retaliation), it becomes disavowed (F. C. Clark, 1995; Dorahy, 2017).

Indeed, Wells (2001) proposed that the regulation of cognitions and emotions is often guided by an individual's survival goals (e.g., eliminating vs. escaping threat) and his or her use of various cognitive strategies (e.g., threat-monitoring vs. redirecting attention) to achieve them. In the case of anger, due to heightened negative beliefs about anger as being dangerous and overpowering, anger can be perceived to be threatening to one's relationships and outside one's control (Møeller & Bech, 2019). If anger is perceived as a threat, negative beliefs about it are likely to encourage the individual to regulate anger through suppression (Møeller, 2016). In line with this, Briere (1992) observed that the "affects most likely to be dissociated or avoided seem to be those most dangerous or unacceptable during the survivor's childhood, such as anger…" (p. 120), while more recently, Stout (2002) noted that "…dissociation may involve a lifelong cordoning off and dispossession of the 'dangerous' emotion of anger." (p. 219). Indeed, this is further corroborated by Rieker and Carmen (1986), and more recently by Stein (2011, 2012), who independently observed that survivors of childhood maltreatment do not usually experience or express anger about the injustices they experienced in childhood, since to them, anger is perceived as a potentially dangerous and uncontrollable emotion.

Despite these observations, however, evidence for the relationship between negative beliefs about anger and dissociative psychopathology has mainly emerged from clinical case discussions of dissociative identity disorder (e.g., see K. R. Clark, 1993; Gullestad, 1995; Winer, 1978; Young, 1992) and its treatment (e.g., see Davenport, 1991; Hegeman & Wohl, 2000; Humphreys *et al.*, 2005). To date and to the best of our knowledge, no empirical studies exist that explore the contributions of negative beliefs about anger in predicting dissociative psychopathology. This is likely due to the absence – until recently – of adequate measures that evaluate meta-cognitive anger processing styles. It was only recently that Møeller (2016) has developed an appropriate measure that fulfils this purpose. Thus, in utilising this measure, our study would be the first to investigate this variable in predicting dissociative psychopathology.

3. Anger at the Perpetrator vs. Anger at the Self

When self-affirming anger is disavowed, attention shifts away from a focus on one's emotions, needs, and desires, and moves instead toward what appears to be necessary for the preservation of a caregiving relationship (F. C. Clark, 1995; Dorahy, 2017). According to Dorahy, this includes the preservation of a positive mental representation of the transgressing caregiver by redirecting this anger inward in response to perceiving oneself as powerless to or responsible for the transgressor's actions.

Consistent with Betrayal Trauma Theory (Freyd, 1994, 1996; Freyd & Birrell, 2013), Dorahy invokes dissociation as a potential mechanism to *compartmentalise* outside of conscious awareness any traumatic experiences that may contradict cherished beliefs about the transgressor's trustworthiness, loving nature, value, and capacity for

connection. This is further corroborated by Darlington (1997), who observed that survivors of childhood maltreatment often have a faint recognition of the transgressor's role in instigating the abuse, opting instead to hold themselves as blameworthy for having within themselves a flaw or defect that, to them, instigated, encouraged, or justified the abuse, or even prevented them from averting or terminating it. As such, anger at the perpetrator is expected to negatively predict dissociative psychopathology, while anger at the self is expected to positively predict dissociative psychopathology.

4. Maltreatment-Related Shame

Shame is an agonising self-conscious emotion that infiltrates one's entire body and encompasses one's total sense of self; it can be conceived as among the most painful of human emotions in that it can cause a person to experience a sense of failure and feel defective, fundamentally flawed, inadequate, insignificant, inferior, dirty, and unworthy of love and belonging (Kaufman, 1996; H. B. Lewis, 1971; M. Lewis 1995; Nathanson, 1992). For young children whose survival is entirely reliant on the care of a trusted other, an experienced or perceived rejection or abandonment by that other can feel extremely threatening (DeYoung, 2015; Gilbert, 2007; Kaufman, 1996). It is because of this that shame has garnered an increased interest by researchers and clinicians as a plausible mediator to explain the relationship between childhood maltreatment and the development and persistence of dissociative psychopathology. In fact, the earliest and perhaps most recognised theory linking shame and dissociation, known as the Bypassed Shame Theory (H. B. Lewis, 1971, 1995), proposes that dissociation serves as an adaptive defence mechanism that is intended to "bypass" (or

expel out of conscious awareness) the unbearable and disorganising emotion of shame, that emerges as a result of traumatic experiences.

The earliest study that investigated this theory was conducted by Irwin (1998a), who sought to expand the empirical literature on the affective predictors of dissociative experiences. Congruent with Bypassed Shame Theory (H. B. Lewis, 1971, 1995), he found that the frequency of experiencing shame significantly predicted higher rates of dissociative experiences in a non-clinical sample of university students. However, a limitation of Irwin's study is that it did not survey respondents about childhood maltreatment, which would have provided further clarification about the difference between maltreated and non-maltreated individuals in experiencing shame as a predictor of dissociative experiences.

More than a decade later, Dorahy *et al.* (2017) published the first paper that sought to experimentally examine whether there exists a direct causal relationship between elevations in shame and reactive experiences of dissociation. They found that in both non-clinical and clinical samples, participants reported higher levels of dissociative symptomatology following exposure to shame-inducing scenarios compared to neutral scenarios, independent of referential cues (i.e., private experiences of shame compared to experiences of shame in the presence of others). They also found that, within their clinical sample, dissociative experiences following shame induction were provoked by upsetting intrusions of shame-based memories. This may suggest the presence of a negative feedback loop in clinical populations where chronic dissociative psychopathology may be sustained through the interaction between acute experiences of shame and the salient shame-laden memories (e.g., Matos & Pinto-Gouveia, 2010).

While not directly stated in their paper, the findings by Dorahy *et al.* (2017) provided partial support for Bypassed Shame Theory (H. B. Lewis, 1971, 1995) at least in that dissociation functions as a defensive reaction against the potent effects of shame-inducing scenarios. However, their findings also demonstrate shortcomings of the theory, where reactive dissociation fails to protect against the noxious effects of shame when its source is internal (e.g., stemming from intrusive shame-laden memories).

To date, only two studies (Platt & Freyd, 2015, 2017) investigated the roles of both betrayal trauma and shame in predicting dissociative psychopathology. In their first study, Platt and Freyd (2015) evaluated the impact of high and low betrayal trauma on reactive shame, fear, and dissociation in response to depictions of interpersonal vs. non-interpersonal threat (e.g., image of children crying and begging vs. image of motor vehicle accident). Their results found that female university students with childhood experiences involving high betrayal trauma, compared to those with childhood experiences involving low betrayal trauma, reported an increase in both shame and dissociation, but not fear following exposure to images depicting interpersonal threat. According to Platt and Freyd (2015), this suggests that for individuals with childhood experiences high in betrayal trauma, reminders of interpersonal threat activates a complex set of biopsychosocial processes geared toward subservience and appeasement in an attempt to abate such perceived threat.

Platt and Freyd's (2017) second study aimed to more directly evaluate the assumptions of the aforementioned Bypassed Shame Theory (H. B. Lewis, 1971, 1995) in female university students with histories of betrayal trauma. They attempted to do this through experimentally inducing dissociation (for a detailed description of this, see Zoellner *et al.*, 2007). Their results demonstrated that baseline feelings of shame were

associated with higher levels of reactive dissociation following the experimental induction. However, reactive dissociation did not reduce the feelings of shame after the induction. In fact, reactive dissociation was found to be associated with even higher levels of shame post-induction. This is likely because the experimental induction may have indirectly prompted the recall of traumatic experiences, which may potentially hold negative appraisals of the self (e.g., Matos & Pinto-Gouveia, 2010). Their results mirrored those of Dorahy and colleagues (Dorahy *et al.*, 2017) mentioned above, and provide partial support for Bypassed Shame Theory (H. B. Lewis, 1971, 1995). Much like their first study (Platt and Freyd, 2015), they also found that female university students with childhood experiences high in betrayal trauma reported higher levels of baseline shame and reactive dissociation, but not fear, compared to their counterparts who had childhood experiences low in betrayal trauma. To explain this finding, they suggest that shame and dissociation interact in such a way as to obscure awareness of experienced harm and betrayal, instead redirecting attention toward the self in an attempt to preserve needed relationships through compliance and surrender.

Taken together, these studies provide some empirical evidence for Dorahy's (2017) conceptual framework on the roles of betrayal trauma and shame in predicting dissociative psychopathology; however, there remains a paucity of scientific literature that addresses these emotional processes, among others such as negative beliefs about anger, anger at the perpetrator, and anger at the self in predicting dissociative psychopathology. Thus, this study aims to add to the literature by examining the roles of these anger-related processes in the prediction of dissociative psychopathology. Additionally, this study seeks to be the first to unite two lines of research (one pertaining to maltreatment-related characteristics while the other relating to trauma-

related reactions) via a model comparison approach, after controlling for the possible therapeutic effects and socioeconomic factors. In this study, cumulative exposure to childhood maltreatment, onset of maltreatment, duration of maltreatment, and severity of maltreatment are all considered maltreatment-related characteristics, while betrayal, negative beliefs about anger, anger at the perpetrator, anger at the self, and maltreatment-related shame, are all considered maltreatment-related reactions.

CHAPTER III

AIMS AND HYPOTHESES

A. Aims

The central objective of this study is to explore the rate and predictors of dissociation among adults who were maltreated in childhood and/or adolescence. Within this broad objective, this study attempts to target two focal aims. The first aim is to establish the rate of dissociative psychopathology in a diverse sample of adults who may utilise mental health services in Lebanon, compared to the rate for those who do not. The second aim of this study is to examine the relative contributions of maltreatment-related reactions (i.e., appraisals of betrayal, negative beliefs about anger, anger at the perpetrator, anger at the self, and shame) to the prediction of dissociative psychopathology. While appraisals of betrayal and maltreatment-related shame have been studied before as predictors of dissociative psychopathology (e.g., DePrince *et al.*, 2011; Platt & Freyd, 2015, 2017), this is the first study to explore three anger-related processes (namely, negative beliefs about anger, anger at the perpetrator, and anger at the self) in predicting dissociative psychopathology. In doing so, the present study seeks to validate Dorahy's (2017) conceptual framework on the roles of various maltreatment-related reactions in the prediction of dissociative psychopathology.

B. Hypotheses

Dissociation has been shown to be prevalent across dissociative disorders, trauma- and stressor-related disorders, personality disorders, somatic symptoms and

related disorders, substance-related and addictive disorders, eating disorders, psychotic disorders, anxiety disorders, obsessive-compulsive and related disorders, depressive disorders, and bipolar and related disorders (Lyssenko *et al.*, 2018).

Hypothesis 1: The rate of dissociative symptoms will be higher across all endorsed DSM–5 diagnostic groups, compared to those who are not diagnosed with a mental health condition.

Cumulative exposure to childhood maltreatment has been found to predict higher rates of dissociative symptoms (Mueller-Pfeiffer *et al.*, 2013; Schalinski *et al.*, 2016). The length of time spent in therapy has been shown to reduce the propensity to dissociate (e.g., Brand *et al.*, 2009; Brand *et al.*, 2013; Brand & Loewenstein, 2014; Myrick *et al.*, 2017). Changes in socioeconomic status in times of economic recession have been shown to have adverse mental health outcomes (Frasquilho *et al.*, 2016; Antunes *et al.*, 2019). For these reasons, average time spent in therapy and financial distress will be considered as control variables in the testing of this study's hypotheses.

Hypothesis 2: Cumulative exposure to childhood maltreatment will positively predict dissociative symptoms after controlling for average time spent in therapy and financial distress.

Age at onset of childhood maltreatment has been found to negatively predict dissociative symptoms (Mueller-Pfeiffer *et al.*, 2013; Schalinski *et al.*, 2016).

Hypothesis 3: Age at onset of childhood maltreatment will negatively predict dissociative symptoms after controlling for average time spent in therapy and financial distress.

Chronicity of childhood maltreatment has been found to predict dissociative symptoms (Mueller-Pfeiffer *et al.*, 2013; Schalinski *et al.*, 2016).

Hypothesis 4: Average duration of childhood maltreatment will positively predict dissociative symptoms after controlling for average time spent in therapy and financial distress.

Severity of childhood maltreatment has been found to predict higher rates of dissociative symptoms (Schalinski *et al.*, 2016).

Hypothesis 5: Subjective impact of childhood maltreatment will positively predict dissociative symptoms after controlling for average time spent in therapy and financial distress.

Appraisals of betrayal have been found to negatively predict dissociative symptoms (DePrince *et al.*, 2011).

Hypothesis 6: Appraisals of betrayal will negatively predict dissociative symptoms after controlling for average time spent in therapy and financial distress.

Heightened negative beliefs about anger are theorised to induce dissociative symptoms to protect the self against experiencing anger, as it is perceived as unacceptable and threatening during one's childhood (Briere, 1992; Stout, 2002).

Hypothesis 7: Negative beliefs about anger will positively predict dissociative symptoms after controlling for average time spent in therapy and financial distress.

Anger at the perpetrator is theorised to be low in individuals who have a higher propensity to dissociative, as they attempt to preserve a positive mental representation of the maltreating caregiver (Dorahy, 2017).

Hypothesis 8: Anger at the perpetrator will negatively predict dissociative symptoms after controlling for average time spent in therapy and financial distress.

Anger at the self is theorised to be high in individuals who have a higher propensity to dissociate, as they are more likely to feel responsible for inducing or failing to halt the abuse (Dorahy, 2017).

Hypothesis 9: Anger at the self will positively predict dissociative symptoms after controlling for average time spent in therapy and financial distress.

Shame has been found to predict dissociative symptoms (Dorahy *et al.*, 2017; Irwin, 1998a).

Hypothesis 10: Maltreatment-related shame will positively predict dissociative symptoms after controlling for average time spent in therapy and financial distress.

Based on Janet's original treatise on dissociative psychopathology (cf. van der Hart & Horst, 1989; van der Hart & Dorahy, 2009; van der Hart & Rydberg, 2019), intolerable emotions resulting from childhood maltreatment are thought to play a greater role in its development and maintenance, over and above that of childhood maltreatment alone. More recent theories, building on Janet's original work, draw similar conclusions (e.g., see Freyd, 1994, 1996; Freyd & Birrell, 2013; Dorahy, 2017).

Hypothesis 11: Maltreatment-related reactions (i.e., appraisals of betrayal, negative beliefs about anger, anger at the perpetrator, anger at the self, and shame) will jointly predict dissociative psychopathology over and above maltreatment-related characteristics (i.e., cumulative occurrence, age at onset, average duration, and subjective impact), after controlling for average time spent in therapy and financial distress.

CHAPTER IV

METHODOLOGY

This Methods chapter will be divided into four subsections. First, the sample and participant characteristics will be described. Second, the psychometric properties of this study's instruments will be outlined. Third, the procedures for data collection will be delineated. Finally, the prospective data screening and analysis procedures will be reviewed.

A. Participants and Sampling Procedures

The population of interest for this study consisted of adults with histories of childhood maltreatment who are currently residing in Lebanon. In line with this, convenience sampling was used to recruit a subset of participants from this targeted population. Participants were included in this study on the basis of (a) being 18 years of age or older, (b) self-identifying as having faced abusive or traumatic experience in childhood and/or adolescence, and (c) residing in Lebanon. Participants were recruited from the *Psychology Student Pool for Research* at the American University of Beirut (AUB) and through advertisements posted on online social media platforms such as Lebanese Facebook Groups, Reddit, twitter, Instagram, and WhatsApp. Adults with histories of childhood maltreatment were chosen to participate in this study as they may have likely experienced dissociative psychopathology, to any given extent, at some point in their lives.

1. Sample Size Determination

A power analysis was conducted using G*Power (Faul *et al.*, 2007, 2009) to determine the minimum sample size needed to perform the main analyses in this study, given a significance level of $\alpha = .05$, a statistical power of $\pi = .90$, and an estimated moderate effect size of $f^2 = .15$ (roughly equivalent to the effect size of $d = .53$ reported in a recent meta-analytic review of studies investigating dissociation in victims of childhood maltreatment; see Vonderlin *et al.*, 2018). Higher statistical power reflects the probability of detecting a significant effect without the risk of making a Type II error (i.e., incorrectly detecting an effect where there is none, otherwise known as a "false positive"; X. S. Liu, 2014). G*Power determined that a sample size of about 116 participants is adequate for performing the main analyses in this study. However, according to the two rules-of-thumb proposed by Tabachnick and Fidell (2013), a minimum sample size between $n \geq 115$ and $n \geq 138$ is required to test seven predictors, following the formulas of $n \geq 50 + 8m$ for testing the multiple correlation and $n \geq 104 + m$ for testing the individual predictors, where m is the number of IVs.

2. Participant Characteristics

A total of 155 participants took part in this study (25.8% male, 72.9% female, 1.3% missing), with ages ranging between 18 and 57 ($M = 22.42$, $SD = 5.54$). Additionally, 85.2% of the participants were Lebanese, 2.6% were Armenian, 0.6% was French, 1.3% were Iraqi, 0.6% were Kurdish, 2.6% were Palestinian, 3.2% were Syrian, and 3.9% endorsed "Other". In terms of highest level of educational attainment, 1.9% completed some high school, 36.8% received a high school diploma, 0.6% received vocational training certification, 15.5% completed some college, 25.2% received a

bachelor's degree, 1.3% received a post-graduate diploma, 15.5% received a master's degree, 1.9% received a doctoral degree, while 1.3% had missing entries. In terms of employment, 25.8% of the sample were currently employed on a full-time basis, 7.7% on a part-time basis, 0.6% were on extended leave from work, 3.2% endorsed working without pay, 1.9% indicated having a job lined up for them, 8.4% were unemployed but currently looking for work, 21.9% were unemployed and not looking for work, 2.6% were unemployed due to being unable to work, 2.6% were unemployed due to the unavailability of job opportunities, 23.9% have never been employed before, while 1.3% did not enter a response. Finally, 20% of the participants were diagnosed with a mental health condition, 78.7% were not, while 1.3% did not enter a response.

B. Recruitment Procedures

After obtaining ethics clearance from the Institutional Review Board (IRB) of AUB to conduct this study, permission was sought from the Coordinator of the *Psychology Student Pool for Research* at AUB to recruit participants from an introductory psychology course. The recruitment of participants from the undergraduate introductory psychology class followed the procedure set by the *Interim Guidance for Access to the Psychology Student Pool for Research*. When permission was granted, students attending the introductory psychology course received an announcement on the Moodle platform detailing the study (see Appendices A and B for the announcement). The announcement contained a brief description of the study and its potential benefits to the scientific and clinical communities at large, coupled with a shortened secure LimeSurvey web link that redirects to the study's online survey. The web link presented participants with the informed consent form (see Appendices C and D) followed by

demographic questions. After which, the participants were presented with the research questionnaires (i.e., IFDFWS, DCI, TEC, TAQ–B, ARSQ, MAPS, and PTAS, respectively). Upon completion of the survey, they were then shown a debriefing statement about the study's aims and hypotheses along with a list of resources to contact if they experienced emotional distress resulting from their participation in the study (see Appendix E and F). They also received extra credit in their psychology course.

The study was also advertised on social media platforms such as Reddit, twitter, Facebook, Instagram, and WhatsApp. A digital representation of the flyer was posted and supplemented with a brief description of the study and its potential benefits to the scientific and clinical communities at large, coupled with a shortened secure LimeSurvey web link to access the study's online survey.

Data collection took place over the span of one month during the Spring semester of 2021. During this period, unfortunately, Lebanon was still unravelling from a multitude of crises (economic, political, biomedical, and security-related), which may have affected participation. Despite this, to preserve interest in the study, reminders of the study's call for participation was posted on twitter, Facebook, and WhatsApp every week. The advertisements of the study informed prospective participants that their participation in the study is completely voluntary and anonymous as no identifying information would be collected. They were also informed that their participation would contribute to psychological research on the impact of childhood trauma in Lebanon, which seeks to better inform the Lebanese mental health community about the importance of addressing these experiences to improve treatment outcomes. The student sample in this study included 77 participants (49.7%) while the community sample included 78 participants (50.3%). About 3.9% participants heard about the study

through Facebook advertisements, 3.9% through Instagram, 23.9% through WhatsApp, 3.9% through Reddit, 49.7% through the Psychology Student Pool at AUB, while 14.2% heard about the study through their friends, acquaintances, and colleagues.

1. Ethical Considerations

A potential risk to participating in this study is that participants may experience mild yet transient emotional distress resulting from some of the study's questionnaires about their histories of childhood maltreatment. To mitigate this risk, participants were asked to complete a brief trauma-informed relaxation exercise, produced by the Australian Health Service in both English and Arabic, to bring them back to the present moment. They were also provided with a list of resources that offer free or low-cost local mental health services, along with the local crisis hotline number of *Embrace Lebanon*. This is to ensure that they had professional support available if they experienced any emotional distress from completing the questionnaires. Participants were also informed, prior to completing the study's questionnaires that they can discontinue their participation in the study at any time as it is completely voluntary.

C. Data Collection Procedures

1. Instruments

a. Demographic Questionnaire

The demographic questions in this study asked about participants' assigned sex, chronological age, ethnic origin, highest level of educational attainment, employment status, formal psychiatric diagnosis, utilisation of psychopharmacological and psychotherapeutic treatments, and their duration. Two additional questions also asked

about participants' current residence and self-identification as a survivor of childhood abuse or trauma. The demographic questions are presented in Appendix G.

b. Socio-Economic Status

According to the United Nations Economic and Social Commission for Western Asia (ESCWA, 2020), poverty rates are rising in Lebanon following an amalgamation of an economic crisis, a health crisis, and the Beirut Port Explosion. Because of this, the present study utilised best practices recommended by Diemer *et al.* (2013) to more accurately capture participants' socio-economic status. On that note, Diemer and colleagues proposed that the most sensitive approach to capture socio-economic status in failing economies is to measure *economic pressure*, which comprises financial distress and lifestyle adjustments in response to economic hardship), as such, the *InCharge Financial Distress/Financial Well-being Scale* (IFDFWS; Prawitz *et al.*, 2006, see Appendix H) was used. The IFDFWS is an 8-item self-report questionnaire that measures perceived financial distress/financial wellness. Sample items of the IFDFWS include "How satisfied are you with your present financial situation?" and "How often do you worry about being able to meet normal monthly living expenses?". Each of the IFDFWS items is rated on a ten-point Likert-type scale, with higher scores indicating higher levels of financial distress. The IFDFWS demonstrated robust internal consistency, with Cronbach's $\alpha = .96$. Convergent, discriminant, concurrent, and construct validity were also demonstrated (Prawitz *et al.*, 2006). In this study, the ten-point Likert-type rating scale for the IFDFWS was abbreviated to five points to reduce participants' response burden.

c. Dissociative Psychopathology

The *Detachment and Compartmentalisation Inventory* (DCI; Butler *et al.*, 2019, see Appendix I) is a 20-item self-report instrument assessing dissociative psychopathology as defined comprehensively by Holmes *et al.* (2005) and Brown (2006). In line with this definition, the DCI is theoretically divided into two subscales: detachment (e.g., "I focus on something going on in my mind and more or less lose track of what is happening around me") and compartmentalisation (e.g., "I do not feel in control of what my body does as if there is someone or something inside me directing my actions"). Items are rated on an eight-point Likert-type scale, ranging from 0 (*never*) to 7 (*daily*), with higher scores indicating increased severity of dissociative psychopathology. The DCI demonstrated excellent internal consistency for the total DCI score (α = .97) and its Detachment and Compartmentalisation subscales (α = .93 and α = .96, respectively). Convergent, discriminant, concurrent, and construct validity were also demonstrated (Butler *et al.*, 2019). In this study, the total score of the DCI was used as the outcome variable when testing the study's hypotheses.

d. History of Childhood Maltreatment

The *Traumatic Experiences Checklist* (TEC; Nijenhuis *et al.*, 2002, see Appendix J) is a self-report questionnaire inquiring about 29 potentially traumatising events, including loss of significant others, threats to life or bodily integrity, exposure to war, and emotional, physical, and sexual trauma. All items ask about the occurrence, age at onset, duration, and the subjective impact of the trauma. Items evaluating emotional neglect, emotional abuse, physical abuse, sexual harassment, and sexual abuse specifically address the perpetrator's affiliation to the victim (i.e., immediate

family member, extended family member, non-family member). The items contain short descriptions that intend to define the events of concern (e.g., “being left alone, receiving insufficient affection” for emotional neglect, “being belittled, teased, called names, threatened verbally, or unjustly punished” for emotional abuse, “being hit, tortured, or wounded” for physical abuse, “acts of a sexual nature that *do not* involve physical contact” for sexual harassment, and “unwanted sexual acts involving physical contact” for sexual abuse).

The TEC is scored by generating different composite scores for each type of childhood maltreatment (i.e., emotional abuse, emotional neglect, physical abuse, sexual harassment, and sexual abuse) and during three developmental periods (i.e., 0–6 years, 7–12 years, and 13–18 years). These generated variables were demonstrated to be homogeneous constructs in samples of patients diagnosed with dissociative and other psychiatric disorders (Nijenhuis *et al.*, 1998). The composite scores involve four domains: (a) occurrence of the traumatic event; (b) age at onset and duration of the trauma; and (c) subjective impact of the trauma. The internal consistency and test-retest reliability of the scores for the presence and impact of these types of childhood maltreatment were satisfactory (Nijenhuis *et al.*, 2002). In this study, the full scope of the composite scores for the TEC was utilised to generate descriptive statistics of childhood maltreatment within the study’s sample, while the earliest age at onset as well as the composite score for the total duration of cumulative exposure to childhood maltreatment were used in testing this study’s hypotheses.

e. Appraisals of Betrayal

The *Trauma Appraisal Questionnaire* (TAQ; DePrince *et al.*, 2010, see Appendix K) is a 54-item self-report measure that examines trauma-related appraisals (i.e., beliefs, emotions, and behaviours that emerge in response to traumatic experiences). Its items are rated on a five-point Likert-type scale ranging from 1 (*not at all true*) to 5 (*completely true*), with higher scores indicating an increased likelihood of possessing these appraisals. The TAQ comprises six distinct appraisal categories (namely, anger, alienation, fear, betrayal, shame, and self-blame). Participants are probed about their thoughts, feelings, and behaviours in response to the difficult experiences they faced in childhood and/or adolescence. The TAQ demonstrated excellent internal consistency for retrospective reports, with Cronbach's α ranging between .89 and .91 across the six subscales. Convergent, discriminant, concurrent, and construct validity were also demonstrated (DePrince *et al.*, 2010). In this study, the 7-item betrayal subscale was used as a predictor in testing the study's hypotheses.

f. Negative Beliefs About Anger

The *Metacognitive Anger Processing Scale* (MAPS; Møeller, 2016, see Appendix M) is a 26-item instrument assessing meta-cognition in relation to anger in three domains: (1) positive beliefs about anger (e.g. "Anger helps me solve problems"), (2) negative beliefs about anger, particularly those focused on danger, harm, and madness (e.g. "Anger could make me go mad"), and (3) uncontrollable angry rumination (e.g. "I cannot let go of angry thoughts"). MAPS items are worded solely to assess anger, avoiding overlap with aggression. The items are rated on a four-point Likert-type scale ranging from 1 (*never true*) to 4 (*always true*), with higher scores

indicating increased likelihood of possessing these beliefs. The MAP internal consistency and test-retest reliability have been shown to be excellent (for positive beliefs, α = .87, for negative beliefs, α = .88, and for angry rumination, α = .91). The MAPS also demonstrated concurrent validity with measures of meta-cognition and anger in student, forensic, and mixed clinical samples in separate studies (Møeller, 2016; Møeller & Bech, 2019). For the purpose of this study, the 9-item subscale for negative beliefs about anger was used in testing the study's hypotheses.

g. Perpetrator-Directed and Self-Directed Anger

The *Post-Traumatic Anger Scale* (PTAS; Orth & Maercker, 2009, see Appendix N) is a 20-item self-report instrument measuring the frequency at which anger is experienced at different targets. The PTAS was developed using a rational approach and comprises five subscales: anger at the perpetrator (e.g., "I was angry at the people who hurt me because my well-being was so unimportant to them"), desire for revenge (e.g., "I imagined how the people who hurt me will once really have to suffer"), anger at the criminal justice system (e.g., "I was angry at the police, courts, or administration because they only care about the perpetrators and not the victims"), anger at bystanders (e.g., "I was angry at other people because they did not prevent these events"), and anger at the self (e.g., "I was angry at myself because I did not prevent these events"). Its items are rated on a six-point Likert-type scale, ranging from 0 (*never*) to 5 (*very often*), with higher scores indicating a higher frequency at which anger is experienced at these different targets. The reliability of the PTAS was very good overall, where the internal consistency of anger at the perpetrator was at α = .74, desire for revenge at α = .88, anger at the criminal justice system at α = .86, anger at other people at α = .68, and

anger at the self at α = .78. For this study, anger at the self and anger at the perpetrator were used as predictors in testing the study's hypotheses.

h. Maltreatment-Related Shame

The *Abuse-Related Shame Questionnaire* (ARSQ; Feiring & Taska, 2005, see Appendix L) is an 8-item self-report instrument that was designed to measure maltreatment-related shame in youth. Its items are rated on a three-point Likert-type scale ranging from 1 (*not true*) to 3 (*very true*), with higher scores indicating higher maltreatment-related shame. The internal consistency for the ARSQ appears to be very good (α = .86) and was shown to be reliable over time in a sample of maltreated youth (Feiring & Taska, 2005; Feiring *et al.*, 2010). In this study, the scale was adapted for use with an adult sample. In line with this, new directions were developed to probe for feelings of shame related to childhood maltreatment. As such, the new directions are as follows:

> Below are a number of statements that describe thoughts and feelings that people sometimes have about themselves in response to difficult experiences they faced during their childhood and/or adolescence. Please read each statement carefully and select the number to the right that best reflects how much it applied to you back then.

Additionally, the Likert-type scale was revised to include a wider range of choices better suited for an adult sample; it now ranges from 1 (*not at all true*) to 5 (*completely true*).

2. Cross-Cultural Adaptation of Study Instruments

The guidelines set forth by the International Test Commission (ITC; Hambleton *et al.*, 2005) were followed in adapting the study's instruments into the Arabic language. In line with this, the instruments were translated by the author of this study (G.S.) and back-translated by N.E.H., both of whom are fluent in both English and Arabic and are familiar with the constructs under study. The instruments then underwent informal pilot testing, where five individuals offered general feedback and suggestions to improve the comprehension of the translated items.

D. Statistical Analysis Procedures

Preliminary data analyses were performed using the R package 'naniar' in RStudio 1.4 to treat missing values and outliers, G*Power 3.1.9.6 was used to determine *a priori* statistical power, while IBM SPSS Statistics 28.0 was used to test for normality, obtain descriptive statistics on demographic information and each of the research variables, as well as perform reliability analyses and diagnostics in preparation for the regression analysis. Following this, an Exploratory Factor Analysis was conducted on the *Metacognitive Anger Processing Scale* (Møeller, 2016) and the *Post-Traumatic Anger Scale* (Orth & Maercker, 2009) to determine their respective factor structures within a Lebanese context. Additionally, prior to hypothesis testing, a Mann-Whitney *U* test was conducted to investigate whether there was a difference between sample distributions (i.e., community sample vs. student sample) on dissociative psychopathology.

To test hypothesis 1 of this study, dissociative psychopathology was compared between those who endorsed having a diagnosis versus those who did not through

computing another Mann-Whitney *U* test. To test hypotheses 2–11 of the study, a Hierarchical Multiple Regression was conducted in three steps, with dissociative psychopathology as the outcome variable. In the first step, the covariates (i.e., time spent in therapy and financial distress) were entered, followed by simultaneously entering the four maltreatment-related characteristics (namely, cumulative occurrences, age at onset, average duration, and subjective impact) as predictors in the second step, then followed by simultaneously entering the five maltreatment-related reactions (namely, appraisals of betrayal, negative beliefs about anger, anger at the perpetrator, anger at the self-, and shame) as predictors in the third step.

CHAPTER V

RESULTS

This chapter describes and summarises the statistical analyses used to evaluate the research questions and hypotheses established in the previous chapters. After the data screening process, this section reports the results of the preliminary analyses, and the main analyses of the study.

A. Data Screening

1. Exclusion and Attrition

A total of 77 participants from the community sample and 116 participants from the student sample were excluded from the study based on not currently residing in Lebanon and not self-identifying as having faced traumatic or abusive experiences during their childhoods and/or adolescence. Further, 51 participants from the community sample and 1 from the student sample did not complete more than 80% of the study and were thus dropped from further analyses.

2. Missing Values Analysis

Summary statistics were generated for IFDFWS, DCI, TAQ–B, ARSQ, MAPS, and PTAS to determine the remaining proportion of missing values in the data. While ARSQ had no missing values, all other measures had less than 5% of their values missing. To determine the pattern of missingness across these measures (namely, the IFDFWS, DCI, TAQ–B, MAPS, and PTAS), a Little's MCAR test was conducted using

the R package ‘naniar’ (Tierney, 2021). Little’s MCAR test was significant for all these measures (p <. 05), except for the TAQ–B. These findings indicate that the missing values in IFDFWS, DCI, MAPS, and PTAS were not missing completely at random, whereas the missing values in TAQ–B were missing completely at random. Since the missing values on these measures do not exceed 5%, no further exploration of their missingness is needed (Tabachnick & Fidell, 2018). In turn, Predictive Mean Matching via the R package ‘mice’ (van Buuren, 2021) was used to impute the missing values. This method was chosen as it draws real values sampled from the data, thus reducing the potential for bias in imputing missing values (Little & Rubin, 2020).

B. Preliminary Analyses

1. Dissociative Psychopathology across Samples

Since dissociative psychopathology was not normally distributed in both the community and student samples (as determined by Shapiro-Wilk’s test of normality, where

p < .001), the Mann–Whitney U test was used to determine whether dissociative psychopathology was different across these two samples. Distributions of dissociative psychopathology scores for the community and student samples were similar, as assessed by visual inspection (see Figure 1). The median dissociative psychopathology scores were not statistically significantly different across both samples (Mdn = 2.13 for the community sample and Mdn = 1.90 for the student sample), U = 2937.50, z = -.234, p = .815. Because of this, data from the community sample and student sample were combined for all subsequent analyses.

2. Factor Analyses

Two Principal Components Analyses (PCAs) were conducted to determine the factor structure of the English versions of the MAPS and PTAS within the Lebanese context. No PCAs were conducted on the Arabic translations of these scales due to an insufficient sample size ($N = 22$). Additionally, no PCAs were conducted on any of the other measures as their total scale scores will be used in testing the study's hypotheses.

The suitability of PCA was assessed prior to analysing the factor structures of both the MAPS and the PTAS. Inspection of the correlation matrix showed that all variables had at least one correlation coefficient greater than 0.3. The overall Kaiser–Meyer–Olkin (KMO) measure of sampling adequacy was 0.82 for both the MAPS and the PTAS with individual KMO measures all greater than 0.7, classifications of 'middling' to 'meritorious' according to Kaiser (1974). Bartlett's test of sphericity was statistically significant ($p < .001$) for both questionnaires, indicating that their data are likely factorisable.

A two-factor solution of the MAPS explained 51.04% of the total variance. A Varimax orthogonal rotation was employed to aid interpretability. The interpretation of the data was consistent with the meta-cognitive processing styles the MAPS was designed to measure with items pertaining to *Positive Beliefs about Anger* strongly loading on Factor 1 and items pertaining to *Negative Beliefs about Anger* strongly loading on Factor 2. Factor loadings and communalities of the rotated solution are presented in Table 1.

Table 1

Rotated Structure Matrix for PCA with Varimax Rotation of a Two-Factor Solution for MAPS

	Factor		
Item	1	2	Communalities
MAPS1	-	**.576**	.342
MAPS2	**.736**	-	.547
MAPS3	.286	**.613**	.458
MAPS4	**.660**	.114	.449
MAPS5	.207	**.592**	.394
MAPS6	**.742**	.000	.551
MAPS7	-	**.675**	.473
MAPS8	**.771**	.054	.597
MAPS9	.039	**.748**	.561
MAPS10	**.811**	-	.662
MAPS11	-	**.753**	.582
MAPS12	**.573**	.101	.338
MAPS13	-	**.780**	.622
MAPS14	**.770**	.000	.592
MAPS15	-	**.672**	.451
MAPS16	**.740**	.107	.560
MAPS17	.090	**.700**	.498

Note. Factor loadings greater than .450 are shown in bold. Factor 1 = Negative Beliefs about Anger; Factor 2 = Positive Beliefs about Anger; MAPS = Meta-cognitive Anger Processing Scale. The original measure has a third factor (ruminative anger), but its items were excluded from this study to reduce respondents' burden, especially since they were not relevant for this study.

A five-factor solution of the PTAS explained 79.48% of the total variance. A Varimax orthogonal rotation was also used to aid interpretability. The rotated solution also exhibited 'simple structure' (Thurstone, 1947). The interpretation of the data was consistent with the targets of post-traumatic anger that the PTAS was designed to measure with items pertaining to *anger at institutions* strongly loading on Factor 1, items pertaining to *anger at the perpetrator* on Factor 2, items pertaining to *desire for revenge* on Factor 3, items pertaining to *anger at the self* on Factor 4, and items

pertaining to *anger at others* on Factor 5. Factor loadings and communalities of the rotated solution are presented in Table 2.

Table 2

Rotated Structure Matrix for PCA with Varimax Rotation of a Five-Factor Solution for PTAS

	Factor					
Item	1	2	3	4	5	Communalities
PTAS1	-.023	**.836**	.200	.321	.138	.861
PTAS2	-.041	**.784**	.095	.216	.249	.734
PTAS3	.043	**.881**	.164	.061	.209	.851
PTAS4	.055	**.828**	.173	.143	.188	.774
PTAS5	.087	.274	**.787**	.111	.193	.751
PTAS6	.099	.346	**.802**	.108	.159	.810
PTAS7	.111	.059	**.858**	.124	.200	.808
PTAS8	.041	.036	**.858**	.161	.200	.805
PTAS9	**.939**	-.024	.082	.036	.135	.909
PTAS10	**.947**	-.010	.084	-.027	.177	.936
PTAS11	**.950**	.008	.038	-.006	.146	.926
PTAS12	**.893**	.071	.100	-.096	.103	.833
PTAS13	.302	.194	.242	.041	**699**	.678
PTAS14	.161	.190	.232	.114	**817**	.796
PTAS15	.250	.329	.138	.165	**743**	.770
PTAS16	.052	.225	.291	.265	**648**	.629
PTAS17	-.060	.013	.159	**.818**	.242	.757
PTAS18	-.074	.184	.177	**.770**	.236	.719
PTAS19	.045	.207	.082	**.852**	-.066	.781
PTAS20	-.014	.242	.072	**.833**	.088	.766

Note. Factor loadings greater than .450 are shown in bold. Factor 1 = Anger at Institutions; Factor 2 = Anger at the Perpetrator; Factor 3 = Desire for Revenge; Factor 4 = Anger at the Self; Factor 5 = Anger at Others; PTAS = Post-Traumatic Anger Scale.

Taken together, these analyses suggest that the original factor structure of both the MAPS and the PTAS are upheld in a mixed non-clinical sample of Lebanese adults, and

these constructs as originally proposed remain valid within a non-clinical Lebanese sample.

3. Reliability Analyses

Estimates of internal consistency were examined separately for both the English and Arabic translations of all the measures used in this study and their corresponding subscales. They are thus outlined below and summarised in Table 3.

For the English version of the IFDFWS, its total score demonstrated excellent internal consistency (α = .90). Similarly, the internal consistency for the Arabic translation was also excellent (α = .92). Both of these reliability statistics are almost comparable to those reported by the scale's authors (cf. Prawitz *et al.*, 2006).

The English version of the DCI and its factors also demonstrated very high internal consistency (α = .89 for the *Detachment* subscale, α = .93 for the *Compartmentalisation* subscale, and α = .95 for the total score). Similarly, the Arabic translation of the DCI and its factors demonstrated very high internal consistency (α = .88 for the *Detachment* subscale,
α = .91 for the *Compartmentalisation* subscale, and α = .94 for the total score). These results, obtained in a Lebanese non-clinical sample, are almost comparable to those reported in the scale's original publication (cf. Butler *et al.*, 2019).

The English version of the TAQ *Betrayal Trauma* subscale demonstrated very high internal consistency (α = .91), which is comparable to the internal consistency reported by the scale's authors (α = .92; cf. DePrince *et al.*, 2010). However, the Arabic translation a adequate reliability (α = .84).

The ARSQ also demonstrated very high internal consistency in its English version
(α = .90) and Arabic translation (α = .89), which is higher than the reliability coefficient obtained by the scale's authors (α = .86; cf. Feiring & Taska, 2005).

Furthermore, both the English version and Arabic translation of the MAPS *Negative Beliefs about Anger* subscale demonstrated identical internal consistency (α = .86). This finding is further identical to that obtained by the scale's author (cf. Møeller, 2016).

Finally, the internal consistency of the PTAS and its factors ranged from acceptable to very high. For the English version, the *Anger at the Perpetrator* subscale yielded high internal consistency (α = .92), *Desire for Revenge* also yielded high internal consistency
(α = .90), *Anger at Institutions* yielded very high internal consistency (α = .96), while *Anger at Others* and *Anger at the Self* yielded adequate internal consistency (α = .86 and α = .88, respectively). Comparably, the internal consistency of the Arabic translation of the scale ranged from acceptable to high. Particularly, *Anger at the Perpetrator* had a reliability coefficient of α = .79, *Desire for Revenge* had a reliability coefficient of α = .87, *Anger at Institutions* had a reliability coefficient of α = .90, *Anger at Others* had a reliability coefficient of α = .85, and *Anger at the Self* had a reliability coefficient of α = .91. Reliability coefficients were not reported for each of the subscales in the original publication of the scale (cf. Orth & Maercker, 2009); however, they reported that the internal consistency of the total score was α = .88. Similar results were obtained for the total scale score of the English version (α = .90) and its Arabic translation (α = .85) in this Lebanese sample.

Table 3

Internal Consistency of the Study Questionnaires

Scale and Subscale	Cronbach's α for English Version	Cronbach's α for Arabic	*N* of Items
IFDFWS	.90	.92	8
DCI	.95	.94	20
Detachment	.89	.88	10
Compartmentalisation	.93	.91	10
TAQ	—	—	—
Betrayal Awareness	.91	.84	7
ARSQ	.90	.89	8
MAPS	—	—	—
Negative Beliefs about	.86	.86	9
Positive Beliefs about	.87	.82	8
PTAS	.90	.85	20
Anger at the Perpetrator	.92	.79	4
Desire for Revenge	.90	.87	4
Anger at Insititutions	.96	.90	4
Anger at Others	.86	.85	4
Anger at the Self	.88	.91	4

Note. IFDFWS = InCharge Financial Distress/Financial Wellness Scale; DCI = Detachment and Compartmentalisation Inventory; TAQ = Trauma Appraisals Questionnaire; ARSQ = Abuse-Related Shame Questionnaire; MAPS = Meta-cognitive Anger Processing Scale; PTAS = Post-Traumatic Anger Scale.

4. Descriptive Analyses

Means, standard deviations, medians, skewness, and kurtosis for the dependent variable, the two covariates, and the nine predictors are shown in Table 4.

Table 4

Descriptive Statistics for the Main Study Variables

Variable	*N*	Min	Max	*M*	*SD*	*Mdn*	Skew	Kurtosis
Dissociative	155	0.10	6.85	2.36	1.52	1.95	0.96	0.30
Average Therapy Duration	64	0.05	6.00	1.27	1.44	0.71	1.73	2.90
Financial Distress	155	1.00	5.00	2.87	0.90	2.88	0.10	-0.62
Cumulative CM	155	0.00	12.00	3.39	2.26	3.00	0.62	0.74
Cumulative CM (Onset)	137	1.00	17.00	7.04	4.43	6.00	0.43	-0.67
Cumulative CM (Duration)	137	1.00	18.00	5.51	3.89	5.00	0.78	0.12
Cumulative CM (Impact)	139	1.00	5.00	3.70	0.95	4.00	-0.80	0.14
Betrayal Awareness	155	1.00	5.00	3.25	1.16	3.29	-0.23	-0.84
Negative Beliefs about	155	1.00	4.00	2.49	0.72	2.44	0.21	-0.79
Anger at the Perpetrator	155	0.00	6.00	3.95	1.71	4.25	-0.63	-0.50
Anger at the Self	155	0.00	6.00	3.26	1.92	3.25	-0.17	-1.14
Maltreatment-Related Shame	155	1.00	5.00	2.64	1.20	2.50	0.34	-1.08

Note. CM = Childhood Maltreatment.

The mean score of *Dissociative Psychopathology* in this sample (M = 2.36, SD = 1.52) was below the midpoint of 3.5 on the DCI, indicating that participants in this sample tended to report lower levels of dissociative psychopathology. Since the variable of *Therapy Duration* appears to be noticeably skewed (almost nearing the absolute critical value of 2), it is thus prudent to report its median of 0,71, which indicated that most participants who endorsed attending therapy (N = 64) have been attending it for less than a year. Considering the low response rate for this variable, however, it will be dropped from further analyses. The mean score of *Financial Distress* in this sample (M = 2.87, SD = 0.90) was above the midpoint of 2.5 on the IFDFWS, indicating that participants reported higher levels of financial distress. The mean score for the *Occurrence* of Cumulative Childhood Maltreatment in this sample (M = 3.39, SD = 2.26) was below the first quartile cut-off point of 3.75 on the composite *Occurrence* score of Cumulative Childhood Maltreatment, indicating that participants, on average,

reported lower occurrence rates of cumulative childhood maltreatment. The mean score for the *Duration* of Cumulative Childhood Maltreatment in this sample (*M* = 5.51, *SD* = 3.89), indicating that participants endured, on average 5.51 years of cumulative childhood maltreatment. The mean score for *Onset* of Cumulative Childhood Maltreatment in this sample (*M* = 7.04, *SD* = 4.43), indicating that participants, on average, tended to be around 7 years old when they first experienced cumulative childhood maltreatment. However, it is worth noting that participant scores tended to vary widely for *Duration* and *Onset* of Cumulative Childhood Maltreatment, as indicated by their respective standard deviations. The mean score for the *Impact* of Cumulative Childhood Maltreatment in this sample (*M* = 3.70, *SD* = 0.95) was well above the midpoint of 2.5 on the *Impact* of Cumulative Childhood Maltreatment composite score generated from the TEC. This indicates that participants, on average, tended to be more severely impacted by cumulative childhood maltreatment in this sample. The mean score of *Betrayal Awareness* in this sample (*M* = 3.25, *SD* = 1.16) was well above the midpoint of 2.5 on the TAQ–BT, indicating that participants, on average, had higher awareness of betrayal trauma as committed by close others. The mean score of *Maltreatment-Related Shame* in this sample (*M* = 2.64, *SD* = 1.20) was slightly above the midpoint of 2.5 on the ARSQ, indicating that participants, on average, tended to report moderate to higher levels of maltreatment-related shame. The mean score of *Negative Beliefs about Anger* in this sample (*M* = 2.49, *SD* = 0.72) was higher than the midpoint of 2.00 on the MAPS, indicating that participants, tended, on average, to have higher levels of negative beliefs about anger. The mean score of *Anger at the Perpetrator* in this sample (*M* = 3.95, *SD* = 1.71) was higher than the midpoint of 3.00 on the PTAS, indicating that participants tended, on average, to report higher rates of

anger directed at perpetrator(s). Finally, the mean score of *Anger at the Self* in this sample (M = 3.26, SD = 1.92) was slightly above the midpoint of 3.00 on the PTAS, indicating that participants tended, on average, to report higher rates of self-directed anger.

To further elucidate the types, average duration, age at onset, and subjective impact of childhood maltreatment reported in this sample, means, standard deviations, medians, skewness, and kurtosis for these variables were computed and are shown in Table 5.

Table 5

Descriptive Statistics for the Types, Durations, Onset, and Impact of Childhood Maltreatment

Variable	*N*	Min	Max	*M*	*SD*	*Mdn*	Skew	Kurtosis
Emotional Neglect (Occurrence)	154	0.00	3.00	1.25	1.00	1.00	0.40	-0.86
Emotional Neglect (Onset)	110	1.00	18.00	8.31	4.89	8.00	0.16	-0.97
Emotional Neglect (Duration)	110	1.00	18.00	6.82	5.04	6.00	0.68	-0. 35
Emotional Neglect (Impact)	114	1.00	5.00	3.60	1.13	4.00	-0.49	-0.60
Emotional Abuse (Occurrence)	154	0.00	3.00	1.01	0.85	1.00	0.56	-0.23
Emotional Abuse (Onset)	104	1.00	18.00	9.15	4.67	10.00	-0.10	-0.86
Emotional Abuse (Duration)	104	1.00	18.00	6.20	4.76	5.00	1.07	0.56
Emotional Abuse (Impact)	109	1.00	5.00	4.02	0.99	4.00	-1.03	0.50
Physical Abuse (Occurrence)	154	0.00	3.00	0.46	0.62	0.00	1.33	0.20
Physical Abuse (Onset)	60	1.00	17.00	7.98	4.70	8.00	0.29	-0.89
Physical Abuse (Duration)	60	1.00	18.00	6.10	5.42	5.00	0.82	-0.53
Physical Abuse (Impact)	60	1.00	5.00	3.78	1.12	4.00	-0.41	-0.92
Sexual Harassment (Occurrence)	154	0.00	3.00	0.40	0.63	0.00	1.51	1.82
Sexual Harassment (Onset)	49	1.00	18.00	11.27	4.31	10.50	-0.41	-0.79
Sexual Harassment (Duration)	49	1.00	18.00	2.99	3.36	1.00	2.57	8.04
Sexual Harassment (Impact)	49	1.00	5.00	3.83	1.13	3.75	-0.66	-0.63
Sexual Abuse (Occurrence)	154	0.00	2.00	0.30	0.53	0.00	1.55	1.53
Sexual Abuse (Onset)	40	3.00	18.00	11.25	4.49	12.00	-0.33	-1.22
Sexual Abuse (Duration)	40	1.00	14.00	2.69	2.92	1.00	2.41	6.22
Sexual Abuse (Impact)	39	1.00	5.00	4.06	1.08	4.00	-1.21	-0.80

In this mixed non-clinical sample, participants, on average, endorsed the *Occurrence* of Emotional Neglect by at least one type of perpetrator (i.e., close family member, extended family member, non-family member), as indicated by $M = 1.25$ ($SD = 1.00$). Among those who endorsed experiencing Emotional Neglect, they also endorsed that, on average, its *Onset* tended to be around the age of 8 (specifically, $M = 8.31$, $SD = 4.89$) and its *Duration* lasted for an average of close to 7 years ($M = 6.82$, $SD = 5.04$). Its *Impact* ($M = 3.60$, $SD = 1.13$) was well above the midpoint of 2.50 on the TEC composite subscale for the *Impact* of Emotional Neglect. This indicates that participants, on average, tended to be more severely impacted by emotional neglect in this sample.

The *Occurrence* of Emotional Abuse in this sample had a mean score of $M = 1.01$ ($SD = 0.85$), indicating that participants, on average, endorsed experiencing emotional abuse by at least one type of perpetrator. Among those who endorsed experiencing Emotional Abuse, they also endorsed that, on average, its *Onset* tended to be around the age of 9 (specifically, $M = 9.15$, $SD = 4.67$) and its *Duration* lasted for an average of more than 6 years ($M = 6.20$, $SD = 4.79$). Its *Impact* ($M = 4.00$, $SD = 0.99$) was well above the midpoint of 2.50 on the TEC composite subscale for the *Impact* of Emotional Abuse. This indicates that participants, on average, tended to be highly impacted by emotional abuse in this sample.

The *Occurrence* of Physical Abuse in this sample had a mean score of $M = 0.46$ ($SD = 0.62$), indicating that participants, on average, had a lower endorsement rate of experiencing physical abuse by at least one type of perpetrator. Among those who endorsed experiencing Physical Abuse, they also endorsed that, on average, its *Onset* tended to be around the age of 8 (specifically, $M = 7.98$, $SD = 4.78$) and its *Duration*

lasted for an average of about 6 years (*M* = 6.10, *SD* = 5.42). Its *Impact* (*M* = 3.78, *SD* = 1.12) was well above the midpoint of 2.50 on the TEC composite subscale for the *Impact* of Physical Abuse. This indicates that participants, on average, tended to be more severely impacted by physical abuse in this sample.

The *Occurrence* of Sexual Harassment in this sample had a mean score of *M* = 0.40 (*SD* = 0.63), indicating that participants, on average, had a lower endorsement rate of experiencing sexual harassment by at least one type of perpetrator. Among those who endorsed experiencing Physical Abuse, they also endorsed that, on average, its *Onset* tended to be around the age of 11 (specifically, *M* = 11.27, *SD* = 4.31) and its *Duration* lasted for a median of 1 year (*Mdn* = 1.00). Its *Impact* (*M* = 3.83, *SD* = 1.13) was well above the midpoint of 2.50 on the TEC composite subscale for the *Impact* of Sexual Harassment. This indicates that participants, on average, tended to be more severely impacted by sexual harassment in this sample.

The *Occurrence* of Sexual Abuse in this sample had a mean score of *M* = 0.30 (*SD* = 0.53), indicating that participants, on average, had a lower endorsement rate of experiencing sexual abuse by at least one type of perpetrator. Among those who endorsed experiencing Sexual Abuse, they also endorsed that, on average, its *Onset* tended to be around the age of 11 (specifically, *M* = 11.25, *SD* = 4.49) and its *Duration* lasted for a median of about 1 year (*Mdn* = 1.00). Its *Impact* (*M* = 4.06, *SD* = 1.08) was well above the midpoint of 2.50 on the TEC composite subscale for the *Impact* of Physical Abuse. This indicates that participants, on average, tended to be highly impacted by physical abuse in this sample.

Finally, to explore the descriptive statistics for cumulative childhood maltreatment across types of perpetrators (i.e., close family members, extended family

members, non-family members) that were reported in this sample, means, standard deviations, medians, skewness, and kurtosis for these variables were computed and are shown in Table 6.

In this sample, participants endorsed, on average, at least one type of childhood maltreatment committed by close family members (M = 1.42, SD = 1.26) out of a total of five maltreatment types (i.e., emotional neglect, emotional abuse, physical abuse, sexual harassment, sexual abuse). Among those who reported experiencing Intrafamilial Cumulative Childhood Maltreatment, they also endorsed that, on average, its *Onset* tended to be around the age of 7 (specifically, M = 7.06, SD = 4.37) and its *Duration* lasted for an average of about 7 years (M = 6.91, SD = 4.91). Its *Impact* (M = 4.06, SD = 1.00) was well above the midpoint of 2.50 on the TEC composite subscale for the *Impact* of Intrafamilial Cumulative Childhood Maltreatment. This indicates that participants in this sample, on average, tended to be highly impacted by cumulative childhood maltreatment committed by close family members.

Table 6

Descriptive Statistics for Cumulative Childhood Maltreatment across Perpetrator Type

Variable	*N*	Min	Max	*M*	*SD*	*Mdn*	Skew	Kurtosis
Intrafamilial CCM (Occurrence)	155	0.00	5.00	1.42	1.26	1.00	0.52	-0.71
Intrafamilial CCM (Onset)	102	1.00	18.00	7.06	4.37	6.00	0.44	-0.44
Intrafamilial CCM (Duration)	102	1.00	18.00	6.91	4.91	6.00	0.56	-0.63
Intrafamilial CCM (Impact)	104	1.00	5.00	4.06	1.00	4.33	-0.81	-0.30
Perifamilial CCM (Occurrence)	155	0.00	4.00	0.72	0.84	1.00	1.23	1.48
Perifamilial CCM (Onset)	77	1.00	18.00	8.34	4.98	8.00	0.26	-0.91
Perifamilial CCM (Duration)	77	1.00	18.00	6.13	5.42	4.00	0.77	-0.56
Perifamilial CCM (Impact)	82	1.00	5.00	3.33	1.26	3.25	-0.21	-1.10
Extrafamilial CCM (Occurrence)	155	0.00	5.00	1.25	1.18	1.00	0.86	0.16
Extrafamilial CCM (Onset)	102	1.00	18.00	10.75	4.32	11.00	-0.48	-0.46
Extrafamilial CCM (Duration)	102	1.00	18.00	4.28	3.77	3.00	1.72	3.43

Extrafamilial CCM (Impact)	106	1.00	5.00	3.70	1.09	4.00	-0.76	-0.27

Note. CCM = Cumulative Childhood Maltreatment.

The *Occurrence* of Perifamilial Cumulative Childhood Maltreatment in this sample had a mean score of $M = 0.72$ ($SD = 0.84$), indicating that participants, on average, had a lower endorsement rate of experiencing at least one type of childhood maltreatment by extended family members. Among those who reported experiencing Perifamilial Cumulative Childhood Maltreatment, they also endorsed that, on average, its *Onset* tended to be around the age of 8 (specifically, $M = 8.34$, $SD = 4.98$) and its *Duration* lasted for an average of about 6 years ($M = 6.13$, $SD = 5.42$). Its *Impact* ($M = 3.33$, $SD = 1.26$) was above the midpoint of 2.50 on the TEC composite subscale for the *Impact* of Perifamilial Cumulative Childhood Maltreatment. This indicates that participants in this sample, on average, tended to be more severely impacted by cumulative childhood maltreatment committed by extended family members.

The *Occurrence* of Extrafamilial Cumulative Childhood Maltreatment in this sample had a mean score of $M = 1.25$ ($SD = 1.18$), indicating that participants, on average, endorsed experiencing at least one type of childhood maltreatment by non-family members. Among those who reported experiencing Extrafamilial Cumulative Childhood Maltreatment, they also endorsed that, on average, its *Onset* tended to be around the age of 11 (specifically,
$M = 10.75$, $SD = 4.32$) and its *Duration* lasted for a median of 3 years ($Mdn = 3.00$). Its *Impact* ($M = 3.70$, $SD = 1.09$) was above the midpoint of 2.50 on the TEC composite subscale for the *Impact* of Extrafamilial Cumulative Childhood Maltreatment. This indicates that participants in this sample, on average, tended to be more severely impacted by cumulative childhood maltreatment committed by non-family members.

C. Main Analyses

1. Differences between Groups

Differences between individuals who endorsed having a mental health condition ($N = 31$) compared to those who did not report having a mental health condition ($N = 122$) were computed. To that end, a Shapiro–Wilk test of normality was computed to determine the distribution of dissociative psychopathology scores for participants with a formal mental health diagnosis and those without a formal mental health diagnosis. Shapiro–Wilk's test was significant ($p < .001$), indicating that dissociative psychopathology scores were not normally distributed across diagnosis status. Accordingly, a Mann–Whitney *U* test was used to determine whether dissociative psychopathology was different between those diagnosed with at least one mental health condition and those who are not. Distributions of dissociative psychopathology scores were not similar for individuals diagnosed with at least one mental health condition compared to those who are not diagnosed with any mental health condition, as assessed by visual inspection (see Figure 2). Dissociative psychopathology scores for individuals diagnosed with at least one mental health condition (mean rank = 94.69) were statistically significantly higher than for those who are not diagnosed with any mental health condition (mean rank = 72.50), $U = 1342.50$, $z = -2.49$, $p = .013$.

2. Hierarchical Multiple Regression

To test the second hypothesis of the study, that maltreatment-related reactions will predict dissociative psychopathology over and above maltreatment-related characteristics and the covariate of financial distress, a hierarchical multiple regression was performed. The first block of the regression analysis contained the covariate of

financial distress, while the second block contained maltreatment-related characteristics (i.e., cumulative occurrence, average duration, age at onset, and subjective impact), and the third block contained maltreatment-related reactions (i.e., betrayal awareness, shame, negative beliefs about anger, anger at the perpetrator, and anger at the self). However, prior to examining the results of the regression analysis, the following sections evaluate the assumptions of the hierarchical multiple regression.

Assumption 0: Absence of Outliers, High Leverage Points, and Influential Values. Studentised deleted residuals, centred leverage values, and Cook's distance were generated to rule out the presence of outliers, high leverage points, and influential values. As demonstrated in Table 7 below, the studentised deleted residuals are well within the range of > -3 *SD*s and < +3 *SD*s, indicating that there are no notable outliers in this model. However, only one leverage point was deemed to be higher than the criterion of 0.2 (particularly the case has a value of 0.234), warranting further inspection to determine whether it carries high influence on the model. In turn, Cook's distance ruled that out, as no highly influential points were identified (i.e., values for Cook's distance were less than the criterion of 1).

Table 7

Outliers, Leverage, and Influence

	Min	Max
Studentised Deleted Residuals	-2.12	2.93
Centred Leverage Values	0.01	0.23
Cook's Distance	0.00	0.08

Assumption 1: Independence of Residuals. The assumption of independence of residuals was met, as assessed by a Durbin–Watson statistic, where DW = 2.06.

Assumption 2: Linearity. As assessed by visual inspection of the studentised residuals plotted against the unstandardised predicted values (see Figure 3), all the independent variables appear to be collectively related in an approximately linear fashion to the dependent variable. Furthermore, each of the independent variables appears to be somewhat linearly related to the dependent variable, based on visual inspection of the partial regression plots displayed in Figures 4–13.

Assumption 3: Homoscedasticity. To test for the homogeneity of variance for this model, the Koenker test was used and yielded a non-significant result ($LM = 12.01$, $p = .285$). This indicates that the assumption of homoscedasticity is satisfied. Further inspection of Figure 3 supports this finding, indicating that the studentised residuals are roughly equal for all values of the predicted dependent variable.

Assumption 4: Absence of Multicolinearity. To test for the absence of multicollinearity among the independent variables of the model, the Variance Inflation Factor (VIF) for each of the independent variables was examined, as seen below.

Table 8

Multicollinearity Statistics

Variable	Tolerance	VIF
Financial Distress [Covariate]	0.948	1.055
Cumulative CM (Occurrence)	0.579	1.726
Cumulative CM (Onset)	0.448	2.232
Cumulative CM (Duration)	0.522	1.915
Cumulative CM (Impact)	0.672	1.487
Betrayal (Awareness/Appraisal)	0.511	1.958
Negative Beliefs about Anger	0.855	1.170
Anger at the Perpetrator	0.578	1.729
Anger at the Self	0.621	1.611
Maltreatment-Related Shame	0.537	1.863

Note. CM = Childhood Maltreatment.

As seen in Table 8 above, all independent variables entered into the final model appear well within the acceptable range of VIF < 10. Taken together, these findings indicate the absence of multicollinearity in the final model of the hierarchical multiple regression. This was further supported by examining the intercorrelations of the model, as seen below.

Table 9

Pearson's Correlations for Main Study Variables

	1	2	3	4	5	6	7	8	9	10	11
1. Dissociative	—										
2. Financial Distress	.363*	—									
3. Cumulative CM	.207	.156	—								
4. Cumulative CM	.139	.036	-	—							
5. Cumulative CM	-.009	-.014	.081	-	—						
6. Cumulative CM	.186*	.098	.388*	-.162	.108	—					
7. Betrayal	.309*	.079	.419*	-.016	.038	.431*	—				
8. Negative Beliefs	.394*	.058	.108	-.081	.064	.187*	.175*	—			
9. Anger at the	.201*	.134	.309*	-.091	.046	.399*	.605*	.142	—		
10. Anger at the Self	.284*	.051	.346*	-	.108	.363*	.349*	.339*	.380*	—	
11. Maltreatment-	.308*	.101	.453*	-	.157	.480*	.438*	.308*	.363*	.548*	—

Note. * $p < .05$ when Bootstrapped $95\%CI_{lower} \cap 95\%CI_{upper} \neq 0$. $N = 136$ (listwise exclusion). CM = Childhood Maltreatment.

Examination of the correlation matrix above demonstrated that none of the intercorrelations between the independent variables was greater than $r = 0.70$, thus indicating no evidence of multicollinearity.

Assumption 5: Normality of the Residuals. To determine the multivariate distribution of this model's residuals, a Shapiro–Wilk test was conducted on its studentised residuals, which indicated that they were not normally distributed, where SW = .977, $p = .024$. Accordingly, a bias-corrected bootstrapped hierarchical multiple regression was performed, with bootstrap samples set to 2,000, since it does not assume a normal distribution of the residuals.

Bootstrapped hierarchical multiple regression. A bootstrapped hierarchical multiple regression with accelerated bias correction was performed to determine if maltreatment-related reactions (i.e., betrayal blindness, negative beliefs about anger,

anger at the perpetrator, anger at the self, and shame) predict dissociative psychopathology over and above maltreatment-related characteristics (i.e., cumulative occurrence, average duration, age at onset, and subjective impact) and the covariate of financial distress. See Table 10 for full details on each regression model. The full model containing the aforementioned covariate, maltreatment-related characteristics, and maltreatment-related reactions predicting dissociative psychopathology (Model 3) was statistically significant, $R^2 = .383$, $F_{(10, 125)} = 7.771$, $p < .001$; adjusted $R^2 = .334$, thus explaining 33.4% of the variance in dissociative psychopathology scores. The addition of the aforementioned maltreatment-related characteristics to the prediction of dissociative psychopathology (Model 2) resulted in a statistically significant increase in R^2 of .093, $F_{(4, 130)} = 3.902$, $p < .005$. The addition of maltreatment-related reactions to the prediction of dissociative psychopathology (Model 3) also resulted in a statistically significant increase in R^2 of .158, $F_{(5, 125)} = 6.415$, $p < .001$.

Table 10

Hierarchical Multiple Regression Predicting Dissociative Psychopathology

	Dissociative Psychopathology								
	Model 1			Model 2			Model 3		
Variable	B	Bias	β	B	Bias	β	B	Bias	β
FD	0.63**	0.012	0.36	0.54**	0.009	0.31	0.53**	0.008	0.30
CCM–CO				0.17**	0.000	0.22	0.09	0.001	0.12
CCM–AO				0.12**	-0.001	0.35	0.11**	-0.001	0.32
CCM–AD				0.08	-0.004	0.20	0.06	-0.002	0.15
CCM–SI				0.17	0.007	0.10	-0.06	0.007	-0.04
ABT							0.21	0.000	0.15
NBA							0.68**	-0.004	0.31
AP							-0.04	0.000	-0.04
AS							0.08	-0.005	0.09
MRS							0.11	0.008	0.09
R^2	0.132			0.225			0.383		
F	20.40**			7.55**			7.77**		
ΔR^2	0.132			0.093			0.158		
ΔF	20.40**			3.90*			6.42**		

Note. * $p < .05$; ** $p < .0001$. FD = Financial Distress; CCM = Cumulative Childhood Maltreatment; CO = Cumulative Occurrence; AD = Average Duration; AO = Age at Onset; SI = Subjective Impact; ABT = Appraisal of Betrayal Trauma; MRS = Maltreatment-Related Shame; NBA = Negative Beliefs about Anger; AP = Anger at the Perpetrator; AS = Anger at the Self.

Of note, as seen in Table 10 above, Financial Distress (β = 0.30, $p < .001$; 95% CI: 0.237, 0.803), Age at Onset (β = 0.32, $p < 0.05$; 95% CI: 0.042, 0.188), and Negative Beliefs about Anger (β = 0.31, $p < .001$; 95% CI: 0.349, 0.999) in Model 3 were statistically significant contributors to the prediction of dissociative psychopathology, thus providing support for hypotheses 3 and 7, while hypotheses 2, 4, 5, 6, 8, 9, and 10 were not supported. It is also worth noting that cumulative occurrence,

average duration, and age at onset of childhood maltreatment were statistically significant predictors of dissociative psychopathology in Model 2; however, after adding maltreatment-related reactions in Model 3, cumulative occurrence and average duration lost their significance, while age at onset of childhood maltreatment remained to be a statistically significant predictor of dissociative psychopathology. Taken together, these results partially support hypothesis 11.

CHAPTER VI

DISCUSSION

This chapter will discuss the results presented in the previous chapter. First, the findings of the preliminary and main analyses will be discussed in reference to possible explanations of the findings and their convergence or divergence with previous literature. Next, theoretical and research implications of the study will be discussed. Finally, limitations of the study will be reviewed and suggestions for future directions within clinical research will be made.

The present study investigated the rate and predictors of dissociative psychopathology in a mixed, non-clinical Lebanese sample of adults who were maltreated in childhood and/or adolescence. A higher rate of dissociative psychopathology has been consistently reported in the literature in relation to exposure to childhood maltreatment (Vonderlin *et al.*, 2018), while dissociative symptoms have been persistently reported in various mental health conditions (Lyssenko *et al.*, 2018). However, since no studies have investigated the presence of dissociative symptoms among individuals diagnosed with various mental health conditions in Lebanon, this study sought to address this research gap.

Our first hypothesis stated that the rate of dissociative symptoms will be higher across all endorsed DSM–5 diagnostic groups, compared to those who are not diagnosed with a mental health condition. Our findings demonstrated a higher rate of dissociative symptoms among those who were diagnosed with at least one mental health condition. These results converged with previous findings, where dissociative symptom scores were collectively elevated in adults who have a psychiatric diagnosis compared

to those who do not (Butler *et al.*, 2019; Perona-Garcelán *et al.*, 2021; Murphy, 1994; Putnam, *et al.*, 1996). This lends further cross-cultural support for the transdiagnostic nature of dissociative experiences, as per the *Traumatic–Dissociative Dimension* proposed by Farina and colleagues (Farina & Liotti, 2013; Farina & Imperatori, 2017; Farina *et al.*, 2019), which aims to account for the presence of dissociative experiences among various mental health conditions, while not being limited to only trauma-related disorders.

While a link between dissociative psychopathology and childhood maltreatment has been consistently established in the literature (Vonderlin *et al.*, 2018), variation remains in how individuals respond and adapt to the trauma of childhood maltreatment. One line of research sought to understand this variation in response through exploring maltreatment-related characteristics that could be implicated in the maintenance of dissociative psychopathology.At the same time, sporadic efforts were being made to identify potent affective and attitudinal factors that could explain this variation in responding and adapting to childhood maltreatment (e.g., Irwin, 1994, 1995, 1998a, 1998b). However, much of these studies did not rely on pre-existing conceptualisations about the possible factors implicated in the development and maintenance of dissociative psychopathology, such as the Traumagenic Dynamics Model (Finkelhor & Browne, 1985, 1988; James, 1989), Constructivist Self-Development Theory (McCann & Pearlman, 1992), and Betrayal Trauma Theory (Freyd, 1994, 1996). The first of those established theories, as discussed in earlier sections, was that of Pierre Janet about the role of trauma-induced vehement emotional experiences (such as fear, anger, chagrin, shame, indignation, discouragement, despair, anguish, pain, weakness, helplessness, irresoluteness, embarrassment, etc.) in the development and maintenance of dissociative

psychopathology (for a more complete discussion of this, see van der Hart & Rydberg, 2019). However, it was not until recently that a comprehensive conceptual framework emerged that delineated the roles of specific maltreatment-related reactions (such as betrayal blindness, negative beliefs about anger, anger at the perpetrator, anger at the self, and shame) in predicting dissociative psychopathology (Dorahy, 2017). While these two separate lines of research attempt to explore the factors maintaining dissociative psychopathology into adulthood, no studies have attempted to investigate them in conjunction with one another. Additionally, no studies have attempted to explore the maltreatment-related reactions outlined by Dorahy (2017) as conjoint predictors of dissociative psychopathology. Thus, our study was the first to do so.

To that end, our study found that, out of the maltreatment-related reactions under investigation, only *negative beliefs about anger* was a strong predictor of dissociative psychopathology in our mixed, non-clinical sample, after controlling for financial distress, which fully supports hypothesis 7 of our study. This finding provides nascent empirical evidence for Briere's (1992) and Stout's (2002) postulates about the role of negative beliefs about anger in inducing dissociative reactions geared toward protecting against the threatening nature of this emotion. This finding also lends further support to Wells' (2001) model pertaining to the metacognitive regulation of cognitions and emotions in line with survival goals. In other words, because anger may have been internalised as a threatening emotion to survival, individuals may engage in the meta-cognitive regulation strategy of escaping it through invoking dissociation. Finally, this finding adds to the burgeoning body of literature about the affective, cognitive, and relational predictors of dissociative psychopathology, since no prior research has

attempted to establish its relationship to dissociation – especially in a mixed non-clinical sample.

Aside from *negative beliefs about anger*, none of the other maltreatment-related reactions measured in this study (i.e., betrayal blindness, anger at the perpetrator, anger at the self, and shame) were significant predictors of dissociative psychopathology; thus, hypotheses 6, 8, 9, and 10 were not supported. These findings are consistent with some recent research, particularly pertaining to anger expression and shame. For instance, a study conducted by Durham *et al.* (in press) found that anger expression was reportedly low in a community sample, especially among participants who experienced mild post-traumatic and dissociative symptoms. Similarly, DePrince *et al.* (2011) found that shame was not a significant predictor of dissociative psychopathology in a community sample of women who were subjected to intimate partner violence. Other research, however, has found that higher rates of shame predicted higher rates of dissociative psychopathology (e.g., Dorahy *et al.*, 2017; Platt & Freyd, 2015; Platt *et al.*, 2017; Irwin, 1998a). Thus, we suspect that lower rates of dissociative psychopathology may be better predicted by a different set of variables than those proposed by Dorahy's (2017) theoretical framework. This is despite these specific variables being found to be significantly correlated to dissociative psychopathology at the bivariate level (see Table 9). Another possible explanation of these non-significant findings is the increased salience of financial distress within the current Lebanese context; in turn, rendering other predictors of dissociative psychopathology less prominent. This is further elaborated in the last paragraph of this chapter.

Among the maltreatment-related characteristics, only *age at onset* of childhood maltreatment significantly predicted dissociative psychopathology in the final model,

after adding the aforementioned maltreatment-related reactions and controlling for financial distress. However, contrary to hypothesis 3, which expected that age at onset of childhood maltreatment would negatively predict dissociative psychopathology, our study found that the direction of this variable was positive, indicating that later ages at onset of childhood maltreatment predicted higher rates of dissociative psychopathology. Thus, hypothesis 3 is considered to have partial support. This finding is consistent with that of Mueller-Pfeiffer *et al.* (2013), where age at onset (when segmented across three developmental time periods: early childhood, middle childhood, and adolescence) was observed to positively predict dissociative psychopathology. However, it is worth noting that in their study, childhood maltreatment with an onset in middle childhood (between the ages of 7 and 12) had a higher explanatory power compared to the other two developmental periods when predicting dissociative symptoms (Mueller-Pfeiffer *et al.*, 2013). Similarly, Schalinski *et al.* (2016) identified the ages of 5 and 14 as developmentally sensitive periods for the development of dissociative symptoms in response to childhood adversities. Thus, we posit that the relationship between age at onset of childhood maltreatment and dissociative symptoms may be curvilinear in nature, a hypothesis worth exploring in future research.

Additionally, our study found that the *cumulative occurrence* and *average duration* of childhood maltreatment were significant predictors of dissociative psychopathology; however, they lost their significance after the addition of the aforementioned maltreatment-related reactions. Thus, in a broader sense, the addition of maltreatment-related reactions over and above maltreatment-related characteristics, explained more of the variation in dissociative psychopathology scores in this mixed non-clinical sample of Lebanese adults. Furthermore, the addition of maltreatment-

related reactions to the prediction of dissociative psychopathology resulted in suppressing the effects of cumulative occurrence and average duration of childhood maltreatment to the prediction of dissociative psychopathology, while only age at onset remained significant. In turn, hypothesis 11 of this study is considered partially supported since not all the maltreatment-related reactions were significant. In general, this finding lends further support to Janet's clinical observations that intense trauma-related reactions play a greater role in the maintenance of dissociative symptoms (van der Hart & Rydberg, 2019).

Finally, but notably, this study found that higher financial distress predicted an increase in dissociative symptoms. This finding is consistent with previous research that found a relationship between exposure to acute, inescapable stress and the experience of dissociative reactions (de Wachter *et al.*, 2006; Morgan *et al.*, 2001). Since 2019, Lebanon has been witnessing a rapid deterioration of its local currency, matched with a rapid increase in the cost of living in the country, causing more than half of the population to fall under the poverty line (ESCWA, 2020). Thus, this finding may suggest that individuals who are currently residing in Lebanon are coping with this inescapable financial distress through invoking dissociative reactions. Accordingly, it may be possible that this acute stress overwhelms individuals' self-regulatory capacities to the point of psychological surrender and autonomic collapse, both hallmarks of dissociative psychopathology.

CHAPTER VII

LIMITATIONS AND IMPLICATIONS

A. Limitations

The results of this study must be interpreted with caution, in light of several limitations. First, this study employed convenient and snowball sampling to recruit participants through various social media platforms. In turn, this introduces bias into the sample as individuals were not randomly sampled from across the population in Lebanon. Secondly, while the study's sample size was deemed to have adequate power to complete the main analyses and reduce the likelihood of error, a bigger sample size may have further allowed for better representation of the phenomena under study, in addition to reducing the potential impact of demand characteristics that may not be known to the authors of the study. Thirdly, in compliance with the IRB requirements, participants were asked to identify whether they currently reside in Lebanon as well as whether they have faced traumatic or abusive experiences during their childhoods and/or adolescents. However, these two questions may have further limited the sample since individuals who may have fled the country in search of better prospects were not eligible for the study. Similarly, individuals who may deny, minimise, or be desensitised to childhood adversities may not necessarily self-identify as survivors of childhood abuse or trauma. Thus, the sample recruited for this study better reflects individuals who explicitly self-identify as survivors of childhood trauma or abuse.

Another limitation of this study is its reliance on self-report measures of childhood maltreatment, which may be subject to inaccurate recall (cf. Baldwin *et al.*, 2019), particularly of specific ages at the onset of various forms of childhood

maltreatment. Additionally, despite the high reliability of this study's measures, they have not yet been rigorously validated within the Middle East, or Lebanon more specifically. While our exploratory factor analyses are a step in that direction, their use in a bigger sample is required to ensure more accurate analyses, in addition to conducting validation studies to determine the questionnaires' cross-cultural validity in the Middle East. Here, it is also worth mentioning that the questionnaires and their Arabic translations were informally piloted. While this was done in the interest of expediency, it may have impacted the more formal verification of the questionnaires' cross-cultural applicability through pilot testing. Furthermore, since the translators of the study questionnaires both have an understanding of psychological concepts, this might have biased the translations in favour of some terms that may not be within the common parlance of the general public.

Yet another limitation of the study is its cohort design. While we detected no differences between the community sample and the student sample (thus, combining them for the final analyses), we believe that these two samples may have various demand characteristics that could potentially influence the manifestations of the variables under study. For instance, prior research reported differences in the mean scores for dissociation, trauma history, betrayal blindness, and shame across student and community samples (e.g., DePrince *et al.*, 2011; Näring & Nijenhuis, 2005). While the demand characteristics that may cause these differences are not yet known, it may be fitting to explore them in future research. On that note, this study was correlational in nature in that it did not attempt any experimental manipulations to arrive at its findings. Thus, no causal inferences could be drawn from the study's findings.

Finally, as this study was conducted during a multitude of serious crises (economic, political, biomedical, and security-related) that were facing Lebanon, its results cannot be generalisable to time periods with fewer existential threats, even though attempts were made to account for the impact of one of these variables on our dependent variable. However, it was not possible for us to control for the effects of the other variables as they have become part-and-parcel of the daily experience of individuals who currently reside in Lebanon. Despite this, the fact that the present study was conducted during this complex time period does provide an insight into the impact of these taxing experiences on the psychological adjustment (or maladjustment), especially for individuals who were maltreated in childhood.

B. Implications

The present study carries several implications for theory, research, training, and practice – both in Lebanon and globally. In terms of its theoretical implications, the present study extends Wells' (2001) model of the metacognitive regulation of cognitions and emotions by demonstrating that dissociation may be one way in which maltreated individuals may fulfil their survival goal of escaping threat, especially when it is experienced in relation to a potent emotional experience such as anger. However, this study demonstrated that Dorahy's theoretical conceptualisation linking childhood maltreatment to dissociative psychopathology through a network of theoretically important variables (e.g., betrayal blindness, anger-related processes, and shame) may not be valid in a mixed non-clinical sample of individuals who experienced childhood maltreatment, suggesting that they may play a bigger role in samples of individuals who

were subjected to specific kinds of maltreatment, such as sexual abuse, or who report higher, clinically significant psychological distress.

In line with this study's theoretical implications, this study also paves the way for further research on the roles of meta-cognitive and meta-affective processes in predicting dissociative psychopathology. For instance, future research could investigate the roles of negative beliefs about and the fear of various trauma-related affective experiences (e.g., negative beliefs about emotions; Wells & Cartwright-Hatton, 2004; fear of emotions; Williams *et al.*, 1997) in predicting dissociative psychopathology. For instance, future research could investigate the role of negative beliefs about fear (e.g., "Fear paralyses me.", "Fear is dangerous for me.", etc.) and the fear of fear (e.g., "It scares me when I am afraid.", "When I am afraid, I fear going crazy.", etc.) in maintaining dissociative psychopathology into adulthood. This is especially important since the phobia of inner experience has been theorised to maintain dissociative psychopathology (van der Hart *et al.*, 2006). Additionally, future research may benefit from testing a curvilinear relationship between maltreatment-related factors and dissociative psychopathology, especially since maltreatment during middle childhood may possibly have a greater impact in the maintenance of dissociative psychopathology into adulthood. Furthermore, future research could also investigate the frequency of childhood maltreatment (e.g., "It happened once," "It happened just a few times," "It happened for months at a time," "It happened for years at a time.") in the prediction of dissociative psychopathology, as it may provide further accuracy in its prediction. Future research in Lebanon could also build on the findings of this study to investigate the rate and predictors of dissociative psychopathology in a more representative sample of adults who were maltreated in childhood. For instance, future research could utilise

broader sampling strategies that aim to recruit individuals who reside across all Lebanese governorates, while also seeking to reduce the possible impact of demand characteristics onto recruitment (e.g., self-selection bias). The present study initially intended to broaden its recruitment and sampling procedures; however, it had to adapt to the limitations imposed by the COVID–19 pandemic and the public health measures geared toward reducing its societal impact. For this reason, the study utilised convenience and snowball sampling through online social media platforms to recruit participants.

The present study also carries implications for clinical training and practice in Lebanon; particularly, it calls for the inclusion of dissociative psychopathology as part of the curricula for graduate students in clinical and counselling psychology, in addition to increased training in the screening, assessment, diagnosis, and treatment of individuals who manifest with dissociative reactions, given that individuals in our study who were formally diagnosed with a DSM–5 mental health condition experienced higher rates of dissociative symptoms compared to those who did not have a psychiatric diagnosis. In addition to this, the present study calls for considering the impact of financial distress and negative beliefs about anger in treatment planning, as they may exacerbate dissociative symptoms and thus act as potential barriers to therapeutic progress. Through assessing for and addressing these factors, especially negative beliefs about anger, therapists may be able to achieve second-order change, since most therapeutic approaches for trauma recovery do not address meta-cognitive and meta-affective beliefs that may be responsible for symptom maintenance.

CHAPTER VIII

CONCLUSION

Based on the preceding discussion of the results, several conclusions were drawn from this study. First, this study served both of its aims in exploring the rate and predictors of dissociative psychopathology in adults who were maltreated in childhood and are currently residing in Lebanon. More specifically, this study serves as a promising first step in identifying the rate of dissociative psychopathology among individuals who have been formally diagnosed with mental health conditions compared to those who are not. While this finding is preliminary, it paves the way to explore this relationship further. It was also concluded that the second aim of this study, pertaining to exploring the predictive power of maltreatment-related reactions over and above maltreatment-related characteristics and financial distress in predicting dissociative psychopathology was also met. However, in our mixed non-clinical sample, *negative beliefs about anger* was the single most important maltreatment-related reaction in predicting dissociative psychopathology, over and above maltreatment-related characteristics and financial distress. Further, financial distress and age at onset remained as significant predictors of dissociative psychopathology in the final model, albeit they explained less of the variance in dissociative symptoms compared to negative beliefs about anger. Lastly, building on these points, the present study provided crucial knowledge that may inform theory, research, training, and practice in the field of clinical psychology, particular as it relates to the maintenance of dissociative symptoms into adulthood.

APPENDIX A

Call for Participation (Community Sample)

Call for Participation (Community Sample), in English

CALL FOR PARTICIPATION

in the

TRAUMATIC OR ABUSIVE LIFE EXPERIENCES

RESEARCH STUDY

This notice is for an AUB IRB-approved research study.

We are conducting a study on the short- and long-term impact of **traumatic or abusive experiences** that people sometimes face during their **childhood and/or adolescence**. We are looking for adults who are over the age of 18, currently living in Lebanon, and having faced traumatic or abusive experiences during their childhood and/or adolescence.

Our Goal:

IMPROVED UNDERSTANDING

By understanding their impact, we hope to inform the Lebanese mental health community about the **importance of addressing these experiences and their often under-recognised consequences** to improve treatment outcomes.

In case of questions, you may contact **Dr Tima El-Jamil** (fa25@aub.edu.lb) or **George Saadé** (qjs09@mail.aub.edu).

WHAT IS INVOLVED IN THIS STUDY?

Reading and completing an **informed consent form**.

Completing a **20-** to **40-minute** web survey on LimeSurvey.

Completing a **brief relaxation exercise** after the survey.

To participate in this research study, please visit the following link:
https://tinyurl.com/mk7as9hc

Call for Participation (Community Sample), in Arabic

APPENDIX B

Call for Participation (Student Sample)

Call for Participation (Student Sample), in English

CALL FOR PARTICIPATION

in the

TRAUMATIC OR ABUSIVE LIFE EXPERIENCES

RESEARCH STUDY

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To participate in this research study, please visit the following link:
https://tinyurl.com/4y9ecctc

Call for Participation (Student Sample), in Arabic

دعوة للمشاركة

في دراسةٍ بحثية

متعلقة بـ

تجارب الحياة المؤلمة أو المؤذية

هذا الإشعار خاص بدراسة بحثية في الجامعة الأميركية في بيروت موافق عليها من قِبل مجلس المراجعة المؤسسية.

نحن نجري دراسة حول التأثير قصير الأمد وطويل الأمد **للتجارب المؤلمة أو المؤذية** التي يواجهها الناس أحياناً خلال **طفولتهم و / أو مراهقتهم**. نحن نبحث عن البالغين الذين تزيد أعمارهم عن ١٨ عاماً، ويعيشون حالياً في لبنان، وقد واجهوا تجارب مؤلمة أو مؤذية خلال طفولتهم و / أو مراهقتهم.

هدفنا:

تحسين الفهم

من خلال فهم تأثيرها، نأمل أن نبلغ مجتمع الصحة النفسية اللبناني **بأهمية معالجة هذه التجارب وتأثيراتها غير المعترف بها بشكلٍ كافٍ** في كثيرٍ من الأحيان لتحسين نتائج العلاج النفسي.

في حال وجود أسئلة، يمكنك التواصل مع **د. فاطمة الجميل** (fa25@aub.edu.lb) أو **جورج سعده** (gjs09@mail.aub.edu).

ما الذي تتضمنه هذه الدراسة؟

قراءة واستكمال **وثيقة الموافقة المستنيرة.**

تعبئة استمارة عبر الإنترنت تستغرق حوالي **٣٠** إلى **٤٠ دقيقة** على LimeSurvey.

إكمال **تمرين استرخاء وجيز** بعد إنهاء الاستمارة.

للمشاركة في هذه الدراسة البحثية، يرجى زيارة الرابط التالي:

https://tinyurl.com/w3rcsjnw

APPENDIX C

Informed Consent Form (Community Sample)

Informed Consent Form (Community Sample), in English – Page 1 of 2

This consent form is for an IRB-approved research study at the American University of Beirut (AUB). It is not an official message from AUB.

Consent to Participate in an Online Research Study

Title:	The Short- and Long-Term Impact of Childhood Adversities in Lebanon	
Researcher(s):	Dr Tima El-Jamil, AUB	George Saadé, AUB
Researcher Contact Info:	+961 1 350 000; Ext. 4372	+961 76 86 15 14
	fa25@aub.edu.lb	gjs09@mail.aub.edu

You are being invited to take part in a research study. The box below highlights key information about this research for you to consider when deciding whether to take part or not. Carefully consider this information and the additional information provided below the box.

Key Information for You to Consider

- **Voluntary Consent**. Your participation in this research study is completely voluntary. It is up to you whether you choose to take part or not. There will be no penalty if you choose not to take part or to discontinue your participation at any time.
- **Purpose**. The purpose of this research study is to explore the short- and long-term consequences of traumatic or abusive experiences that people sometimes face during their childhoods and/or adolescence.
- **Eligibility**. To take part in this study, you must be over 18 years of age and currently residing in Lebanon.
- **Sample.** You are one of approximately 140 participants that have been approached via online advertisements and personal contacts, to take part in this study.
- **Duration.** It is expected that your participation will last approximately 20 to 40 minutes.
- **Procedures and Activities.** You will be asked to complete an online survey. This survey contains 9 questionnaires that ask about childhood adversities as well as their short- and long-term consequences.
- **Risks.** In earlier research on this topic, a small number of participants experienced mild emotional distress when answering some of the research questionnaires; however, that distress was temporary.
- **Protective Measures.** To minimise this distress, you will be asked to complete a brief 6-minute relaxation exercise when your participation in the study is over. You will also have access to this exercise if you choose to withdraw your participation from the study at any time.
- **Benefits**. You may not directly benefit from this research; however, we hope that your participation in the study may advance our understanding about the short- and long-term consequences of childhood adversities experienced by people currently residing in Lebanon.
- **Alternatives.** Your alternative is to not take part in this research study.

Note: For scientific reasons, this consent form only offers general information about the research question being studied. You will be given more specific information when your participation in the study is over. You will also have access to this information if you choose to withdraw your participation at any time.

This consent form is for an IRB-approved research study at the American University of Beirut (AUB). It is not an official message from AUB.

What happens to the information collected for this research?

Information collected for this research will be used to inform the Lebanese mental health community about the importance of addressing childhood adversities and their often underrecognized impact to improve treatment outcomes.

How will my privacy and data confidentiality be protected?

Your participation in this study is completely ***anonymous***. Accordingly, no personally identifiable information will be collected from you.

Will I be paid for taking part in this research?

You will not be paid for taking part in this research.

How can I withdraw or conclude my participation from the study?

To withdraw or conclude your participation in the study at any time, you may press the "Next" button on each page of the survey until you reach the Debriefing page. After which, you will be asked about whether you would like to have your data included in the analyses of the study's hypotheses. You will also be provided with more specific information about the study and access to helpful resources.

Who can answer my questions about this research?

If you have questions or concerns, please contact the research team at:

Tima El-Jamil, PhD
+961 1 350 000; Ext. 4372
fa25@aub.edu.lb

George Saadé
+961 76 86 15 14
gjs0@mail.aub.edu

An Institutional Review Board ("IRB") is overseeing this research. An IRB is a group of people who perform independent review of research studies to ensure the rights and welfare of participants are protected. If you have questions about your rights or wish to speak with someone other than the research team, you may contact:

Institutional Review Board Office
American University of Beirut
P. O. Box: 11-0236 F15
Riad El Solh, Beirut 1107 2020
+961 1 350 000; Ext. 5445
irb@aub.edu.lb

STATEMENT OF CONSENT

By clicking "Next" below, you are indicating that you are at least 18 years old, have read this consent form, and agree to participate in this research study. You are free to skip any question that you choose.

Next | I do not agree.

Informed Consent Form (Community Sample), in Arabic – Page 1 of 2

وثيقة الموافقة هذه مخصصة لدراسةٍ بحثية معتمدة من مجلس المراجعة المؤسسية (IRB) في الجامعة الأمريكية في بيروت (AUB). إنها ليست رسالة رسمية من الجامعة الأميركية في بيروت.

الموافقة على المشاركة في دراسةٍ بحثية عبر الإنترنت

العنوان:	آثار محن الطفولة على المدى القصير والطويل في لبنان	
الباحثون:	د. فاطمة الجميل، AUB	جورج سعادة، AUB
معلومات الاتصال بالباحثين:	+961 1 350 000; Ext. 4372	+961 76 86 15 14
	fa25@aub.edu.lb	gjs09@mail.aub.edu

أنت مدعو(ة) للمشاركة في دراسةٍ بحثية. يسلط المربع أدناه الضوء على المعلومات الأساسية حول هذا البحث لتأخذها بعين الاعتبار عند اتخاذ قرار بشأن المشاركة أو عدم المشاركة. أمعن النظر بهذه المعلومات والمعلومات الإضافية الواردة أدناه.

معلومات أساسية لتأخذها بعين الاعتبار

- **الموافقة الطوعية.** مشاركتك في هذه الدراسة البحثية طوعية تماماً. الأمر متروك لك لتختار إذا ما كنت تود المشاركة أو عدم المشاركة. لن تكون هناك أي عقوبة أو جزاء إذا اخترت عدم المشاركة أو التوقف عن مشاركتك في أي وقت.
- **غرض الدراسة.** الغرض من هذه الدراسة البحثية هو استكشاف آثار التجارب المؤلمة أو المؤذية على المدى القصير والطول التي يواجهها الناس أحياناً خلال طفولتهم و / أو مراهقتهم.
- **شروط المشاركة.** للمشاركة في هذه الدراسة، يجب أن يكون عمرك أكثر من ١٨ عاماً وأن تكون مقيماً حالياً في لبنان.
- **عدد المشاركين.** أنت واحد(ة) من حوالي ١٤٠ مشارك(ة) تم التواصل معهم عبر الإعلانات الإلكترونية وجهات الاتصال الشخصية، للمشاركة في هذه الدراسة.
- **المدة الزمنية.** من المتوقع أن تستمر مشاركتك حوالي ٢٠ إلى ٤٠ دقيقة.
- **الإجراءات والأنشطة.** سيُطلب منك إكمال استمارة عبر الإنترنت. تحتوي هذه الاستمارة على ٩ استبيانات تسأل عن محن الطفولة بالإضافة إلى آثارها قصيرة وطويلة المدى.
- **المخاطر.** في أبحاثٍ سابقة حول هذا الموضوع، عانى عدد صغير من المشاركين من اضطراب عاطفي خفيف المستوى عند الإجابة على بعض استبيانات البحث. ومع ذلك، كان ذلك الاضطراب مؤقت.
- **التدابير الوقائية.** لتقليل هذا الاضطراب إلى أدنى حدٍ ممكن، سيُطلب منك إكمال تمرين استرخائي قصير مدته ٦ دقائق عند انتهاء مشاركتك في هذه الدراسة. ستحصل أيضاً على هذا التمرين إن اخترت سحب مشاركتك من الدراسة في أي وقت.
- **الفوائد.** قد لا تستفيد بشكلٍ مباشر من هذا البحث؛ ومع ذلك، نأمل أن تؤدي مشاركتك في هذه الدراسة إلى تعزيز فهمنا لآثار محن الطفولة على المدى القصير والطويل التي يعاني منها الأشخاص المقيمون حالياً في لبنان.
- **الخيارات.** خيارك الآخر هو عدم المشاركة في هذه الدراسة البحثية.

ملاحظة: لأسباب علمية، لا تقدم وثيقة الموافقة هذه سوى معلومات عامة حول سؤال البحث قيد الدراسة. ستحصل على معلومات أكثر تحديداً عند انتهاء مشاركتك في الدراسة. ستحصل على هذه المعلومات أيضاً إن اخترت أن تسحب مشاركتك في أي وقت.

Informed Consent Form (Community Sample), in Arabic – Page 2 of 2

وثيقة الموافقة هذه مخصصة لدراسةٍ بحثية معتمدة من مجلس المراجعة المؤسسية (IRB) في الجامعة الأمريكية في بيروت (AUB). إنها ليست رسالة رسمية من الجامعة الأميركية في بيروت.

ماذا يحدث للمعلومات التي يتم السؤال عنها في هذا البحث؟

تُستخدم المعلومات التي يتم السؤال عنها في هذا البحث لإعلام المجتمع المهني في مجال الصحة النفسية في لبنان بأهمية معالجة محن الطفولة وتأثيراتها غير المعترف بها بالشكل الكافي في كثيرٍ من الأحيان بهدف تحسين نتائج العلاج.

كيف ستتم حماية خصوصيتي وسرية بياناتي؟

مشاركتك في هذه الدراسة مجهولة تماماً. وفقًا لذلك، لن يتم سؤالك عن أي معلومات تعرف عنك شخصياً.

هل سأحصل على مبلغٍ مالي مقابل المشاركة في هذا البحث؟

لن تحصل على مبلغٍ مالي مقابل المشاركة في هذا البحث.

كيف يمكنني سحب أو إنهاء مشاركتي من الدراسة؟

لسحب أو إنهاء مشاركتك في الدراسة في أي وقت، يمكنك الضغط على زر "التالي" في كل صفحة من صفحات الاستمارة حتى تصل إلى صفحة بيان المعلومات. بعد ذلك، سيتم سؤالك عما إذا كنت ترغب في إدراج أجوبتك في اختبار فرضيات الدراسة. سيتم أيضاً تزويدك بمزيدٍ من المعلومات المحددة حول الدراسة، وإرشادات للحصول على الموارد المفيدة.

من يستطيع أن يجيب على أسئلتي حول هذا البحث؟

إذا كانت لديك أسئلة أو مخاوف، فيرجى الاتصال بفريق البحث على:

د. فاطمة الجميل
+961 1 350 000; Ext. 4372
fa25@aub.edu.lb

جورج سعاده
+961 76 86 15 14
gjs0@mail.aub.edu

يشرف مجلس المراجعة المؤسسية ("IRB") على هذا البحث. مجلس المراجعة المؤسسية هو مجموعة من الأشخاص الذين يقومون بإجراء مراجعة مستقلة للدراسات البحثية لضمان حماية حقوق وسلامة المشاركين. إذا كانت لديك أسئلة حول حقوقك أو ترغب في التحدث مع شخصٍ آخر خارج فريق البحث، فيمكنك الاتصال بـ:

مكتب مجلس المراجعة المؤسسية
الجامعة الأمريكية في بيروت
صندوق البريد: 11-0236 F15
رياض الصلح، بيروت 1107-2020
+961 1 350 000; Ext. 5445
irb@aub.edu.lb

بيان الموافقة

بالنقر على "التالي" أدناه، فإنك تشير إلى أن عمرك لا يقل عن ١٨ عاماً، وقد قرأت وثيقة الموافقة هذه، وتوافق على المشاركة في هذه الدراسة البحثية. أنت حر في التغاضي عن إجابة أي سؤال تود أن تتخطاه.

التالي

APPENDIX D

Informed Consent Form (Student Sample)

Informed Consent Form (Student Sample), in English – Page 1 of 2

This consent form is for an IRB-approved research study at the American University of Beirut (AUB). It is not an official message from AUB.

Consent to Participate in an Online Research Study

Title:	The Short- and Long-Term Impact of Childhood Adversities in Lebanon	
Researcher(s):	Dr Tima El-Jamil, AUB	George Saadé, AUB
Researcher Contact Info:	+961 1 350 000; Ext. 4372 fa25@aub.edu.lb	+961 76 86 15 14 gjs09@mail.aub.edu

You are being invited to take part in a research study as part of your Introductory Psychology course. The box below highlights key information about this research for you to consider when deciding whether to take part or not. Carefully consider this information and the additional information provided below the box.

Key Information for You to Consider

- **Voluntary Consent**. Your participation in this research study is completely voluntary. It is up to you whether you choose to take part or not. There will be no penalty if you choose not to take part or to discontinue your participation at any time.
- **Purpose**. The purpose of this research study is to explore the short- and long-term consequences of traumatic or abusive experiences that people sometimes face during their childhoods and/or adolescence.
- **Eligibility**. To take part in this study, you must be over 18 years of age and currently residing in Lebanon.
- **Sample.** You are one of approximately 140 participants that have been approached via online advertisements and personal contacts, to take part in this study.
- **Duration.** It is expected that your participation will last approximately 20 to 40 minutes.
- **Procedures and Activities.** You will be asked to complete an online survey. This survey contains 9 questionnaires that ask about childhood adversities as well as their short- and long-term consequences.
- **Risks.** In earlier research on this topic, a small number of participants experienced mild emotional distress when answering some of the research questionnaires; however, that distress was temporary.
- **Protective Measures.** To minimise this distress, you will be asked to complete a brief 6-minute relaxation exercise when your participation in the study is over. You will also have access to this exercise if you choose to withdraw your participation from the study at any time.
- **Benefits**. You may not directly benefit from this research; however, we hope that your participation in the study may advance our understanding about the short- and long-term consequences of childhood adversities experienced by people currently residing in Lebanon.
- **Alternatives.** Your alternative is to write a scientific report for an extra credit as suggested by your instructor.

Note: For scientific reasons, this consent form only offers general information about the research question being studied. You will be given more specific information when your participation in the study is over. You will also have access to this information if you choose to withdraw your participation at any time.

This consent form is for an IRB-approved research study at the American University of Beirut (AUB). It is not an official message from AUB.

What happens to the information collected for this research?

Information collected for this research will be used to inform the Lebanese mental health community about the importance of addressing childhood adversities and their often underrecognized impact to improve treatment outcomes.

How will my privacy and data confidentiality be protected?

Your participation in this study is completely ***anonymous***. Accordingly, no personally identifiable information will be collected from you.

Will I be compensated for taking part in this research?

You will receive a total of one extra percentage point on your final course grade once your research participation is complete. If you choose to discontinue your participation, you are still eligible to receive that extra credit.

How can I withdraw or conclude my participation from the study?

To withdraw or conclude your participation in the study at any time, you may press the "Next" button on each page of the survey until you reach the Debriefing page. After which, you will be asked about whether you would like to have your data included in the analyses of the study's hypotheses. You will also be provided with more specific information about the study, instructions to redeem that extra credit, and access to helpful resources.

Who can answer my questions about this research?

If you have questions or concerns, please contact the research team at:

Tima El-Jamil, PhD
+961 1 350 000; Ext. 4372
fa25@aub.edu.lb

George Saadé
+961 76 86 15 14
gjs0@mail.aub.edu

An Institutional Review Board ("IRB") is overseeing this research. An IRB is a group of people who perform independent review of research studies to ensure the rights and welfare of participants are protected. If you have questions about your rights or wish to speak with someone other than the research team, you may contact:

Institutional Review Board Office
American University of Beirut
P. O. Box: 11-0236 F15
Riad El Solh, Beirut 1107 2020
+961 1 350 000; Ext. 5445
irb@aub.edu.lb

STATEMENT OF CONSENT

By clicking "Next" below, you are indicating that you are at least 18 years old, have read this consent form, and agree to participate in this research study. You are free to skip any question that you choose.

Next | I do not agree.

Informed Consent Form (Student Sample), in Arabic – Page 1 of 2

وثيقة الموافقة هذه مخصصة لدراسةٍ بحثية معتمدة من مجلس المراجعة المؤسسية (IRB) في الجامعة الأمريكية في بيروت (AUB). إنها ليست رسالة رسمية من الجامعة الأميركية في بيروت.

الموافقة على المشاركة في دراسةٍ بحثية عبر الإنترنت

العنوان:	آثار محن الطفولة على المدى القصير والطويل في لبنان	
الباحثون:	د. فاطمة الجميل، AUB	جورج سعادة، AUB
معلومات الاتصال بالباحثين:	+961 1 350 000; Ext. 4372	+961 76 86 15 14
	fa25@aub.edu.lb	gjs09@mail.aub.edu

أنت مدعو(ة) للمشاركة في دراسةٍ بحثية كجزءٍ من الدورة التمهيدية لعلم النفس (PSYC 201). يسلط المربع أدناه الضوء على المعلومات الأساسية حول هذا البحث لتأخذها بعين الاعتبار عند اتخاذ قرار بشأن المشاركة أو عدم المشاركة. أمعن النظر بهذه المعلومات والمعلومات الإضافية الواردة أدناه.

معلومات أساسية لتأخذها بعين الاعتبار

- **الموافقة الطوعية.** مشاركتك في هذه الدراسة البحثية طوعية تماماً. الأمر متروك لك لتختار إذا ما كنت تود المشاركة أو عدم المشاركة. لن تكون هناك أي عقوبة أو جزاء إذا اخترت عدم المشاركة أو التوقف عن مشاركتك في أي وقت.
- **غرض الدراسة.** الغرض من هذه الدراسة البحثية هو استكشاف آثار التجارب المؤلمة أو المؤذية على المدى القصير والطول التي يواجهها الناس أحياناً خلال طفولتهم و / أو مراهقتهم.
- **شروط المشاركة.** للمشاركة في هذه الدراسة، يجب أن يكون عمرك أكثر من ١٨ عاماً وأن تكون مقيماً حالياً في لبنان.
- **عدد المشاركين.** أنت واحد(ة) من حوالي ١٤٠ مشاركـ(ة) تم التواصل معهم عبر الإعلانات الإلكترونية وجهات الاتصال الشخصية، للمشاركة في هذه الدراسة.
- **المدة الزمنية.** من المتوقع أن تستمر مشاركتك حوالي ٢٠ إلى ٤٠ دقيقة.
- **الإجراءات والأنشطة.** سيُطلب منك إكمال استمارة عبر الإنترنت. تحتوي هذه الاستمارة على ٩ استبيانات تسأل عن محن الطفولة بالإضافة إلى آثارها قصيرة وطويلة المدى.
- **المخاطر.** في أبحاثٍ سابقة حول هذا الموضوع، عانى عدد صغير من المشاركين من اضطراب عاطفي خفيف المستوى عند الإجابة على بعض استبيانات البحث. ومع ذلك، كان ذلك الاضطراب مؤقت.
- **التدابير الوقائية.** لتقليل هذا الاضطراب إلى أدنى حدٍ ممكن، سيُطلب منك إكمال تمرين استرخائي قصير مدته ٦ دقائق عند انتهاء مشاركتك في هذه الدراسة. ستحصل أيضاً على هذا التمرين إن اخترت سحب مشاركتك من الدراسة في أي وقت.
- **الفوائد.** قد لا تستفيد بشكلٍ مباشر من هذا البحث؛ ومع ذلك، نأمل أن تؤدي مشاركتك في هذه الدراسة إلى تعزيز فهمنا لآثار محن الطفولة على المدى القصير والطويل التي يعاني منها الأشخاص المقيمون حالياً في لبنان.
- **الخيارات.** خيارك الآخر هو كتابة تقرير علمي للحصول على علامة إضافية وفقاً لاقتراح مدرسـ(ت)ـك.

ملاحظة: لأسبابٍ علمية، لا تقدم وثيقة الموافقة هذه سوى معلومات عامة حول سؤال البحث قيد الدراسة. ستحصل على معلومات أكثر تحديداً عند انتهاء مشاركتك في الدراسة. ستحصل على هذه المعلومات أيضاً إن اخترت أن تسحب مشاركتك في أي وقت.

Informed Consent Form (Student Sample), in Arabic – Page 2 of 2

وثيقة الموافقة هذه مخصصة لدراسةٍ بحثية معتمدة من مجلس المراجعة المؤسسية (IRB) في الجامعة الأمريكية في بيروت (AUB). إنها ليست رسالة رسمية من الجامعة الأميركية في بيروت.

ماذا يحدث للمعلومات التي يتم السؤال عنها في هذا البحث؟

تُستخدم المعلومات التي يتم السؤال عنها في هذا البحث لإعلام المجتمع المهني في مجال الصحة النفسية في لبنان بأهمية معالجة محن الطفولة وتأثيراتها غير المعترف بها بالشكل الكافي في كثيرٍ من الأحيان بهدف تحسين نتائج العلاج.

كيف ستتم حماية خصوصيتي وسرية بياناتي؟

مشاركتك في هذه الدراسة مجهولة تماماً. وفقًا لذلك، لن يتم سؤالك عن أي معلومات تعرف عنك شخصياً.

هل سيتم مكافأتي على المشاركة في هذا البحث؟

ستحصل على إجمالي نقطة مئوية إضافية على معدلك النهائي في الدورة التمهيدية لعلم النفس (PSYC 201) بمجرد اكمال مشاركتك البحثية. إن اخترت سحب مشاركتك، فلا يزال بإمكانك الحصول على هذه العلامة الإضافية.

كيف يمكنني سحب أو إنهاء مشاركتي من الدراسة؟

لسحب أو إنهاء مشاركتك في الدراسة في أي وقت، يمكنك الضغط على زر "التالي" في كل صفحة من صفحات الاستمارة حتى تصل إلى صفحة بيان المعلومات. بعد ذلك، سيتم سؤالك عما إذا كنت ترغب في إدراج أجوبتك في اختبار فرضيات الدراسة. سيتم أيضاً تزويدك بمزيدٍ من المعلومات المحددة حول الدراسة، وإرشادات للحصول على تلك العلامة الإضافية.، والموارد المفيدة.

من يستطيع أن يجيب على أسئلتي حول هذا البحث؟

إذا كانت لديك أسئلة أو مخاوف، فيرجى الاتصال بفريق البحث على:

د. فاطمة الجميل
+961 1 350 000; Ext. 4372
fa25@aub.edu.lb

جورج سعاده
+961 76 86 15 14
gjs0@mail.aub.edu

يشرف مجلس المراجعة المؤسسية ("IRB") على هذا البحث. مجلس المراجعة المؤسسية هو مجموعة من الأشخاص الذين يقومون بإجراء مراجعة مستقلة للدراسات البحثية لضمان حماية حقوق وسلامة المشاركين. إذا كانت لديك أسئلة حول حقوقك أو ترغب في التحدث مع شخصٍ آخر خارج فريق البحث، فيمكنك الاتصال بـ:

مكتب مجلس المراجعة المؤسسية
الجامعة الأمريكية في بيروت
صندوق البريد: 11-0236 F15
رياض الصلح، بيروت 1107-2020
+961 1 350 000; Ext. 5445
irb@aub.edu.lb

بيان الموافقة

بالنقر على "التالي" أدناه، فإنك تشير إلى أن عمرك لا يقل عن ١٨ عاماً، وقد قرأت وثيقة الموافقة هذه، وتوافق على المشاركة في هذه الدراسة البحثية. أنت حر في التغاضي عن إجابة أي سؤال تود أن تتخطاه.

التالي

APPENDIX E

Debriefing Form (Community Sample)

Debriefing Form (Community Sample), in English – Page 1 of 3

This debriefing form is for an IRB-approved research study at the American University of Beirut (AUB). It is not an official message from AUB.

Debriefing after Participation in an Online Research Study

Now, let us take a few moments to complete a brief relaxation exercise.

Click **here** to access the relaxation exercise.

We would like to thank you for your participation in this research study. For this study, it was important that we provide you with general information about some aspects of the study initially. Now that your participation is complete, we will describe the study to you in more details and provide you with the opportunity to make a decision on whether you would like to have your data included in this study.

Purpose of the Study:

- Earlier in our consent form, we informed you that the purpose of the study was to explore the short- and long-term consequences of traumatic or abusive experiences that people sometimes face during their childhoods and/or adolescence.
- **In actuality**, our study is about exploring the rate of dissociation in a diverse sample of adults residing in Lebanon.
- It also aims to investigate the factors that may influence higher rates of dissociation within this sample by looking at:
  1) the possible influence of trauma-related characteristics (such as cumulative exposure, timing, duration, and severity) on the rate of dissociation; and
  2) the possible influence of trauma-related reactions (such as being oblivious to betrayal, anger suppression, shame, and anger at the self) on the rate of dissociation.
- Accordingly, we hypothesize that being oblivious to betrayal, anger suppression, shame, and anger at the self will influence the rate of dissociation more so than cumulative exposure, timing, duration, and severity of childhood maltreatment.
- *Dissociation* is one way our minds cope with extreme stress resulting from traumatic events that cannot be easily escaped, such as those experienced in childhood maltreatment.
- It describes an experience where you may feel in some way disconnected from, or unaware of, your behaviors, movements, bodily sensations, experience of the world, emotions, memories, and/or sense of self.

Unfortunately, to rigorously test our hypothesis, we could not provide you with all these details prior to your participation. This ensures that your answers to this study's questionnaires were precise and not influenced by prior knowledge about the purpose of the study. We regret this initial withholding of information, but we hope you understand the reason for it.

Now that you know the true purpose of our study and are fully informed, you may decide whether you do or do not want your data used in this research. Please indicate below if you do, or do not, give permission to have your data included in testing this study's hypotheses:

◎ I give permission to have my data included in testing this study's hypotheses.

◎ I **do not** give permission to have my data included in testing this study's hypotheses.

Please do not disclose research procedures and/or hypotheses to anyone who might participate in this study in the future as this could affect the results of the study.

This debriefing form is for an IRB-approved research study at the American University of Beirut (AUB). It is not an official message from AUB.

Useful Contact Information:

If you have any questions or concerns regarding this study, its purpose or procedures, or if you have a research-related problem, please feel free to contact the researchers:

Tima El-Jamil, PhD
+961 1 350 000; Ext. 4372
fa25@aub.edu.lb

George Saadé
+961 76 86 15 14
gjs0@mail.aub.edu

If you have any questions concerning your rights as a research subject, you may contact the Institutional Review Board (IRB) at the American University of Beirut:

Institutional Review Board Office
American University of Beirut
P. O. Box: 11-0236 F15
Riad El Solh, Beirut 1107 2020
+961 1 350 000; Ext. 5445
irb@aub.edu.lb

If you feel upset after having completed the study or find that some questions or aspects of the study triggered distress, talking with a qualified clinician may help. If you feel you would like assistance, please contact the **Embrace Lifeline** for immediate or out-of-hours support at **1564**, or any of the following **affordable** or **free** local mental health services:

AUBMC's Outpatient Department
+961 1 350 000; Ext. 5740

Embrace's Mental Health Centre
+961 81 00 38 70

Institute for Development, Research, Advocacy, and Applied Care (IDRAAC)
+961 76 10 05 76

The Blue Mission Organisation
+961 78 96 50 62

Restart Center
+961 76 70 80 83

International Medical Corps (IMC)
+961 71 38 30 97

Caritas Lebanon
+961 1 49 97 67

Medical Care and Community Development (SIDC)
+961 70 98 34 27

Further Readings:

If you would like to learn more about childhood maltreatment, complex traumatization, and dissociation, please see the following references:

ISTSS Resources:

1. Information on Childhood Abuse and Neglect
2. Remembering Childhood Trauma

ISSTD Resources:

1. Trauma and Complex Trauma: An Overview
2. Post-Traumatic Stress Disorders
3. Trauma-Related Dissociation: An Introduction
4. What Are the Dissociative Disorders?
5. Getting Treatment for Complex Trauma and Dissociation

Once again, thank you for your participation in this study!

Submit

Debriefing Form (Community Sample), in Arabic – Page 1 of 3

بيان المعلومات بعد المشاركة في دراسة بحثية عبر الإنترنت

الآن، فلنأخذ بضع لحظات لإكمال تمرين استرخاء وجيز.

انقر هنا للدخول إلى تمرين الاسترخاء.

نود أن نشكرك على مشاركتك في هذه الدراسة البحثية. بالنسبة لهذه الدراسة، كان من المهم أن نقدم لك معلومات عامة حول بعض جوانب الدراسة في البداية. الآن بعد أن انتهت مشاركتك، سنقوم بوصف الدراسة لك بمزيدٍ من التفاصيل وسنوفر لك الفرصة لاتخاذ قرار بشأن ما إذا كنت ترغب بإدراج أجوبتك في هذه الدراسة.

الغرض من الدراسة:

- في وقتٍ سابق في وثيقة الموافقة المستنيرة، أبلغناك أن الغرض من الدراسة هو استكشاف آثار قصيرة وطويلة المدى للتجارب المؤلمة أو المؤذية التي يواجهها الأشخاص أحياناً خلال طفولتهم و / أو مراهقتهم.
- **في الواقع**، تدور دراستنا حول استكشاف نسبة العوارض في شريحة متنوعة من البالغين المقيمين في لبنان.
- كما أنها تهدف إلى التحقيق في العوامل التي قد تؤثر على ارتفاع نسب الظواهر الانفصالية داخل هذه الشريحة من خلال النظر في:

1) التأثير المحتمل للخصائص المرتبطة بالصدمات (مثل التعرض التراكمي والتوقيت والمدة والحدة) على نسبة العوارض؛ و

2) التأثير المحتمل لردود الفعل المرتبطة بالصدمات (مثل الغفول عن للغدر، وكبت الغضب، والشعور بالعار، والغضب من الذات) على نسبة وجود الظواهر الانفصالية.

- وفقاً لذلك، نفترض أن الغفول عن الغدر وكبت الغضب والعار والغضب من الذات سيؤثر على نسبة العوارض أكثر من التعرض التراكمي والتوقيت والمدة والحدة لسوء المعاملة في مرحلة الطفولة.
- الانفصال هو إحدى الطرق التي تتعامل بها عقولنا مع الضغط الشديد الناتج عن الأحداث الصادمة التي لا يمكن الهروب منها بسهولة، مثل تلك التي تُختبر ضمن سوء المعاملة في مرحلة الطفولة.
- وإنه يصف تجربة قد تشعر فيها بالانفصال أو الغفول عن سلوكياتك وتحركاتك وأحاسيسك الجسدية واختبارك للعالم والعواطف والذكريات و / أو مفهومك للذات.

لسوء الحظ، لاختبار فرضيتنا بدقة، لم نتمكن من تزويدك بكل هذه التفاصيل قبل مشاركتك. يضمن ذلك أن تكون إجاباتك على استبيانات هذه الدراسة دقيقة وغير متأثرة بالمعرفة المسبقة حول الغرض من الدراسة. نأسف لهذا الحجب الأولي للمعلومات، لكننا نأمل أن تتفهم سبب ذلك.

الآن بعد أن عرفت الغرض الحقيقي من دراستنا وأصبحت على اطلاع كامل، يمكنك أن تقرر ما إذا كنت تريد أو لا تريد أن تُستخدم أجوبتك في هذا البحث. يرجى الإشارة أدناه إلى ما إذا كنت تمنح أو لا تمنح الإذن لإدراج أجوبتك في اختبار فرضية هذه الدراسة:

◎ أعطي الإذن لإدراج أجوبتي في اختبار فرضيات هذه الدراسة.

◎ **لا** أعطي الإذن لإدراج أجوبتي في اختبار فرضيات هذه الدراسة.

يرجى عدم الإفصاح عن إجراءات و / أو فرضيات البحث لأي شخصٍ قد يشارك في هذه الدراسة في المستقبل لأن ذلك قد يؤثر على نتائج الدراسة.

معلومات الاتصال المفيدة:

إذا كانت لديك أي أسئلة أو مخاوف بشأن هذه الدراسة، أو الغرض منها أو إجراءاتها، أو إذا كانت لديك مشكلة متعلقة بالبحث، فلا تتردد في الاتصال بالباحثين:

د. فاطمة الجميل
+961 1 350 000; Ext. 4372
fa25@aub.edu.lb

جورج سعاده
+961 76 86 15 14
gjs0@mail.aub.edu

إذا كانت لديك أي أسئلة بخصوص حقوقك كمشاركٍ في البحث، فيمكنك الاتصال بمجلس المراجعة المؤسسية (IRB) في الجامعة الأمريكية في بيروت:

مكتب مجلس المراجعة المؤسسية
الجامعة الأمريكية في بيروت
صندوق البريد: 11-0236 F15
رياض الصلح، بيروت 1107-2020
+961 1 350 000; Ext. 5445
irb@aub.edu.lb

إذا شعرت بالحزن بعد الانتهاء من الدراسة أو وجدت أن بعض الأسئلة أو جوانب الدراسة قد أزعجتك، فقد يساعدك التحدث مع أخصائي مؤهل. إذا كنت تشعر أنك بحاجة إلى المساعدة، فيرجى الاتصال بـ **Embrace Lifeline** للحصول على دعم فوري أو خارج ساعات العمل على الرقم **١٥٦٤**، أو أيٍ من خدمات الصحة النفسية المحلية التالية ذات التكلفة **المخفضة** أو **المجانية:**

المركز الطبي في الجامعة الأمريكية في بيروت (AUBMC) – قسم العيادات الخارجية
+961 1 350 000; Ext. 5740

مركز إمبرايس للصحة النفسية
+961 81 00 38 70

معهد التنمية والبحوث والتوعية والرعاية التطبيقية (IDRAAC)
+961 76 10 05 76

منظمة البعثة الزرقاء (Blue Mission)
+961 78 96 50 62

مركز ريستارت (Restart Centre)
+961 76 70 80 83

الهيئة الطبية الدولية (IMC)
+961 71 38 30 97

كاريتاس لبنان
+961 1 49 97 67

جمعية التنمية الصحية والاجتماعية (SIDC)
+961 70 98 34 27

لمزيدٍ من المعلومات:

إذا كنت تود معرفة المزيد عن سوء المعاملة في سن الطفولة والصدمات المعقدة والظواهر الانفصالية، يرجى الاطلاع على المراجع التالية:

موارد من *ISTSS*:

1. معلومات الإنترنت حول إساءة معاملة الأطفال وإهمالهم
2. تذكر صدمات الطفولة

موارد من *ISSTD*:

1. الصدمات والصدمات المعقدة: نظرة عامة
2. اضطرابات الاجهاد ما بعد الصدمة
3. الانفصال المرتبط بالصدمات: مقدمة
4. ما هي الاضطرابات الانفصالية؟
5. تلقي العلاج للصدمات المعقدة والظواهر الانفصالية

مرة أخرى، شكراً لك على مشاركتك في هذه الدراسة!

الإرسال

APPENDIX F

Debriefing Form (Student Sample)

Debriefing Form (Student Sample), in English – Page 1 of 2

This debriefing form is for an IRB-approved research study at the American University of Beirut (AUB). It is not an official message from AUB.

Debriefing after Participation in an Online Research Study

Now, let us take a few moments to complete a brief relaxation exercise.

Click **here** to access the relaxation exercise.

We would like to thank you for your participation in this research study. For this study, it was important that we provide you with general information about some aspects of the study initially. Now that your participation is complete, we will describe the study to you in more details and provide you with the opportunity to make a decision on whether you would like to have your data included in this study.

Purpose of the Study:

- Earlier in our consent form, we informed you that the purpose of the study was to explore the short- and long-term consequences of traumatic or abusive experiences that people sometimes face during their childhoods and/or adolescence.
- **In actuality**, our study is about exploring the rate of dissociation in a diverse sample of adults residing in Lebanon.
- It also aims to investigate the factors that may influence higher rates of dissociation within this sample by looking at:
  1) the possible influence of trauma-related characteristics (such as cumulative exposure, timing, duration, and severity) on the rate of dissociation; and
  2) the possible influence of trauma-related reactions (such as being oblivious to betrayal, anger suppression, shame, and anger at the self) on the rate of dissociation.
- Accordingly, we hypothesize that being oblivious to betrayal, anger suppression, shame, and anger at the self will influence the rate of dissociation more so than cumulative exposure, timing, duration, and severity of childhood maltreatment.
- *Dissociation* is one way our minds cope with extreme stress resulting from traumatic events that cannot be easily escaped, such as those experienced in childhood maltreatment.
- It describes an experience where you may feel in some way disconnected from, or unaware of, your behaviors, movements, bodily sensations, experience of the world, emotions, memories, and/or sense of self.

Unfortunately, to rigorously test our hypothesis, we could not provide you with all these details prior to your participation. This ensures that your answers to this study's questionnaires were precise and not influenced by prior knowledge about the purpose of the study. We regret this initial withholding of information, but we hope you understand the reason for it.

Now that you know the true purpose of our study and are fully informed, you may decide whether you do or do not want your data used in this research. Please indicate below if you do, or do not, give permission to have your data included in testing this study's hypotheses:

◎ I give permission to have my data included in testing this study's hypotheses.

◎ I **do not** give permission to have my data included in testing this study's hypotheses.

Whether you agree or do not agree to have your data used for this study, you will still receive one extra percentage point on your final course grade as compensation for your participation. To redeem the extra credit, please follow these instructions.

Please do not disclose research procedures and/or hypotheses to anyone who might participate in this study in the future as this could affect the results of the study.

This debriefing form is for an IRB-approved research study at the American University of Beirut (AUB). It is not an official message from AUB.

Useful Contact Information:

If you have any questions or concerns regarding this study, its purpose or procedures, or if you have a research-related problem, please feel free to contact the researchers:

Tima El-Jamil, PhD
+961 1 350 000; Ext. 4372
fa25@aub.edu.lb

George Saadé
+961 76 86 15 14
gjs0@mail.aub.edu

If you have any questions concerning your rights as a research subject, you may contact the Institutional Review Board (IRB) at the American University of Beirut:

Institutional Review Board Office
American University of Beirut
P. O. Box: 11-0236 F15
Riad El Solh, Beirut 1107 2020
+961 1 350 000; Ext. 5445
irb@aub.edu.lb

If you feel upset after having completed the study or find that some questions or aspects of the study triggered distress, talking with a qualified clinician may help. If you feel you would like assistance, please contact the **Embrace Lifeline** for immediate or out-of-hours support at **1564**. or any of the following **free** mental health services available to the AUB community:

AUB Counselling Center
+961 1 350 000; Ext. 3196
counselingcenter@aub.edu.lb

AUBMC's Department of Psychiatry
+961 1 350 000; Ext. 5650
(sessions are covered under HIP)

Due to the COVID–19 pandemic, both mental health services are offering appointments by phone or online.

Further Readings:

If you would like to learn more about childhood maltreatment, complex traumatization, and dissociation, please see the following references:

ISTSS Resources:

1. Information on Childhood Abuse and Neglect
2. Remembering Childhood Trauma

ISSTD Resources:

1. Trauma and Complex Trauma: An Overview
2. Post-Traumatic Stress Disorders
3. Trauma-Related Dissociation: An Introduction
4. What Are the Dissociative Disorders?
5. Getting Treatment for Complex Trauma and Dissociation

Once again, thank you for your participation in this study!

Submit

Debriefing Form (Student Sample), in Arabic – Page 1 of 2

بيان المعلومات بعد المشاركة في دراسة بحثية عبر الإنترنت

الآن، فلنأخذ بضع لحظات لإكمال تمرين استرخاء وجيز.

انقر **هنا** للدخول إلى تمرين الاسترخاء.

نود أن نشكرك على مشاركتك في هذه الدراسة البحثية. بالنسبة لهذه الدراسة، كان من المهم أن نقدم لك معلومات عامة حول بعض جوانب الدراسة في البداية. الآن بعد أن انتهت مشاركتك، سنقوم بوصف الدراسة لك بمزيدٍ من التفاصيل وسنوفر لك الفرصة لاتخاذ قرار بشأن ما إذا كنت ترغب بإدراج أجوبتك في هذه الدراسة.

الغرض من الدراسة:

- في وقتٍ سابق في وثيقة الموافقة المستنيرة، أبلغناك أن الغرض من الدراسة هو استكشاف آثار قصيرة وطويلة المدى للتجارب المؤلمة أو المؤذية التي يواجهها الأشخاص أحياناً خلال طفولتهم و / أو مراهقتهم.
- **في الواقع**، تدور دراستنا حول استكشاف نسبة العوارض في شريحة متنوعة من البالغين المقيمين في لبنان.
- كما أنها تهدف إلى التحقيق في العوامل التي قد تؤثر على ارتفاع نسب الظواهر الانفصالية داخل هذه الشريحة من خلال النظر في:

1) التأثير المحتمل للخصائص المرتبطة بالصدمات (مثل التعرض التراكمي والتوقيت والمدة والحدة) على نسبة العوارض؛ و

2) التأثير المحتمل لردود الفعل المرتبطة بالصدمات (مثل الغفول عن الغدر، واكبت الغضب، والشعور بالعار، والغضب من الذات) على نسبة وجود الظواهر الانفصالية.

- وفقاً لذلك، نفترض أن الغفول عن الغدر وكبت الغضب والشعور بالعار والغضب من الذات سيؤثر على نسبة العوارض أكثر من التعرض التراكمي والتوقيت والمدة والحدة لسوء المعاملة في مرحلة الطفولة.
- الانفصال هو إحدى الطرق التي تتعامل بها عقولنا مع الضغط الشديد الناتج عن الأحداث الصادمة التي لا يمكن الهروب منها بسهولة، مثل تلك التي تُختبر ضمن سوء المعاملة في مرحلة الطفولة.
- وإنه يصف تجربة قد تشعر فيها بالانفصال أو الغفول عن سلوكياتك وتحركاتك وأحاسيسك الجسدية واختبارك للعالم والعواطف والذكريات و / أو مفهومك للذات.

لسوء الحظ، لاختبار فرضيتنا بدقة، لم نتمكن من تزويدك بكل هذه التفاصيل قبل مشاركتك. يضمن ذلك أن تكون إجاباتك على استبيانات هذه الدراسة دقيقة وغير متأثرة بالمعرفة المسبقة حول الغرض من الدراسة. نأسف لهذا الحجب الأولي للمعلومات، لكننا نأمل أن تتفهم سبب ذلك.

الآن بعد أن عرفت الغرض الحقيقي من دراستنا وأصبحت على اطلاع كامل، يمكنك أن تقرر ما إذا كنت تريد أم لا تريد أن تُستخدم أجوبتك في هذا البحث. يرجى الإشارة أدناه إلى ما إذا كنت تمنح أم لا تمنح الإذن لإدراج أجوبتك في اختبار فرضية هذه الدراسة:

◎ أعطي الإذن لإدراج أجوبتي في اختبار فرضيات هذه الدراسة.

◎ **لا** أعطي الإذن لإدراج أجوبتي في اختبار فرضيات هذه الدراسة.

سواء أكنت توافق أم لا توافق على استخدام أجوبتك في هذه الدراسة، فلا يزال بإمكانك الحصول على النقطة المئوية الإضافية على معدلك النهائي للدورة كمكافأة لمشاركتك. للاستحصال على العلامة الإضافية، يرجى اتباع هذه التعليمات.

يرجى عدم الإفصاح عن إجراءات و / أو فرضيات البحث لأي شخصٍ قد يشارك في هذه الدراسة في المستقبل لأن ذلك قد يؤثر على نتائج الدراسة.

Debriefing Form (Student Sample), in Arabic – Page 2 of 2

وثيقة بيان المعلومات هذه مخصصة لدراسةٍ بحثية معتمدة من مجلس المراجعة المؤسسية (IRB) في الجامعة الأمريكية في بيروت (AUB). إنها ليست رسالة رسمية من الجامعة الأميركية في بيروت.

معلومات الاتصال المفيدة:

إذا كانت لديك أي أسئلة أو مخاوف بشأن هذه الدراسة، أو الغرض منها أو إجراءاتها، أو إذا كانت لديك مشكلة متعلقة بالبحث، فلا تتردد في الاتصال بالباحثين:

د. فاطمة الجميل
+961 1 350 000; Ext. 4372
fa25@aub.edu.lb

جورج سعاده
+961 76 86 15 14
gjs0@mail.aub.edu

إذا كانت لديك أي أسئلة بخصوص حقوقك كمشاركٍ في البحث، فيمكنك الاتصال بمجلس المراجعة المؤسسية (IRB) في الجامعة الأمريكية في بيروت:

مكتب مجلس المراجعة المؤسسية
الجامعة الأمريكية في بيروت
صندوق البريد: 11-0236 F15
Riad El Solh, Beirut 1107 2020
+961 1 350 000; Ext. 5445
irb@aub.edu.lb

إذا شعرت بالحزن بعد الانتهاء من الدراسة أو وجدت أن بعض الأسئلة أو جوانب الدراسة قد أزعجتك، فقد يساعدك التحدث مع أخصائي مؤهل. إذا كنت تشعر أنك بحاجة إلى المساعدة، فيرجى الاتصال بـ **Embrace Lifeline** للحصول على دعم فوري أو خارج ساعات العمل على الرقم **١٥٦٤**، أو أي من خدمات الصحة النفسية **المجانية** التالية المتاحة لمجتمع الجامعة الأميركية في بيروت:

مركز المشورة النفسية في الجامعة الأميركية في بيروت
+961 1 350 000; Ext. 3196
counselingcenter@aub.edu.lb

المركز الطبي في الجامعة الأمريكية في بيروت – قسم الطب النفسي
+961 1 350 000; Ext. 5650
(يتم تغطية الجلسات ضمن خطة التأمين الصحي *HIP*)

بسبب وباء COVID-19، تُقدم كلٍ من خدمات الصحة النفسية جلسات عبر الهاتف أو عبر الإنترنت.

لمزيدٍ من المعلومات:

إذا كنت تود معرفة المزيد عن سوء المعاملة في سن الطفولة والصدمات المعقدة والظواهر الانفصالية، يرجى الاطلاع على المراجع التالية:

موارد من *ISTSS*:

1. معلومات الإنترنت حول إساءة معاملة الأطفال وإهمالهم
2. تذكر صدمات الطفولة

موارد من *ISSTD*:

1. الصدمات والصدمات المعقدة: نظرة عامة
2. اضطرابات الاجهاد ما بعد الصدمة
3. الانفصال المرتبط بالصدمات: مقدمة
4. ما هي الاضطرابات الانفصالية؟
5. تلقي العلاج للصدمات المعقدة والظواهر الانفصالية

مرة أخرى، شكراً لك على مشاركتك في هذه الدراسة!

الإرسال

APPENDIX G

Demographic Questionnaire

Demographic Questionnaire – English

Background Information

Where did you find out about the study?
❍ Facebook ❍ Instagram ❍ twitter
❍ Reddit ❍ PSYC201 Course
❍ Other, please specify: ✍_____

What device are you using to answer this survey?
❍ Smartphone ❍ Computer/Laptop
❍ Tablet ❍ Other, please specify: ✍_____

What was your assigned sex at birth?
❍ Male ❍ Female ❍ Intersex

What is your age?
Please specify: ✍_____ years old.

What is your ethnic origin?
Please specify: ✍_____

What is the highest level of education you have completed?
❍ Some high school
❍ High school diploma or equivalent
❍ Vocational training
❍ Some college
❍ Associate's degree
❍ Bachelor's degree
❍ Post-graduate diploma
❍ Master's degree
❍ Doctoral degree
❍ Other, please specify: ✍_____

Are you currently employed?
❍ Yes, full-time
❍ Yes, part-time
❍ Yes, but on extended leave
❍ Yes, but it is unpaid work
❍ No, but I have a job lined up
❍ No, but I am currently looking for work
❍ No, and I am currently not looking for work
❍ No, I am a full-time parent/homemaker
❍ No, I am unable to work
❍ No, I am not able to find work
❍ No, and I never had a job
❍ No, because I am retired

Mental Health Information

Have you ever been formally diagnosed with a mental health condition?
❍ Yes ❍ No

If so, which one(s)?	Diagnosed at what age?	How was it treated?	If with therapy, for how long?
❑ A Depressive Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ Bipolar (or a Related) Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ A Schizophrenia Spectrum Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ An Anxiety Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ Obsessive–Compulsive (or Related) Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ A Trauma- (or a Stressor-) Related Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ A Dissociative Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ Somatic Symptom (or a Related) Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ An Eating Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ A Sleep Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ A Sexual Dysfunction	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ Gender Dysphoria	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ An Impulse Control Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ A Substance-Related (or an Addictive) Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____
❑ A Personality Disorder	Please specify: ✍_____	❑ With Medications ❑ With Psychotherapy	Please specify: ✍_____

Have you ever attended psychotherapy or counselling sessions for <u>any other reason(s)</u>?
❍ Yes ❍ No

If so, for what other reason(s)?	At what age(s)?	For how long?
✍_____ _____	✍_____ _____	✍_____ _____

Demographic Questionnaire – Arabic

معلومات اساسية

أين علمت عن الدراسة؟

○ فايسبوك (Facebook) ○ إنستاغرام (Instagram) ○ تويتر (twitter)
○ ردت (Reddit) ○ صف PSYC201
○ غير ذلك، يرجى التحديد: ✍_____

ما الجهاز الذي تستخدمه للإجابة على هذه الدراسة؟

○ الهاتف الذكي ○ الحاسوب
○ الجهاز اللوحي ○ غير ذلك، يرجى التحديد: ✍_____

ما هو الجنس المحدد لك عند الولادة؟

○ ذكر ○ أنثى ○ مزدوجي الجنس

ما هو عمرك؟

يرجى التحديد: ✍____ سنة

ما هو اصلك العرقي؟

يرجى التحديد: ✍_____

ما هو أعلى مستوى تعليمي أكملته؟

○ بعض الدراسة الثانويّة
○ شهادة الدراسة الثانوية أو ما يعادلها
○ تدريب مهني
○ بعض الدراسة الجامعية
○ شهادة الزمالة
○ شهادة البكالوريوس أو الليسانس
○ دبلوم الدراسات العليا
○ شهادة الماجستير
○ شهادة الدكتوراه
○ غير ذلك، يرجى التحديد: ✍_____

هل انت موظف حالياً؟

○ نعم، بدوام كامل
○ نعم، بدوام جزئي
○ نعم، لكنني في إجازة مطولة
○ نعم، لكنه عمل غير مدفوع الأجر
○ كلا، ولكن لدي وظيفة تنتظرني
○ كلا، لكنني أبحث عن عمل حالياً
○ كلا، ولست أبحث عن عمل حالياً
○ كلا، لأنني والد(ة) / ربة(ة) منزل متفرغ
○ كلا، لست قادراً على العمل
○ كلا، ليس بإمكاني العثور على عمل
○ كلا، ولم يكن لدي عملٌ قط
○ كلا، لأنني متقاعد(ة)

معلومات عن الصحة النفسية

هل سبق أن تم تشخيصك رسمياً باضطرابات في الصحية النفسية؟

○ نعم ○ كلا

إذا كان الأمر كذلك، أي مما يلي؟	تم تشخيصها في أي عمر؟	كيف تم علاجها؟	إذا بواسطة العلاج، لِكم من الوقت (المدة الزمنية)؟
❑ اضطراب اكتئابي *A Depressive Disorder*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب ثنائي القطب (أو ما يتعلّق به) *Bipolar (or a Related) Disorder*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب من طيف الفصام الذهاني *A Schizophrenia Spectrum Disorder*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب القلق *An* Anxiety Disord*er*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب الوسواس القهري (أو ما يتعلّق به) *Obsessive–Compulsive (or Related) Disorder*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب يتعلّق بالصدمات (أو بالضغوطات) *A Trauma- (or a Stressor-) Related Disorder*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب انفصالي *A Dissociative Disorder*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب جسدي الشكل (أو ما يتعلّق به) *Somatic Symptom (or a Related) Disorder*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب في تناول الطعام *An Eating Disorder*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب في النوم و/أو اليقظة *A Sleep–Wake Disorder*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ خلل في الوظائف الجنسية *A Sexual Dysfunction*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب في الهوية الجنسية *Gender Dysphoria*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب في السيطرة على الانفعالات *An Impulse Control Disorder*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب يتعلّق بالمواد المسببة للإدمان *A Substance-Related (or an Addictive) Disorder*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____
❑ اضطراب في الشخصية *A Personality Disorder*	يرجى التحديد: ✍_____	❑ بواسطة الأدوية ❑ بواسطة العلاج النفسي	يرجى التحديد: ✍_____

هل سبق لك أن حضرت جلسات علاج نفسي أو مشورة نفسية <u>لأي سبب (أسباب) آخر</u>؟

○ نعم ○ كلا

إذا كان الأمر كذلك، لأي مشكلة (مشاكل)؟	في أي عمر (أعمار)؟	لِكم من الوقت (المدة الزمنية)؟
✍_____	✍_____	✍_____

APPENDIX H

InCharge Financial Distress/Financial Well-being Scale

InCharge Financial Distress/Financial Well-being Scale – English

Directions For each of the following 8 questions, select the number that corresponds most accurately to your situation.

1. What do you feel is the **level** of your **financial stress today**?				
1 No stress at all	2 Low stress	3 Moderate stress	4 High stress	5 Overwhelming stress
2. How **satisfied** are you with your present financial situation?				
1 Not at all satisfied	2 Slightly satisfied	3 Moderately satisfied	4 Very satisfied	5 Extremely satisfied
3. How do you feel about your **current financial situation**?				
1 Not at all worried	2 Slightly worried	3 Moderately worried	4 Very worried	5 Extremely worried
4. How often do you worry about being **able to meet** normal monthly living expenses?				
1 Never	2 Rarely	3 Sometimes	4 Often	5 All the time
5. How confident are you that you could find the money to pay for a **financial emergency** that costs about **$1,000**?				
1 Not at all confident	2 Slightly confident	3 Moderately confident	4 Very confident	5 Extremely confident
6. How often does this happen to you: You want to go out to eat, go to a movie, or do something else and **don't go because you can't afford to**?				
1 Never	2 Rarely	3 Sometimes	4 Often	5 All the time
7. How frequently do you find yourself just getting by financially and living **paycheque-to-paycheque**?				
1 Never	2 Rarely	3 Sometimes	4 Often	5 All the time
8. How **stressed** do you feel about your personal finances **in general**?				
1 Not at all stressed	2 Mildly stressed	3 Moderately stressed	4 Very stressed	5 Extremely stressed

InCharge Financial Distress/Financial Well-being Scale – Arabic

التوجيهات لكل سؤال من الأسئلة الثمانية التالية، حدد الرقم الذي يتوافق بدقة مع حالتك.

١. ما هو شعورك بالنسبة ل**مستوى ضغوطك المالية اليوم**؟				
1 لا ضغط على الإطلاق	2 ضغط متدنى	3 ضغط معتدل	4 ضغط مرتفع	5 ضغط هائل
٢. ما مدى **رضاك** عن وضعك المالي الحالي؟				
1 غير راضٍ على الإطلاق	2 راضٍ قليلاً	3 راضٍ إلى حدٍ ما	4 راضٍ جداً	5 راضٍ للغاية
٣. ما هو شعورك حيال **وضعك المالي الحالي**؟				
1 غير قلق على الإطلاق	2 قلقٌ قليلاً	3 قلقٌ إلى حدٍ ما	4 قلقٌ جداً	5 قلقٌ للغاية
٤. كم من الوقت تقلق بشأن **قدرتك على تغطية** نفقات المعيشة الشهرية الاعتيادية؟				
1 أبداً	2 نادراً	3 أحياناً	4 غالباً	5 دائماً
٥. ما مدى ثقتك أنه بإمكانك إيجاد المال لدفع نفقات **حالة طوارئ مالية** تكلف حوالي ١٠٠٠ **دولار**؟				
1 غير واثق على الإطلاق	2 واثقٌ قليلاً	3 واثقٌ إلى حدٍ ما	4 واثقٌ جداً	5 واثقٌ للغاية
٦. كم من الوقت يحدث هذا لك: تريد الخروج لتناول الطعام، أو الذهاب إلى السينما، أو القيام بشيءٍ آخر و**لا تذهب لأنك لا تستطيع تحمل تكلفته**؟				
1 أبداً	2 نادراً	3 أحياناً	4 غالباً	5 دائماً
٧. كم من الوقت تجد نفسك بالكاد تدبر أمرك مالياً حيثما تعيش من **راتبٍ شهري إلى آخر**؟				
1 أبداً	2 نادراً	3 أحياناً	4 غالباً	5 دائماً
٨. ما مدى **شعورك بالتوتر** حيال أموالك الشخصية **بشكلٍ عام**؟				
1 غير متوتر على الإطلاق	2 متوتر قليلاً	3 متوتر إلى حدٍ ما	4 متوتر جداً	5 متوتر للغاية

APPENDIX I

Detachment and Compartmentalisation Inventory

Detachment and Compartmentalisation Inventory – English

Directions This questionnaire assesses experiences you may have. For each item, select the number to the right that best describes how often you have these experiences when **NOT** under the influence of alcohol or drugs. Select "0" if it has never happened to you, select "7" if it happens to you daily. If it occurs sometimes but not daily, select the number between 1 and 6 that is the best fit for you.

	Never	Once or twice in my life	No more than once a year	Once every few months	At least once a month	At least once a week	Multiple times a week	Daily
1. When listening to someone talk, I suddenly realise that I do not hear part or all of what was said.	0	1	2	3	4	5	6	7
2. What I see looks 'flat' or 'lifeless', as if I am looking at a picture.	0	1	2	3	4	5	6	7
3. I focus on something going on in my mind and more or less lose track of what is happening around me.	0	1	2	3	4	5	6	7
4. I feel like I am watching a situation as an observer or spectator.	0	1	2	3	4	5	6	7
5. I feel divided, as if I have several parts or forces that have feelings, ideas, memories, and behaviours that I do not regard as my own.	0	1	2	3	4	5	6	7
6. I feel as if something or someone has possessed me.	0	1	2	3	4	5	6	7
7. At times, I go into a trance-like state in which I am barely aware, or unaware, of what is happening around me.	0	1	2	3	4	5	6	7
8. I have strong feelings that do not seem to belong to me.	0	1	2	3	4	5	6	7
9. For no medical or physical reason, I cannot feel all or parts of my body.	0	1	2	3	4	5	6	7
10. I feel detached from memories of things that have happened to me, as if I had not been involved in them.	0	1	2	3	4	5	6	7
11. I "blank out" or "space out" or my mind goes totally empty.	0	1	2	3	4	5	6	7
12. People tell me that my behaviour changes drastically, or that I seem like a different person.	0	1	2	3	4	5	6	7
13. I find myself in a place and have no idea how I got there or why I am there.	0	1	2	3	4	5	6	7
14. At times, I feel disconnected from a body that does not seem like mine.	0	1	2	3	4	5	6	7
15. Something inside of me seems to make me do things that I do not want to do.	0	1	2	3	4	5	6	7
16. I feel mechanical, like a robot, or like I'm not really human.	0	1	2	3	4	5	6	7
17. I look at the clock and realise that time has gone by and I cannot remember what has happened.	0	1	2	3	4	5	6	7
18. I do not feel in control of what my body does as if there is someone or something inside me directing my actions.	0	1	2	3	4	5	6	7
19. I switch back and forth between feelings that seem to belong to me and feelings that I do not experience as my own.	0	1	2	3	4	5	6	7
20. I feel my sense of time changes and things seem to happen in slow motion or in double time.	0	1	2	3	4	5	6	7

Detachment and Compartmentalisation Inventory – Arabic

التوجيهات

يقيم هذا الاستبيان التجارب التي قد تختبرها. لكل عبارة، حدد الرقم الموجود على اليسار الذي يصف بدقة عدد المرات التي مررت فيها بهذه التجارب عندما **لا تكون** تحت تأثير الكحول أو المخدرات. حدد "0" إذا لم تحدث لك تلك التجربة أبداً، وحدد "7" إذا حدثت لك تلك التجربة يومياً. إذا حدثت تلك التجربة أحياناً وليس يومياً، فحدد الرقم المناسب بين "1" و "6".

	أبداً	مرة أو مرتين في حياتي	لا تتجاوز المرتين في السنة	مرة كل بضعة أشهر	مرة واحدة في الشهر على الأقل	مرة واحدة على الأقل في الأسبوع	عدة مرات في الأسبوع	يومياً
١. عند الاستماع إلى حديث شخصٍ ما، أدرك فجأة أنني لا أسمع جزء من أو كل ما قيل.	0	1	2	3	4	5	6	7
٢. ما أراه يبدو "مسطحاً" أو "هامداً"، كما لو كنت أنظر إلى صورة.	0	1	2	3	4	5	6	7
٣. أركز على شيءٍ ما يدور في ذهني لدرجة فقدان الاحساس بما يجري من حولي بشكلٍ أو بآخر.	0	1	2	3	4	5	6	7
٤. أشعر وكأنني أشاهد موقفًا كمراقب أو متفرج.	0	1	2	3	4	5	6	7
٥. أشعر بالانقسام، وكأن لدى عدة أجزاء أو قوى لها مشاعر وأفكار وذكريات وسلوكيات لا أعتبر أنها تنتمي إلي.	0	1	2	3	4	5	6	7
٦. أشعر كما لو أن شيئاً ما أو شخصاً ما قد تملكني / تلبسني.	0	1	2	3	4	5	6	7
٧. في بعض الأحيان، أدخل في حالة تشبه الغيبوبة حيثما بالكاد أدرك أو لا أدرك ما يحدث من حولي ..	0	1	2	3	4	5	6	7
٨. لدي مشاعر قوية لا يبدو أنها تنتمي إلي.	0	1	2	3	4	5	6	7
٩. دون سببٍ طبي أو عضوي، لا أستطيع أن أشعر بجميع أنحاء جسدي أو البعض منها.	0	1	2	3	4	5	6	7
١٠. أشعر بالانفصال عن ذكريات الأشياء التي حدثت معي، كأنني لم أشارك فيها.	0	1	2	3	4	5	6	7
١١. "أسرح" أو "أشرد"، أو يعجز عقلي تماماً عن التّفكير.	0	1	2	3	4	5	6	7
١٢. يخبرني الآخرون أن سلوكي يتغير بشكلٍ كبير، أو أنني أبدو كشخصٍ مختلف.	0	1	2	3	4	5	6	7
١٣. أجد نفسي في مكانٍ ما وليس لدي أي فكرة كيف وصلت إلى هناك أو لماذا أنا هناك.	0	1	2	3	4	5	6	7
١٤. في بعض الأحيان، أشعر بالانفصال عن جسد لا يبدو أنه ينتمي إلي.	0	1	2	3	4	5	6	7
١٥. يبدو أن هناك شيئاً ما بداخلي يجعلني أفعل أشياء لا أريد القيام بها.	0	1	2	3	4	5	6	7
١٦. أشعر بأنني ميكانيكي كالروبوت، أو كما لو أنني لست إنساناً بالفعل.	0	1	2	3	4	5	6	7
١٧. أنظر إلى الساعة وأدرك أن الوقت قد مضى ولا أتذكر ما حدث.	0	1	2	3	4	5	6	7
١٨. لا أشعر بالسيطرة على ما يفعله جسدي كما لو كان هناك شخصٌ ما أو شيءٌ ما بداخلي يوجه أفعالي.	0	1	2	3	4	5	6	7
١٩. أتقلب بين المشاعر التي يبدو أنها تنتمي إلي والمشاعر التي أختبرها كمشاعر لا تنتمي إلي.	0	1	2	3	4	5	6	7
٢٠. أشعر أن إحساسي بمرور الوقت يتغير بحيث يبدو أن الأمور تحدث ببطء أو بسرعة فائقة.	0	1	2	3	4	5	6	7

APPENDIX J

Traumatic Experiences Checklist

Traumatic Experiences Checklist – English

Directions People may experience a variety of traumatic events during their life. We would like to know:

1) if you have experienced any of the following 29 events,
2) how old you were when they happened, and
3) how much of an impact these experiences had upon you.

A) In the **first** column, indicate whether you had each of the 29 experiences by circling the appropriate answer.
B) In the **second** column, for each experience where you selected **YES**, list your age(s) when it happened.
- If it happened more than once, list **ALL** the ages when this happened to you.
- If it happened for years (e.g., age 7-12), list the age range (i.e., age 7–12).

C) In the **third** column, indicate the **IMPACT** by circling the appropriate number.

1. Having to look after your parents and/or brothers and sisters when you were a child.		
Did this happen to you?	**How old were you when this happened?**	**How much did this impact you?**
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount
2. Family problems (e.g., parent with alcohol or psychiatric problems, domestic violence, poverty).		
Did this happen to you?	**How old were you when this happened?**	**How much did this impact you?**
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount
3. Loss of a family member (brother, sister, parent) when you were a CHILD.		
Did this happen to you?	**How old were you when this happened?**	**How much did this impact you?**
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount
4. Loss of a family member (brother, sister, parent) when you were an ADULT.		
Did this happen to you?	**How old were you when this happened?**	**How much did this impact you?**
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount
5. Serious bodily injury (e.g., loss of a limb, mutilation, burns).		
Did this happen to you?	**How old were you when this happened?**	**How much did this impact you?**
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount
6. Threat to life from illness, a surgical operation, medical procedure, or an accident.		
Did this happen to you?	**How old were you when this happened?**	**How much did this impact you?**
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount
7. Separation or divorce of your parents.		
Did this happen to you?	**How old were you when this happened?**	**How much did this impact you?**
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

Traumatic Experiences Checklist – English

8. Your own separation or divorce.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

9. Threat to life from another person (e.g., during a crime).

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

10. Intense pain (e.g., from an injury, surgery, or medical procedure).

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

11. War-time experiences (e.g., imprisonment, loss of relatives, deprivation, injury).

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

12. Second-generation war victim (war-time experiences of parents or close relatives).

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

13. Witnessing others undergo trauma.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

14. Emotional neglect (e.g., being left alone, insufficient affection) by your parents, brothers or sisters.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

15. Emotional neglect by more distant members of your family (e.g., uncles, aunts, nephews, nieces, grandparents).

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

16. Emotional neglect by non-family members (e.g., neighbours, friends, step-parents, teachers).

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

Traumatic Experiences Checklist – English

17. Emotional abuse (e.g., being belittled, teased, called names, threatened verbally, or unjustly punished) by your parents, brothers or sisters.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

18. Emotional abuse by more distant members of your family.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

19. Emotional abuse by non-family members.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

20. Physical abuse (e.g., being hit, tortured, or wounded) by your parents, brothers, or sisters.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

21. Physical abuse by more distant members of your family.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

22. Physical abuse by non-family members.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

23. Bizarre or unusual punishments.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

24. Sexual harassment (acts of a sexual nature that DO NOT involve physical contact) by your parents, brothers, or sisters.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

25. Sexual harassment by more distant members of your family.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

Traumatic Experiences Checklist – English

26. Sexual harassment by non-family members.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

27. Sexual abuse (unwanted sexual acts involving physical contact) by your parents, brothers, or sisters.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

28. Sexual abuse by more distant members of your family.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

29. Sexual abuse by non-family members.

Did this happen to you?	How old were you when this happened?	How much did this impact you?
0 No 1 Yes	_____ _____	1 Not at all 2 A little bit 3 A moderate amount 4 Quite a bit 5 An extreme amount

Traumatic Experiences Checklist – Arabic

التوجيهات

قد يتعرض الناس لمجموعة متنوعة من التجارب المؤلمة خلال حياتهم. نود أن نعرف:
١) إذا كنت قد واجهت أياً من الأحداث الـ٢٩ التالية،
٢) ما كان عمرك عند حدوثها، و
٣) ما مدى تأثير هذه التجارب عليك.

أ) في الخانة **الأولى**، حدد ما إذا كنت قد واجهت عدد من التجارب الـ٢٩ وأشر إلى عدد المرات التي كنت قد مررت بها عبر وضع دائرة حول الإجابة المناسبة.
ب) في الخانة **الثانية**، أذكر عمرك عند حدوث كل تجربة أجبت عليها بـ«نعم».
- إذا حدثت أكثر من مرة، قم بإدراج جميع الأعمار عندما حدثت هذه التجربة لك.
- إذا حدثت لسنوات (مثلاً، من سن الـ٧ إلى الـ١٢ سنة)، قم بإدراج الفئة العمرية)على سبيل المثال، ٧–١٢).

ج) في الخانة **الثالثة**، أشر إلى «**التأثير**» بوضع دائرة حول الإجابة المناسبة.

١. الاضطرار إلى رعاية والديك و/أو أشقاءك عندما كنت طفلاً.

هل حدث هذا لك؟		كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟	
0 كلا	1 نعم	_____	1 لا تأثير أبداً	2 تأثير ضئيل
			3 تأثير معتدل	4 تأثير كبير
		_____	5 تأثير هائل	

٢. مشاكل أسرية (مثل معاناة أحد الوالدين من الإدمان على الكحول أو الأمراض النفسية والعنف المنزلي والفقر).

هل حدث هذا لك؟		كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟	
0 كلا	1 نعم	_____	1 لا تأثير أبداً	2 تأثير ضئيل
			3 تأثير معتدل	4 تأثير كبير
		_____	5 تأثير هائل	

٣. فقدان أحد أفراد العائلة (سواء كان أحد من الأشقاء أو أحد من الوالدين) أثناء الطفولة.

هل حدث هذا لك؟		كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟	
0 كلا	1 نعم	_____	1 لا تأثير أبداً	2 تأثير ضئيل
			3 تأثير معتدل	4 تأثير كبير
		_____	5 تأثير هائل	

٤. فقدان أحد أفراد العائلة (سواء كان أحد من الأشقاء أو أحد من الوالدين) أثناء البلاغية.

هل حدث هذا لك؟		كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟	
0 كلا	1 نعم	_____	1 لا تأثير أبداً	2 تأثير ضئيل
			3 تأثير معتدل	4 تأثير كبير
		_____	5 تأثير هائل	

٥. إصابة جسدية بالغة (على سبيل المثال، فقدان أحد الأطراف أو التشوه أو الحروق).

هل حدث هذا لك؟		كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟	
0 كلا	1 نعم	_____	1 لا تأثير أبداً	2 تأثير ضئيل
			3 تأثير معتدل	4 تأثير كبير
		_____	5 تأثير هائل	

٦. خطر على الحياة بسبب المرض أو عملية جراحية أو إجراء طبي أو حادثٍ ما.

هل حدث هذا لك؟		كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟	
0 كلا	1 نعم	_____	1 لا تأثير أبداً	2 تأثير ضئيل
			3 تأثير معتدل	4 تأثير كبير
		_____	5 تأثير هائل	

٧. انفصال أو طلاق والديك.

هل حدث هذا لك؟		كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟	
0 كلا	1 نعم	_____	1 لا تأثير أبداً	2 تأثير ضئيل
			3 تأثير معتدل	4 تأثير كبير
		_____	5 تأثير هائل	

Traumatic Experiences Checklist – Arabic

٨. انفصالك أو طلاقك.

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

٩. تهديد للحياة من شخصٍ آخر (على سبيل المثال، أثناء جريمة).

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

١٠. ألم شديد (على سبيل المثال، بسبب إصابة أو عملية جراحية أو إجراء طبي).

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

١١. تجارب الحرب (مثل السجن وفقدان الأقارب والحرمان والإصابة).

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

١٢. الوقوع ضحية حرب من الجيل الثاني (نتيجة تجارب الحرب لدى الوالدين أو الأقارب المقربين).

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

١٣. رؤية الآخرين يتعرضون لتجارب مروعة.

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

١٤. إهمال عاطفي (على سبيل المثال، تركك بمفردك أو حرمانك من العاطفة) من قِبل والديك أو أشقاءك.

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

١٥. إهمال عاطفي من قِبل أفراد أسرتك الممتدة (على سبيل المثال، الأعمام والعمات والأخوال والخالات وأبناء الأشقاء والأجداد).

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

١٦. إهمال عاطفي من قِبل أشخاص ليسوا من أفراد الأسرة (مثل الجيران والأصدقاء وأزواج الأهل والمعلمين وأصدقاء الأسرة).

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

Traumatic Experiences Checklist – Arabic

١٧. إيذاء عاطفي (على سبيل المثال، التقليل من شأنك، أو إغاظتك، أو شتمك، أو تهديدك لفظياً، أو معاقبتك بغير حق) من قِبل والديك أو أشقاءك.

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

١٨. إيذاء عاطفي من قِبل أفراد أسرتك الممتدة.

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

١٩. إيذاء عاطفي من قِبل أشخاص ليسوا من أفراد الأسرة.

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

٢٠. إيذاء جسدي (مثل التعرض للضرب أو التعذيب أو الإصابة بجروح) من قِبل والديك أو أشقاءك.

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

٢١. إيذاء جسدي من قِبل أفراد أسرتك الممتدة.

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

٢٢. إيذاء جسدي من قِبل أشخاص ليسوا من أفراد الأسرة.

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

٢٣. عقوبات غريبة أو غير معتادة.

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

٢٤. تحرش جنسي (أفعال ذات طبيعة جنسية <u>لا تشمل</u> التلامس الجسدي) من قبل والديك أو أشقاءك.

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

٢٥. تحرش جنسي من قِبل أفراد أسرتك الممتدة.

هل حدث هذا لك؟	كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟
0 كلا 1 نعم	_____ _____	1 لا تأثير أبداً 2 تأثير ضئيل 3 تأثير معتدل 4 تأثير كبير 5 تأثير هائل

Traumatic Experiences Checklist – Arabic

٢٦. تحرش جنسي من قِبل أشخاص ليسوا من أفراد الأسرة.

هل حدث هذا لك؟		كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟	
0 كلا	1 نعم	_____	1 لا تأثير أبداً	2 تأثير ضئيل
			3 تأثير معتدل	4 تأثير كبير
		_____	5 تأثير هائل	

٢٧. إيذاء جنسي (أفعال جنسية غير مرغوب فيها وتشمل التلامس الجسدي) من قِبل والديك أو أشقاءك.

هل حدث هذا لك؟		كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟	
0 كلا	1 نعم	_____	1 لا تأثير أبداً	2 تأثير ضئيل
			3 تأثير معتدل	4 تأثير كبير
		_____	5 تأثير هائل	

٢٨. إيذاء جنسي من قِبل أفراد أسرتك الممتدة.

هل حدث هذا لك؟		كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟	
0 كلا	1 نعم	_____	1 لا تأثير أبداً	2 تأثير ضئيل
			3 تأثير معتدل	4 تأثير كبير
		_____	5 تأثير هائل	

٢٩. إيذاء جنسي من قِبل أشخاص ليسوا من أفراد الأسرة.

هل حدث هذا لك؟		كم كان عمرك عند حدوث هذا لك؟	ما مدى تأثير هذا عليك؟	
0 كلا	1 نعم	_____	1 لا تأثير أبداً	2 تأثير ضئيل
			3 تأثير معتدل	4 تأثير كبير
		_____	5 تأثير هائل	

APPENDIX K

Trauma Appraisals Questionnaire – Betrayal Subscale

Trauma Appraisals Questionnaire – Betrayal Subscale – English

Directions Below are several statements that describe thoughts, feelings, or experiences that people sometimes have in response to difficult experiences they faced **in childhood and/or adolescence**.

Please continue thinking about the difficult experiences you faced during your childhood and/or adolescence. We are interested in how you *thought*, *felt,* and *behaved* **at the time of these experiences**. Accordingly, please select the number to the right that indicates how true these descriptions were for you **back then**.

	Not at all true	A little true	Somewhat true	Mostly true	Completely true
1. The people who were supposed to be closest to me hurt me the most.	1	2	3	4	5
2. Important people (such as a parent, partner, or friend) let this happen to me.	1	2	3	4	5
3. If these people really cared about me, they would not have done what they did.	1	2	3	4	5
4. I felt betrayed.	1	2	3	4	5
5. I felt double-crossed (i.e., deceived, misled).	1	2	3	4	5
6. Someone important (such as a parent, partner, or friend) should have kept me safe.	1	2	3	4	5
7. The people that I was supposed to trust the most hurt me.	1	2	3	4	5

Trauma Appraisals Questionnaire – Betrayal Subscale – Arabic

التوجيهات

فيما يلي العديد من العبارات التي تصف الأفكار أو المشاعر أو التجارب التي يمر بها الأشخاص أحياناً رداً على التجارب المؤلمة أو المؤذية التي واجهوها **في الطفولة و / أو المراهقة**.

يرجى الاستمرار بالتفكير في التجارب المؤلمة أو المؤذية التي واجهتها خلال طفولتك و / أو مراهقتك. إننا معنيون مهتمون بطريقة **تفكيرك** و**شعورك** و**تصرفك في وقت حدوث هذه التجارب**. وفقاً لذلك، يرجى تحديد الرقم على اليسار الذي يشير إلى مدى صحة هذه الأوصاف لك في **ذلك الوقت من الزمن**.

	غير صحيح أبداً	صحيح قليلاً	صحيح نسبياً	صحيح تقريباً	صحيح تماماً
١. الأشخاص الذين كان من المفترض أن يكونوا الأقرب إليّ هم أكثر من أذوني.	1	2	3	4	5
٢. أشخاصٌ مهمون (مثل الوالد/ة أو الشريك/ة أو الصديق/ة) تركوا تلك الأمور تحدث لي.	1	2	3	4	5
٣. إذا كان هؤلاء الأشخاص يهتمون بي حقاً، لما فعلوا ما فعلوه.	1	2	3	4	5
٤. شعرت بالغدر.	1	2	3	4	5
٥. شعرت بأنني قد خدعت.	1	2	3	4	5
٦. كان يجب على شخصٌ مهم (مثل الوالد/ة أو الشريك/ة أو الصديق/ة) أن يحافظ على سلامتي.	1	2	3	4	5
٧. الأشخاص الذين كان من المفترض أن أثق بهم هم أكثر من أذوني.	1	2	3	4	5

APPENDIX L

Abuse-Related Shame Questionnaire

Abuse-Related Shame Questionnaire – English

Directions Below are several statements that describe *thoughts* and *feelings* that people sometimes have about themselves in response to difficult experiences they faced **during their childhood and/or adolescence**. Please read each statement carefully and select the number to the right that best reflects how much it applied to you **back then**.

	Not at all true	A little true	Somewhat true	Mostly true	Completely true
1. I felt ashamed because I thought that people could tell from looking at me what happened to me.	1	2	3	4	5
2. I wanted to go away, sit by myself, and hide.	1	2	3	4	5
3. I was ashamed because I felt that I was the only person in my school who this has happened to.	1	2	3	4	5
4. I felt dirty.	1	2	3	4	5
5. I felt like covering my body.	1	2	3	4	5
6. I wished that I was invisible.	1	2	3	4	5
7. I felt disgusted with myself.	1	2	3	4	5
8. I felt exposed.	1	2	3	4	5

Abuse-Related Shame Questionnaire – Arabic

التوجيهات

فيما يلي العديد من العبارات التي تصف **الأفكار والمشاعر** التي يكونها الناس أحياناً عن أنفسهم رداً على التجارب المؤلمة أو المؤذية التي واجهوها **خلال طفولتهم و / أو مراهقتهم**. يرجى قراءة كل عبارة بعناية وتحديد الرقم على اليسار الذي يعكس بشكلٍ دقيق مدى انطباقه عليك **في ذلك الوقت**.

	غير صحيح أبداً	صحيحٌ قليلاً	صحيحٌ نسبياً	صحيحٌ تقريباً	صحيحٌ تماماً
١. شعرت بالعار لأنني اعتقدت أنه بإمكان الآخرين معرفة ما حدث لي بمجرد النظر إلي.	1	2	3	4	5
٢. أردت الذهاب بعيداً والجلوس بمفردي والاختفاء.	1	2	3	4	5
٣. شعرت بالعار لأنني اعتقدت أنني الشخص الوحيد في مدرستي الذي حدثت تلك التجارب له.	1	2	3	4	5
٤. شعرت بأنني قذر/ة.	1	2	3	4	5
٥. شعرت برغبة في تغطية جسدي.	1	2	3	4	5
٦. تمنيت لو كنت غير مرئي/ة.	1	2	3	4	5
٧. شعرت بالاشمئزاز من نفسي.	1	2	3	4	5
٨. أشعر أنني عارٍ.	1	2	3	4	5

APPENDIX M

Meta-Cognitive Anger Processing Scale

Meta-Cognitive Anger Processing Scale – English

Directions The statements below describe *beliefs* that people have about their own *feelings*. Please read each statement carefully and select the number to the right that best reflects how *generally* true each statement was for you **during your childhood and/or adolescence**. Please respond to all the statements as there are no right or wrong answers.

I believed that...	Never true	Sometimes true	Often true	Always true
1. ...my anger harms me.	1	2	3	4
2. ...anger helps me see things the way they really are.	1	2	3	4
3. ...anger could make me go mad.	1	2	3	4
4. ...anger helps me solve problems.	1	2	3	4
5. ...my anger could hurt others.	1	2	3	4
6. ...anger helps me handle threats and dangers.	1	2	3	4
7. ...anger makes me a bad person.	1	2	3	4
8. ...anger protects me.	1	2	3	4
9. ...my anger is dangerous for me.	1	2	3	4
10. ...anger makes me a strong and competent person.	1	2	3	4
11. ...when I am angry, I lose sight of different points of view.	1	2	3	4
12. ...my anger will make people realise that they went too far.	1	2	3	4
13. ...anger means loss of control.	1	2	3	4
14. ...anger is necessary to get by in the world.	1	2	3	4
15. ...anger will make other people think badly about me.	1	2	3	4
16. ...anger keeps me alert.	1	2	3	4
17. ...anger makes me insensitive to others.	1	2	3	4

Meta-Cognitive Anger Processing Scale – Arabic

التوجيهات

تصف العبارات أدناه **المعتقدات** التي تتكون لدى الناس حول أفكارهم ومشاعرهم. يرجى قراءة كل عبارة بعناية وتحديد الرقم على اليسار الذي يعكس بشكلٍ دقيق مدى صحة كل عبارة بشكل عام بالنسبة لك **خلال طفولتك و / أو مراهقتك**. يرجى الرد على جميع العبارات حيث لا توجد إجابات صحيحة أو خاطئة.

اعتقدت أن...	غير صحيح أبداً	صحيح أحياناً	صحيح غالباً	صحيح دائماً
١. ...غضبي يؤذيني.	1	2	3	4
٢. ...الغضب يساعدني على رؤية الأشياء كما هي في الواقع.	1	2	3	4
٣. ...الغضب يمكن أن يجعلني أشعر بالجنون.	1	2	3	4
٤. ...الغضب يساعدني في حل المشاكل.	1	2	3	4
٥. ...غضبي يمكن أن يؤذي الآخرين.	1	2	3	4
٦. الغضب يساعدني في التعامل مع التهديدات والمخاطر.	1	2	3	4
٧. ...الغضب يجعلني شخصاً سيئاً.	1	2	3	4
٨. ...الغضب يحميني.	1	2	3	4
٩. ...غضبي يشكل خطرٌ علي.	1	2	3	4
١٠. ...الغضب يجعلني شخصًا قويًا وكفؤًا.	1	2	3	4
١١. ...عندما أغضب، أعجز عن إدراك وجهات النظر المختلفة.	1	2	3	4
١٢. ...غضبي سيجعل الأخرين أن يدركوا أنهم تجاوزوا حدودهم.	1	2	3	4
١٣. ...الغضب يعني فقدان السيطرة.	1	2	3	4
١٤. ...الغضب ضروري للنجاة في العالم.	1	2	3	4
١٥. ...الغضب سيجعل الآخرين يفكرون بي بشكلٍ سيء.	1	2	3	4
١٦. ...الغضب يبقيني متيقظاً.	1	2	3	4
١٧. ...الغضب يجعلني عديم الإحساس تجاه الآخرين.	1	2	3	4

APPENDIX N

Post-Traumatic Anger Scale

Post-Traumatic Anger Scale – English

Directions Below are several statements that describe *thoughts and feelings of anger* that people sometimes have in response to difficult experiences they faced **during their childhood and/or adolescence**. Please read each statement carefully and select the number to the right that best reflects how often you had these diverse types of anger **back then**.

	Never	Very rarely	Rarely	Occasionally	Regularly	Often	Very often
I was angry at the people who hurt me...							
1. ...because they caused so much harm in my life.	0	1	2	3	4	5	6
2. ...because my well-being was so unimportant to them.	0	1	2	3	4	5	6
3. ...because they failed to accept their guilt.	0	1	2	3	4	5	6
4. ...because they behaved badly even in the time after these events.	0	1	2	3	4	5	6
I imagined...							
5. ...how the people who hurt me would be victims one day.	0	1	2	3	4	5	6
6. ...how the people who hurt me will once really have to suffer.	0	1	2	3	4	5	6
7. ...how I will pay back the people who hurt me for what they did to me.	0	1	2	3	4	5	6
8. ...how I will get even with the people who hurt me.	0	1	2	3	4	5	6
I was angry at the police, courts, or administration...							
9. ...because they did not prevent these events.	0	1	2	3	4	5	6
10. ...because they did not do their work well enough.	0	1	2	3	4	5	6
11. ...because they dealt with me without comprehension.	0	1	2	3	4	5	6
12. ...because they only care about the perpetrators and not the victims.	0	1	2	3	4	5	6
I was angry at other people...							
13. ...because they did not prevent these events.	0	1	2	3	4	5	6
14. ...because they treated me badly in the time since these events happened.	0	1	2	3	4	5	6
15. ...because they did not show understanding for my situation.	0	1	2	3	4	5	6
16. ...because they had the good luck not to become victims.	0	1	2	3	4	5	6
I was angry at myself...							
17. ...because I did not prevent these events.	0	1	2	3	4	5	6
18. ...because I should have behaved differently when these events happened.	0	1	2	3	4	5	6
19. ...because I still feel weak and vulnerable because of these events.	0	1	2	3	4	5	6
20. ...because I cannot cope with these events as well as I would expect myself to.	0	1	2	3	4	5	6

Post-Traumatic Anger Scale – Arabic

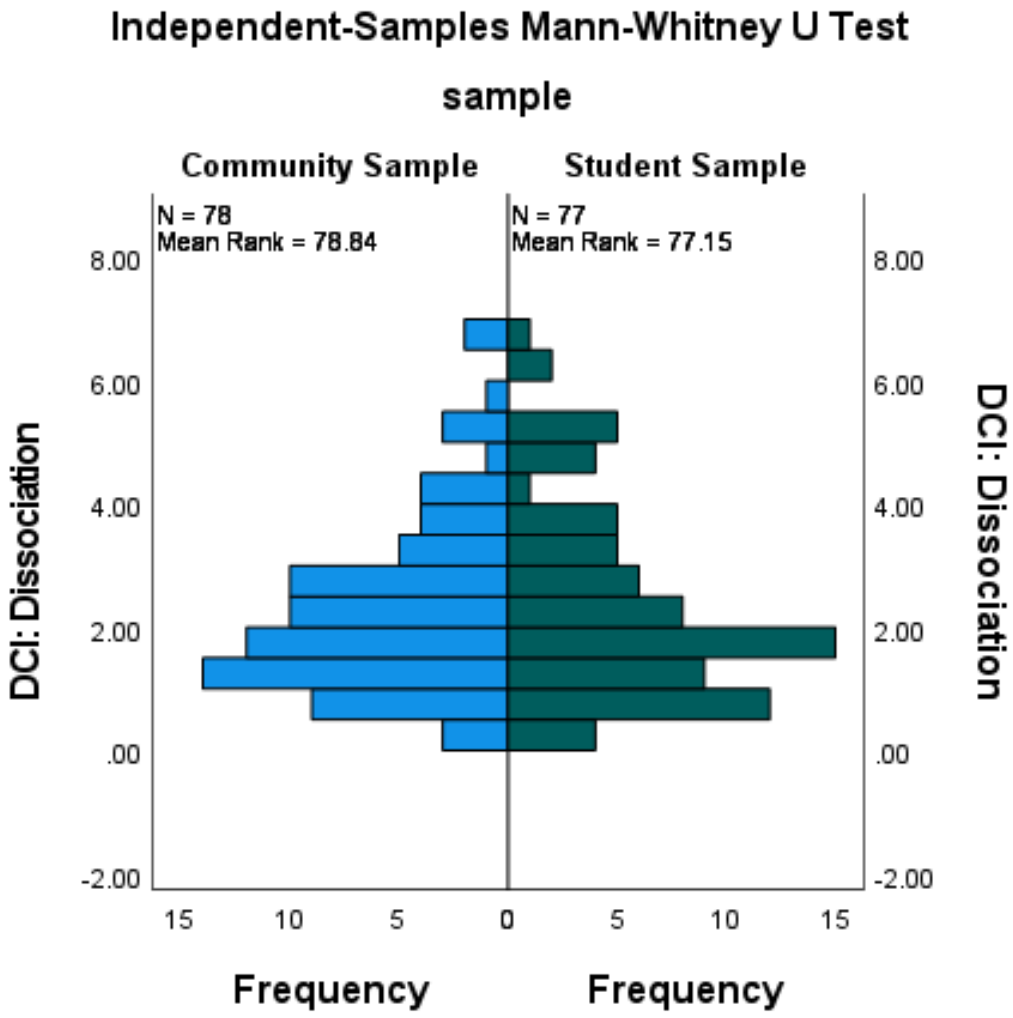
التوجيهات

فيما يلي العديد من العبارات التي تصف **أفكار ومشاعر غاضبة** والتي يشعر بها الأشخاص أحياناً رداً على التجارب المؤلمة أو المؤذية التي واجهوها **خلال طفولتهم و / أو مراهقتهم**. يرجى قراءة كل عبارة بعناية وتحديد الرقم الموجود على اليسار الذي يعكس بدقة عدد المرات التي اختبرت فيها هذه الأنواع المختلفة من الغضب **في ذلك الوقت من الزمن**.

	أبداً	نادراً جداً	نادراً	أحياناً	بشكل منتظم	غالباً	كثيراً
كنت غاضباً/ة من الأشخاص الذين أذوني...							
١. ...لأنهم تسببوا بالكثير من الضرر في حياتي.	0	1	2	3	4	5	6
٢. ...لأن سلامتي كانت غير مهمة بالنسبة لهم.	0	1	2	3	4	5	6
٣. ...لأنهم رفضوا الاعتراف بأنهم مذنبون.	0	1	2	3	4	5	6
٤. ...لأنهم تصرفوا بشكل سيء حتى بعد تلك الأحداث.	0	1	2	3	4	5	6
كنت أتخيل...							
٥. ...كيف سيكون الأشخاص الذين أذوني ضحايا يوماً ما.	0	1	2	3	4	5	6
٦. ...كيف يجب حقاً أن يعاني الأشخاص الذين أذوني.	0	1	2	3	4	5	6
٧. ...كيف سأرد على من آذاني لما فعلوه بي.	0	1	2	3	4	5	6
٨. ...كيف سأنتقم من الأشخاص الذين آذوني.	0	1	2	3	4	5	6
كنت غاضباً/ة من الشرطة أو المحاكم أو السلطات المختصة...							
٩. ...لأنهم لم يمنعوا هذه الأحداث.	0	1	2	3	4	5	6
١٠. ...لأنهم لم يؤدوا عملهم بشكلٍ كافٍ.	0	1	2	3	4	5	6
١١. ...لأنهم تعاملوا معي دون فهم.	0	1	2	3	4	5	6
١٢. ...لأنهم يهتمون فقط بالجناة وليس بالضحايا.	0	1	2	3	4	5	6
كنت غاضباً/ة من الآخرين...							
١٣. ...لأنهم لم يمنعوا تلك الأحداث.	0	1	2	3	4	5	6
١٤. ...لأنهم عاملوني معاملة سيئة منذ وقوع تلك الأحداث.	0	1	2	3	4	5	6
١٥. ...لأنهم لم يبدوا تفهماً لوضعي.	0	1	2	3	4	5	6
١٦. ...لأنه كان لديهم حسن الحظ لعدم وقوعهم ضحايا.	0	1	2	3	4	5	6
كنت غاضباً/ة من نفسي...							
١٧. ...لأنني لم أمنع تلك الأحداث.	0	1	2	3	4	5	6
١٨. ...لأنه كان يجب أن أتصرف بشكلٍ مختلف عندما وقعت تلك الأحداث.	0	1	2	3	4	5	6
١٩. ...لأنني ما زلت أشعر بالضعف والهشاشة بسبب تلك الأحداث.	0	1	2	3	4	5	6
٢٠. ...لأنني لم أستطع التعامل مع تلك الأحداث كما كنت أتوقع من نفسي.	0	1	2	3	4	5	6

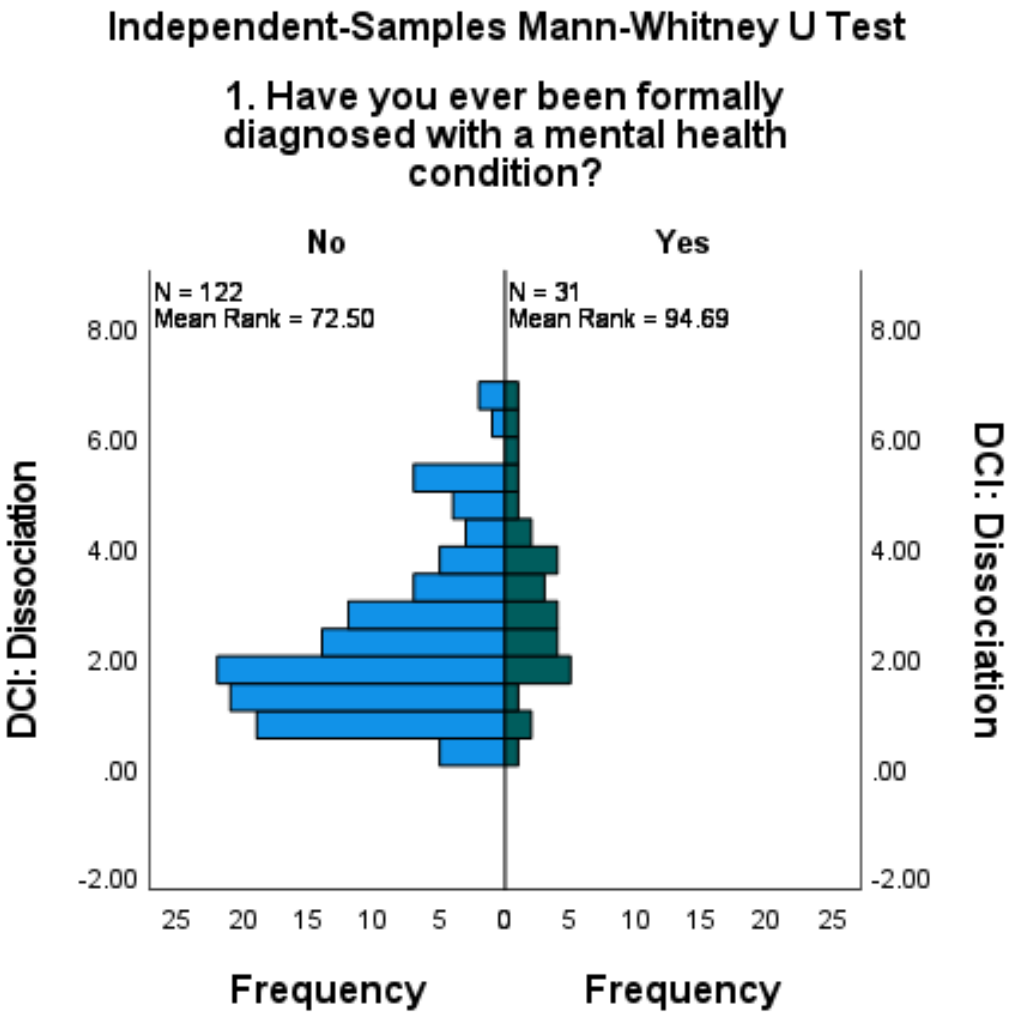
APPENDIX O

Figure 1: Differences of Dissociative Psychopathology across Samples



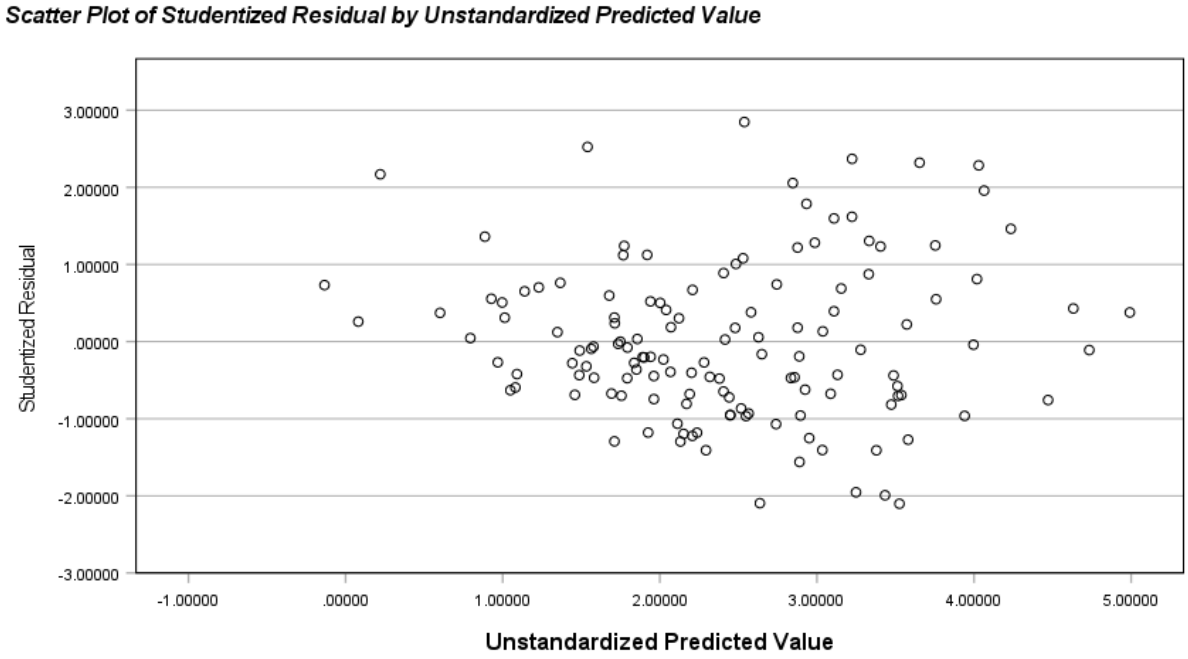
APPENDIX P

Figure 2: Differences of Dissociative Psychopathology across Diagnostic Statuses



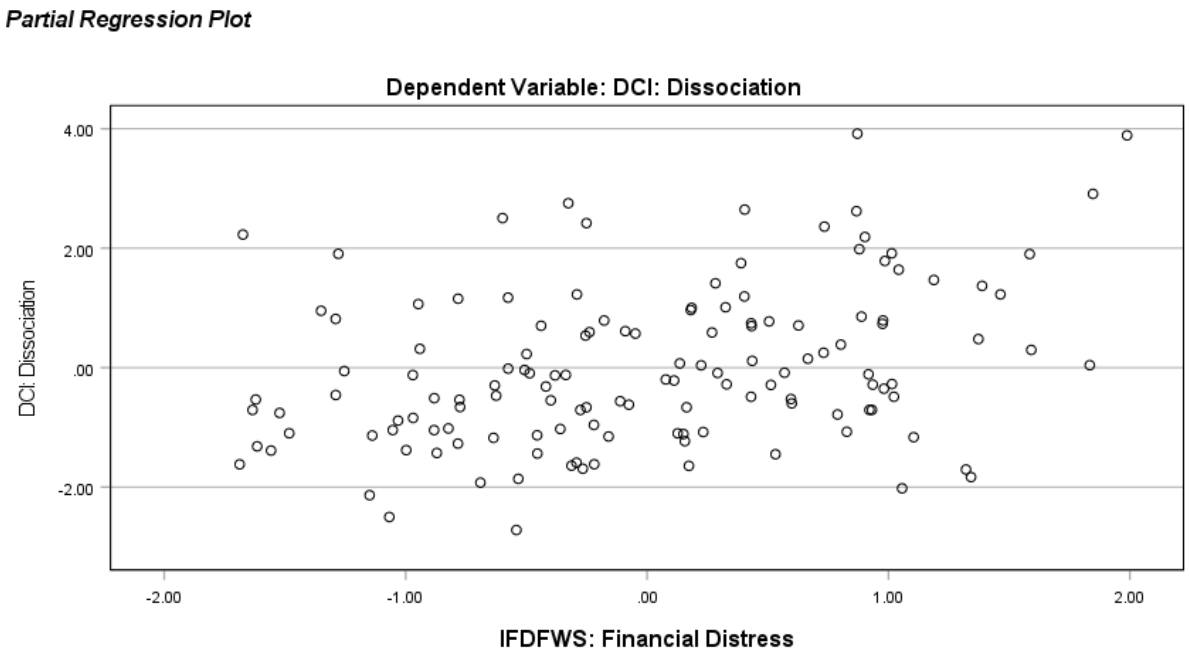
APPENDIX Q

Figure 3: Scatter Plot of Studentised Residuals by Unstandardised Predicted Values



APPENDIX R

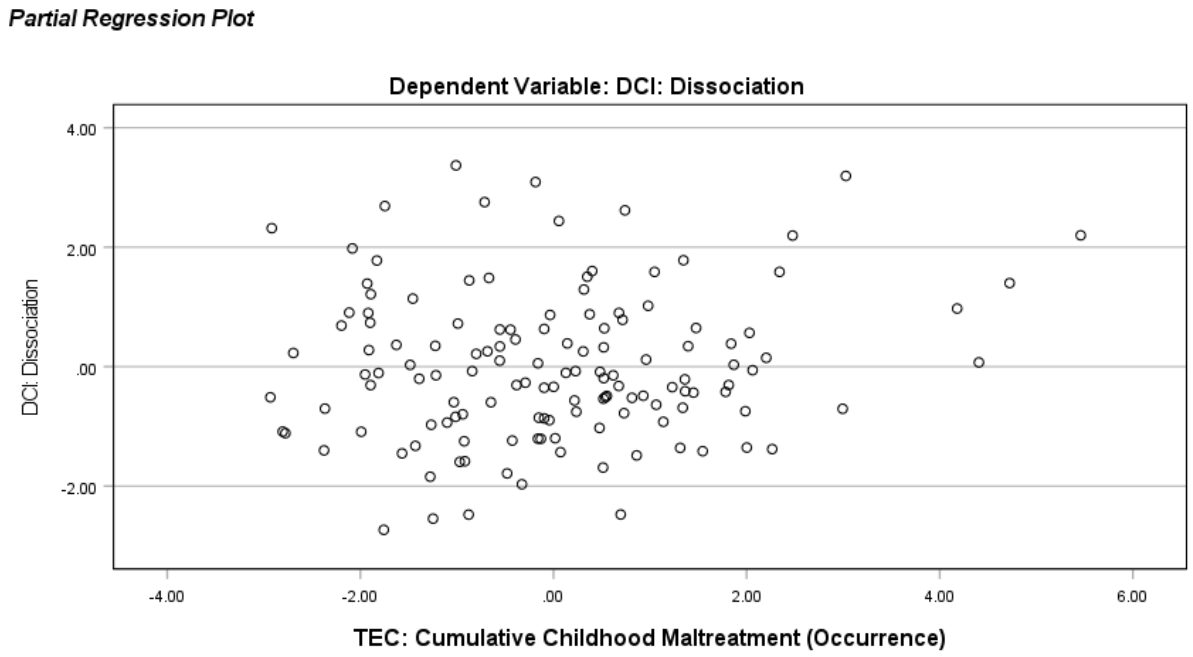
Figure 4: Partial Regression of Dissociative Psychopathology by Financial Distress



APPENDIX S

Figure 5: Partial Regression of Dissociative Psychopathology

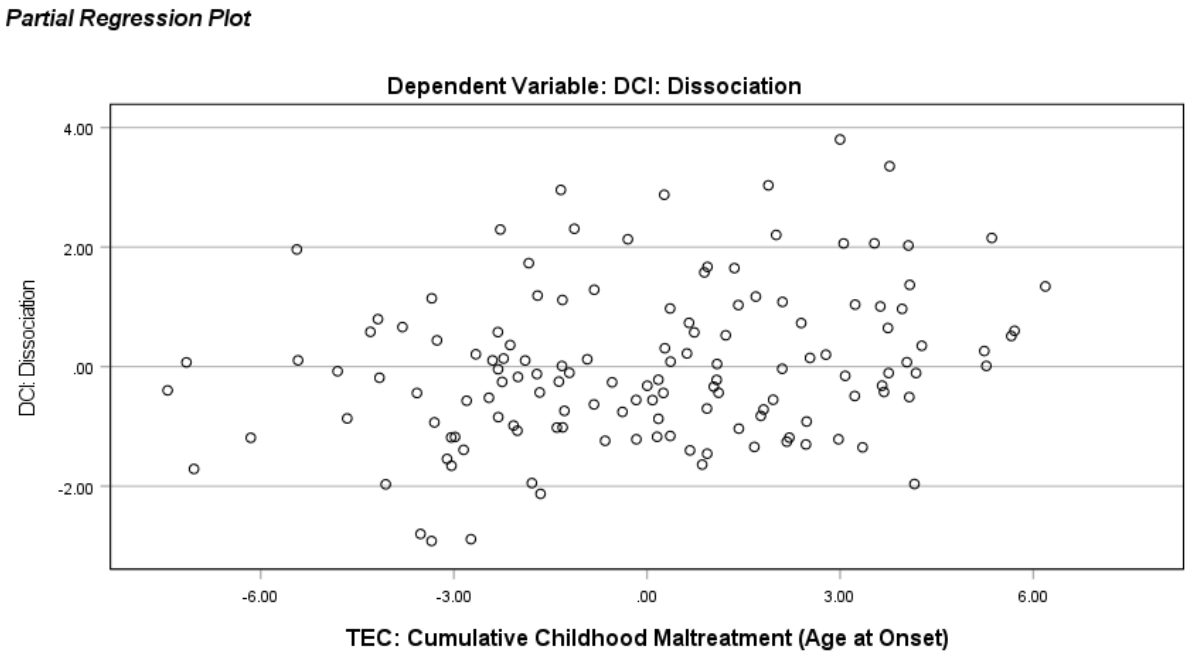
by Cumulative Childhood Maltreatment (Occurrence)



APPENDIX T

Figure 6: Partial Regression of Dissociative Psychopathology

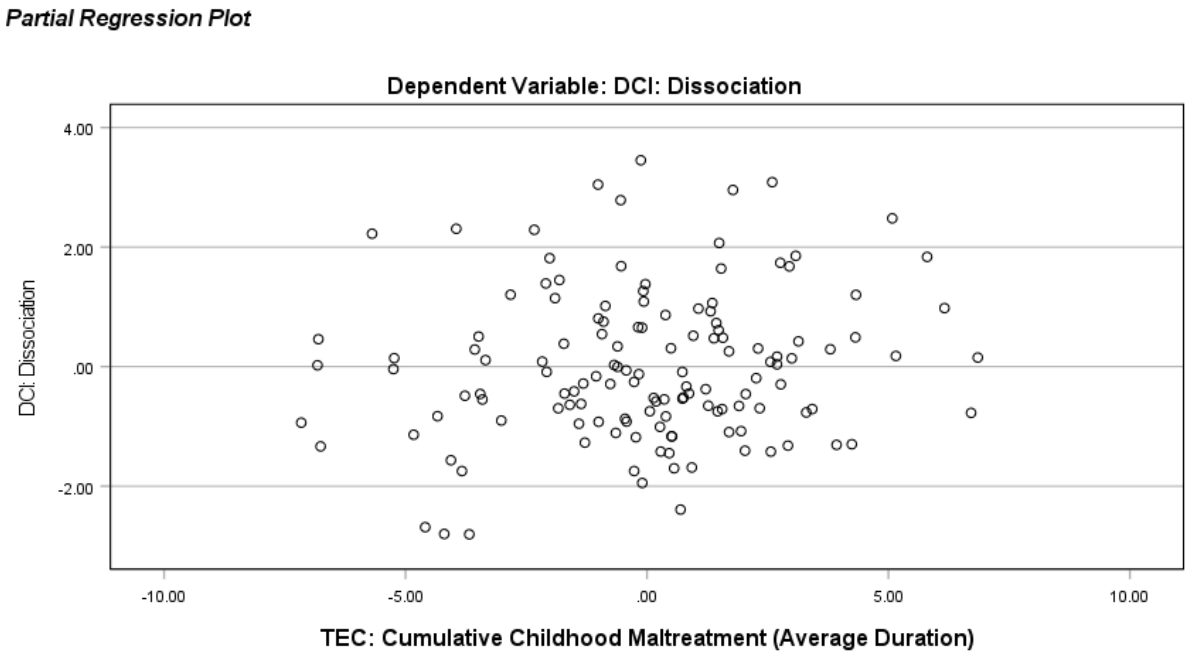
by Cumulative Childhood Maltreatment (Onset)



APPENDIX U

Figure 7: Partial Regression of Dissociative Psychopathology

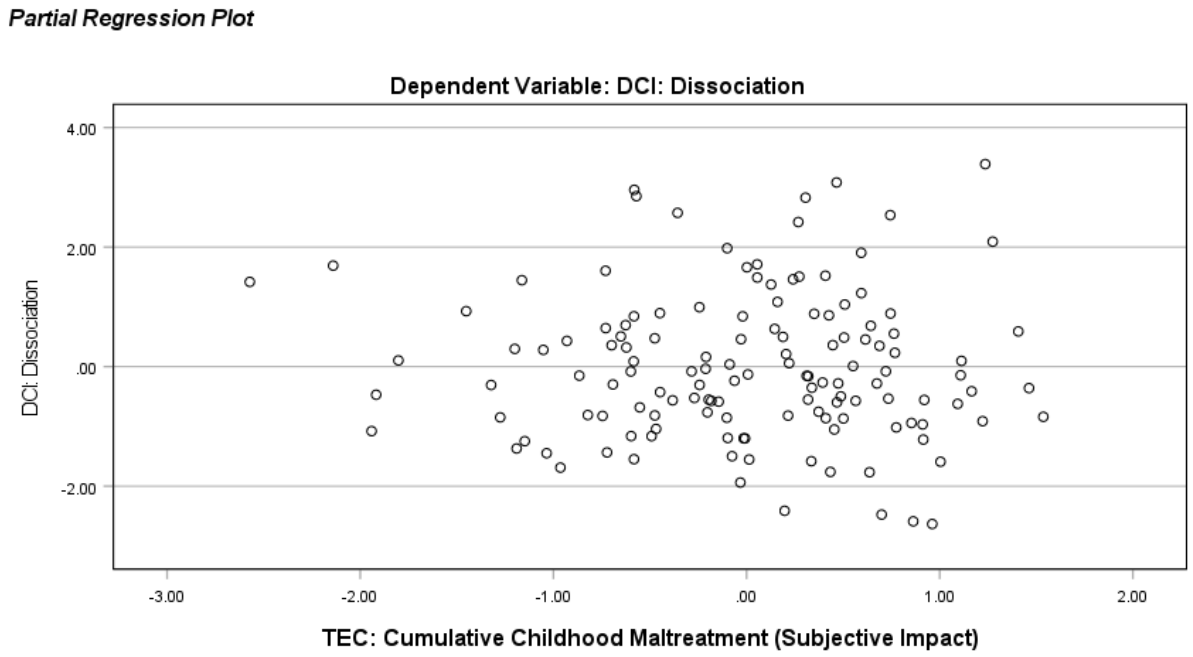
by Cumulative Childhood Maltreatment (Duration)



APPENDIX V

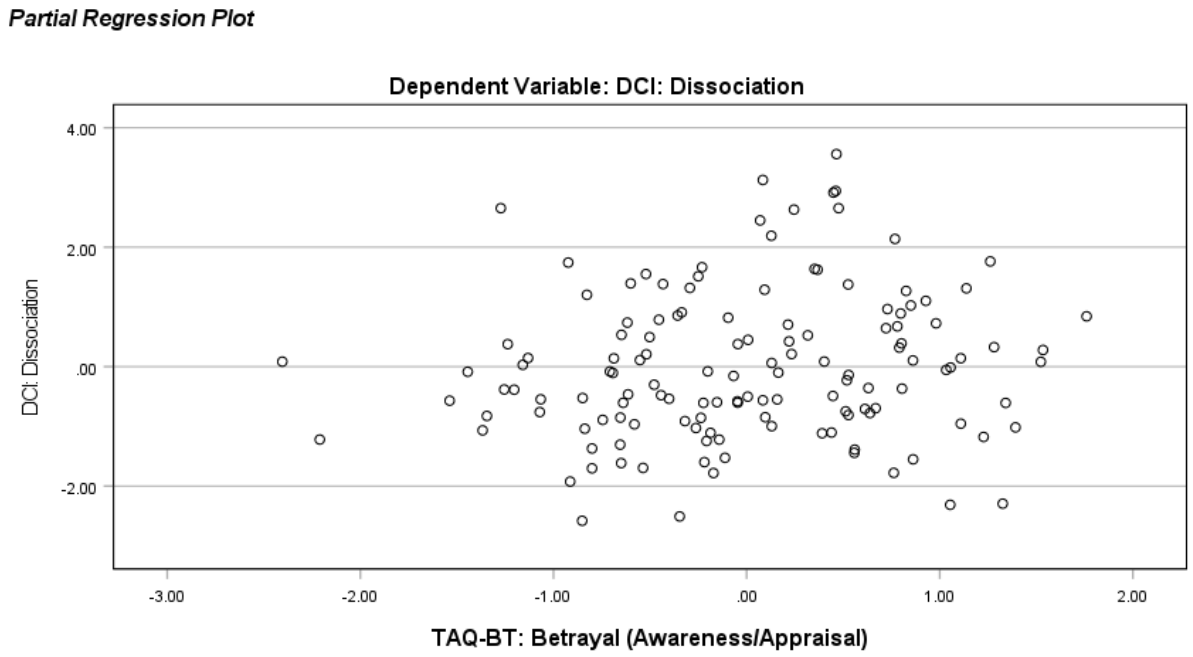
Figure 8: Partial Regression of Dissociative Psychopathology

by Cumulative Childhood Maltreatment (Impact)



APPENDIX W

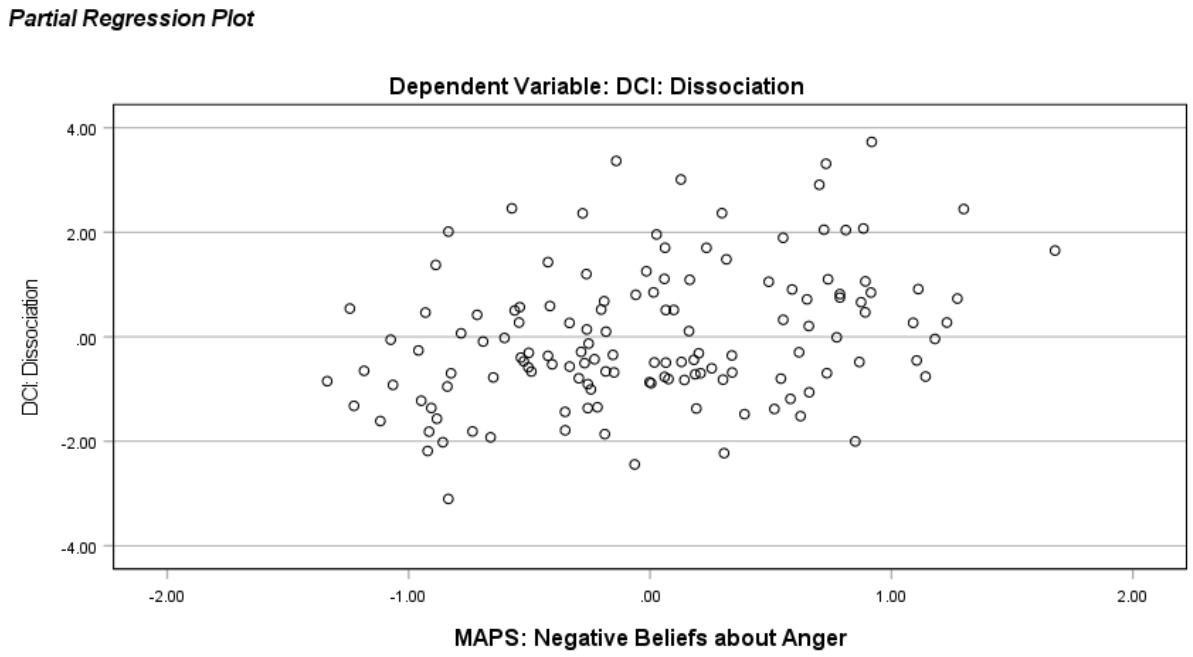
Figure 9: Partial Regression of Dissociative Psychopathology by Betrayal Awareness



APPENDIX X

Figure 10: Partial Regression of Dissociative Psychopathology

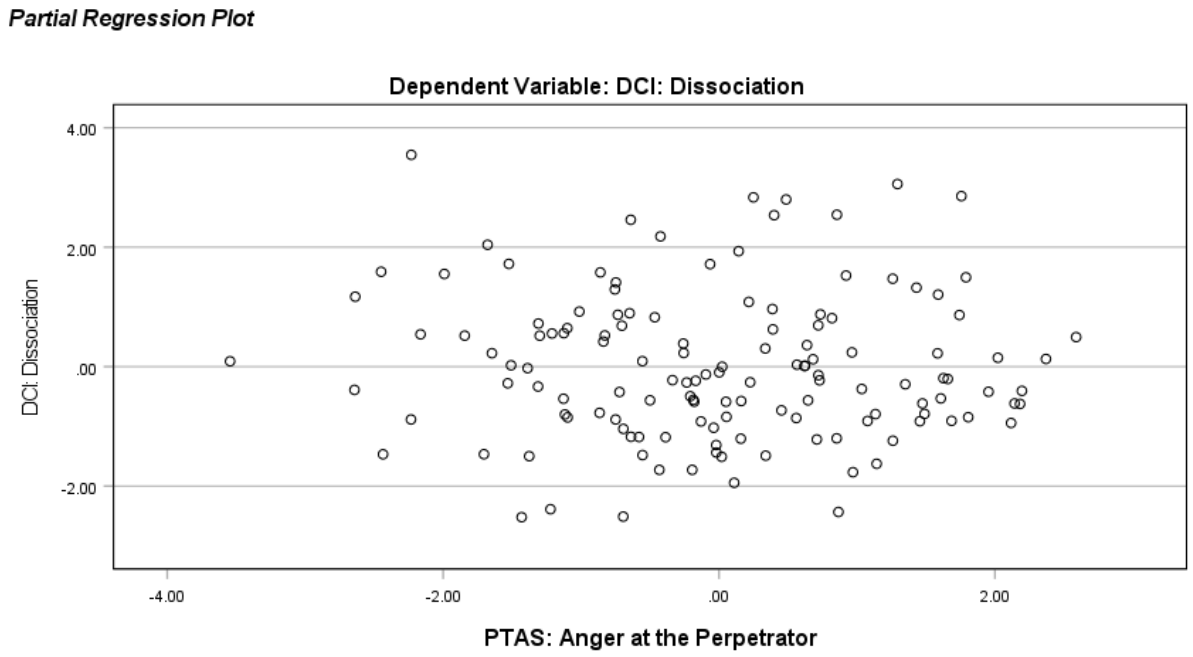
by Negative Beliefs about Anger



APPENDIX Y

Figure 11: Partial Regression of Dissociative Psychopathology

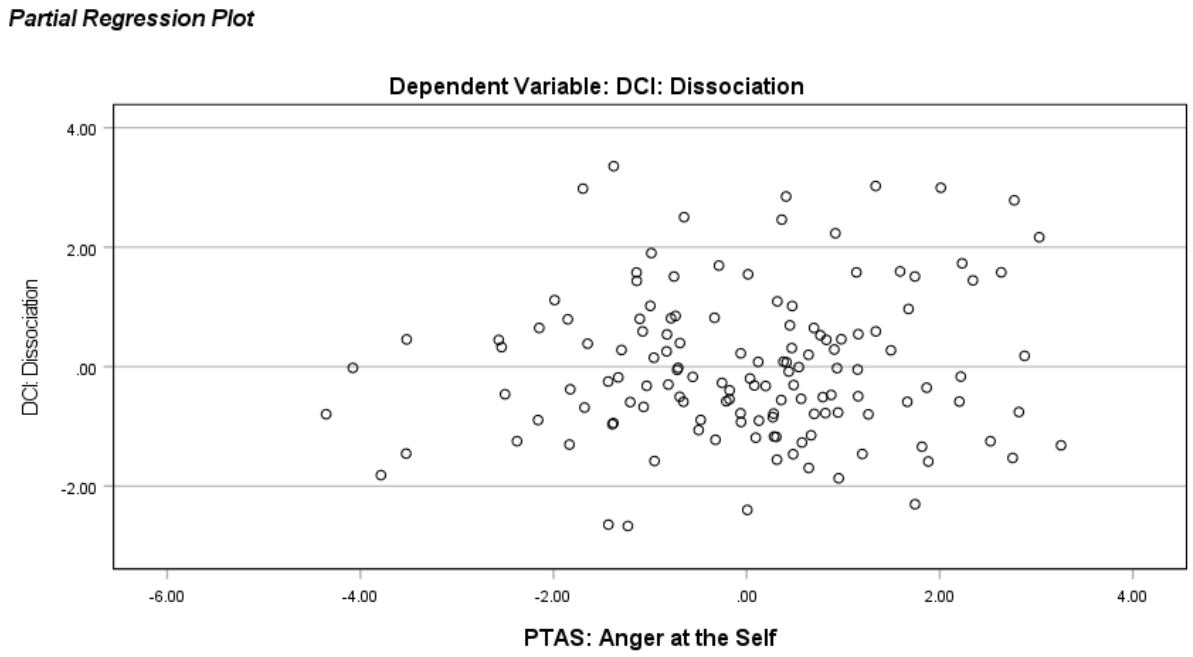
by Anger at the Perpetrator



APPENDIX Z

Figure 12: Partial Regression of Dissociative Psychopathology

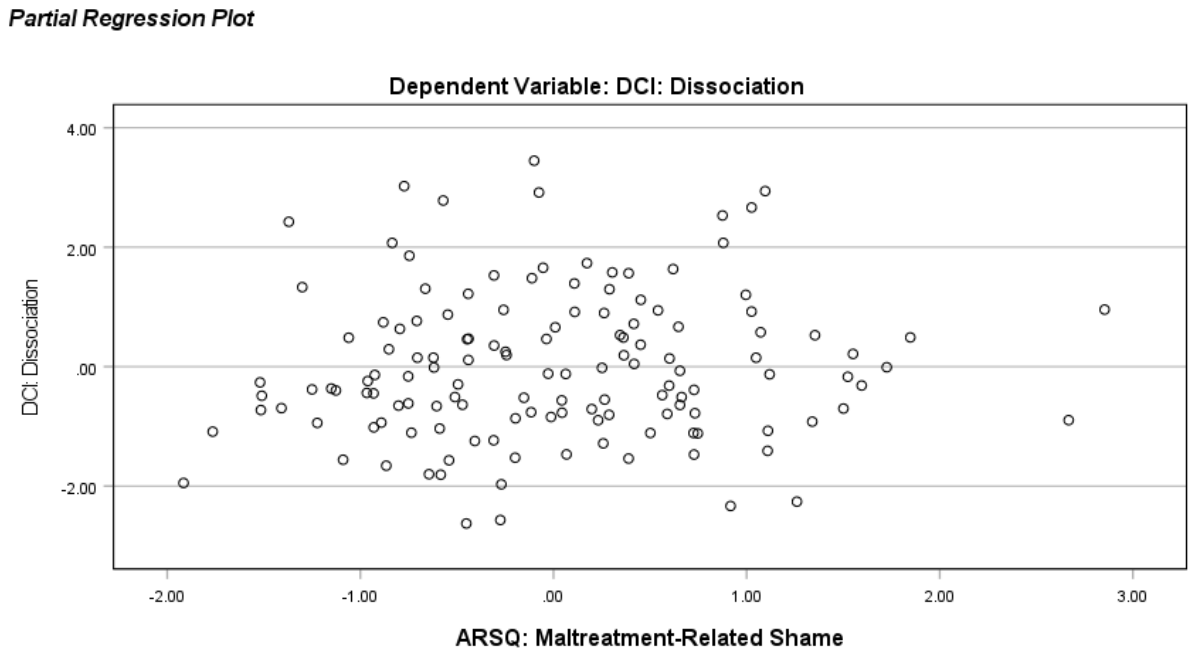
by Anger at the Self



APPENDIX AA

Figure 13: Partial Regression of Dissociative Psychopathology

by Maltreatment-Related Shame



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