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Keywords: Hazara; PTSD; DERS; social support



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Article

# The Mediating Role of Social Support Between Post-Traumatic Stress, Disorder and Difficulties in Emotion Regulation Among Students of the Hazara Community in Quetta

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## Abstract

Post-traumatic stress disorder (PTSD) is an anxiety disorder that can develop after experiencing a sequence of reactions to recurrent trauma, stress, and frightening thoughts. This quantitative research study explores the intricate connections between Post-Traumatic Stress Disorder (PTSD), Difficulties in Emotion Regulation Scale (DERS), and social support among students from the Hazara community in Quetta. A sample of 250 participants (125 male, 125 female) was selected through convenience sampling. Correlation analysis was performed, revealing strong positive correlations between PTSD and various components of DERS total (.410\*\*,  $p < .001$ ), DERS non-acceptance (.238\*\*,  $p < .001$ ), DERS goals (.291\*\*,  $p < .001$ ), DERS impulses (.251\*\*,  $p < .001$ ), DERS awareness (.300\*\*,  $p < .001$ ), DERS strategies (.254\*\*,  $p < .001$ ), DERS clarity (.251\*\*,  $p < .001$ ) indicating that higher PTSD symptoms are associated with increased difficulties in emotion regulation. Conversely, a strong negative correlation emerged between social support and both PTSD (-.488\*\*,  $p < .001$ ) and DERS components, suggesting that higher social support relates to lower PTSD severity and better emotion regulation skills. In addition, personal characteristics, family characteristics, PTSD severity are significant predictors of DERS. The study further investigated the mediating role of social support in the relationship between PTSD and DERS. The results demonstrated that social support partially mediates this relationship, emphasizing the importance of social support networks in mitigating the impact of PTSD on emotion regulation. The findings underscore the significance of addressing social support as a potential protective factor for individuals managing PTSD symptoms and enhancing emotion regulation skills.

**Keywords:** Hazara; PTSD; DERS; social support

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## Introduction

Living in a state of war with constant terrorist assaults is a dreadful feature of today's society. In contrast to natural calamities, war and terrorism are human-initiated acts of violence that are frequently wicked in character (Shaw, 2003). Post-traumatic stress disorder (PTSD), one of many mental health diseases, has become a serious issue since it affects millions of individuals all over the world. Exposure to traumatic experiences frequently results in the development of PTSD, a complicated and crippling disorder that leaves its sufferers with long-lasting psychological scars. Understanding the effects of PTSD is especially important in communities that have endured hardship and suffering in the past. The Hazara community, an ethnic minority group primarily residing in Central and South Asia, has been subject to a long history of persecution and violence, leading to experiences of trauma and distress. The Hazara people have faced discrimination, targeted attacks, and systematic marginalization, leaving deep emotional imprints on their collective psyche.

Among those who bear the brunt of such traumatic experiences are students of the Hazara community.

PTSD and other trauma and stress-related diseases are associated with significant psychological morbidity, substance abuse, and other harmful outcomes for physical health. Terrorism might be included as a concern that is progressively affecting the whole world. Terrorism's main objective is to instill a sense of fear, panic, bewilderment, and sadness among large numbers of people (Gidron, 2002). A terrorist attack was defined as a political-motivated planned human-made violent incident. Based on an analysis of six such studies carried out in France, Northern Ireland, Israel, and the United States, the prevalence rate of PTSD following terrorist incidents was found to be 28% (range 18-50%). Compared to security forces, lay people looked to be far more common (Gidron, 2002). Research was conducted in Northeast Nigeria on Rates of Occurrence and Influence of Trauma Exposure on Posttraumatic Stress Disorder Symptoms Among Survivors of Terrorist. The research found that PTSD was quite prevalent (65.72%) (Abiama et al., 2021).

Motreff et al. 2020 conducted research on Factors associated with PTSD and partial PTSD among first responders in the aftermath of the November 2015 Paris terror attacks. There were 130 fatalities, 643 injuries, and thousands more individuals were mentally traumatized. First responders who intervened during the night and/or in the aftermath of the terror attacks were given the opportunity to participate in web-based study 8-12 months later. They met the DSM 5 diagnosis of PTSD's criterion A (Motreff et al., 2020).

In a previous study Aftab, Obaid Ullah, Khadija Nawaz (2018) conducted research on post-traumatic stress disorder among Army Public School Peshawar students six months after a terrorist incident. The research included 205 kids. PTSD was detected in 154 (75.2%) of the 205 schoolchildren who participated, whereas only 24.8% showed no PTSD symptoms. Moreover, half of PTSD positive schoolchildren exhibited functional impairment in each of the following categories: fun and hobbies, friendship, schoolwork, family relationships, completing chores, general happiness, and praying(Khan et al., 2018).

Emotion regulation often refers to a person's ability to accept, regulate, control, and cope with a highly emotional situation. When experiencing unpleasant feeling, emotion regulation refers to the ability to manage impulses, engage in goal-directed behaviors, be aware of and understand one's emotional reactions, accept one's emotions, have access to effective emotion regulation techniques, and be in control of one's impulses(Boden et al., 2012). Problems with emotion regulation in general have consistently been related to more severe PTSD symptoms in cross-sectional research. (Christ et al., 2021).

To determine if emotion dysregulation and potential posttraumatic stress disorder (PTSD) were associated, 180 African American freshmen attending a historically black institution in the south of the nation were examined. Participants with probable PTSD who had experienced trauma reported significantly higher levels of general emotion dysregulation compared to participants without the criterion, as well as the dimensions of emotional unacceptance, difficulty engaging in goal-directed behavior when upset, difficulty controlling impulsive behavior when upset, and limited access to efficient emotion regulation strategies. Traumatizing experiences and individuals who meet the criteria A stressful experience but no PTSD (after adjusting for age and bad mood). Results revealed that participants who met Criterion A but had no PTSD were considerably less likely to develop PTSD than those who did not meet that criterion. Unable to access effective emotion regulation techniques (controlling for age and negative affect), those who have experienced trauma report difficulty in restraining impulsive behaviors when upset. (Weiss et al., 2012).

(Mazloom & Yaghubi, 2016) The study investigated how thought control and emotion regulation relate to predicting post-traumatic stress disorder. The participants were 149 persons who lived in communities in Harris City after the earthquake. The findings show a statistically significant association between PTSD, emotion regulation, and cognitive control techniques. Post-traumatic stress disorder was positively associated with self-punishment, difficulty with goal-directed behavior, limited availability to effective emotion regulation approaches, and rejection of emotion

strategies. Regression analysis results showed that two subscales of issues with emotion regulation methods (challenges in goal-directed behavior and limited availability to efficient emotion regulation strategies) predicted 29% of the variance in PTSD in the sample group.

One of these protective variables that might affect how people react to stress and negative experiences is social support. Social support is the term used to describe how well-liked interactions are judged to be inside a person's social network, or as any kind of support provided to friends and family members through difficult times (Sarason, 2013). A protective factor against the onset of PTSD is social support. (Alipour & Ahmadi, 2020) studied earthquake survivors, social support, and posttraumatic stress disorder (PTSD) to comprehend the role of social support in the prevention and treatment of PTSD in earthquake survivors. The results of the included studies indicated that social support may generally have a positive impact on PTSD prevention.

One of the most important risk factors for posttraumatic stress disorder (PTSD) is a lack of social support following a stressful incident. Early PTSD theorists proposed that the presence of strong social support shields against the emergence of post-stress psychopathology and facilitates the healing process. (Robinaugh et al., 2011). Social support's impact on mental health has long been recognized both positively and negatively (Durkheim, 1951). There are several ways that social interactions might affect mental health. Social support, for instance, may encourage normative behavior, which may result in either beneficial health outcomes (such as frequent physical exercise) or poor health consequences (such as excessive alcohol consumption) (Cohen & Wills, 1985). Furthermore, having access to greater assistance from community, religious, or other organizations may boost access to tools and practices that promote good health, such as receiving frequent checkups. (Berkman & Glass, 2000). By sparking a person's sense of purpose, belonging, security, or self-worth, feelings of social integration may lead to positive stress. The three facets of a person's life that make up the concept of social support are typically regarded as received support (i.e., receiving actual help), perceived support (i.e., believing that help is available if needed), and embedded support (i.e., the number, variety, and size of social roles). (Berkman et al., 2000), (Kaniasty & Norris, 2008). Low levels of anxiety and depressed symptoms, as well as a slowed rate of aging-related cognitive loss, have all been repeatedly associated to high levels of embedded support. (Berkman & Glass, 2000), (Cohen, 2004). Strong evidence suggests that a greater perceived availability of social support might reduce the rate and intensity of psychological pain, despondency, and anxiety that may develop after experiencing a traumatic event. (Cohen & Wills, 1985), (Moak & Agrawal, 2010).

Despite the fact that studies demonstrate that social support is compromised by emotion instability (Flannery et al., 2016) The link between emotion dysregulation and posttraumatic psychopathology may be masked by the adverse association between social support and emotion dysregulation. If emotional dysregulation contributed to posttraumatic psychopathology and had a detrimental impact on social support. We discovered that social support somewhat mitigates the effects of emotion dysregulation on PTSD and depressive symptoms in 90 military veterans who are engaged in an outpatient PTSD treatment program. (Clapp & Beck, 2009).

Social support helps people deal with stressful events and is closely related to mental health. People with low levels of social support experienced higher levels of stress, mental health morbidity for PTSD and depression, and death than people with high levels of social support. (Southwick et al., 2014). To comprehend the mediating functions of social support and resilience, research was done on black women who had experienced sexual abuse. Nearly 46% of the cohort suffered from severe depression, and 27% from severe PTSD. In exposed women, resilience plays a part in mediating the connection between severe depressive symptoms and perceived stress. In exposed women, social support modifies the association between high levels of PTSD symptoms and perceived stress. (Catabay et al., 2019).

1. There will be a significant relationship between PTSD, social support and DERS.
2. Social support will significantly mediate the relationship between PTSD and difficulties in emotion regulation symptoms among students of the Hazara community in Quetta.

3. It is hypothesized that DERS will be a predictor of social support and PTSD among the students of the Hazara community.

## Method

### *Design*

This cross-sectional study was conducted with students from Quetta's various government and private institutions. In July 2023, data gathering took place in all institutions throughout college and university days.

### *Participants and Procedure*

The data for this study was collected from different insititutes of Quetta, Adults 18 years and above through Convenience sampling. A protocol comprising of three questionair was adminitered that took mostly 5 to 10 minutes. Primarily collected through self report questionaires. Before administered the questionair Participants were given an explanation of the present study's purpose, and their informed permission was interpreted as their agreement to participate in the investigation. Participants were told that even if they decide to participate, their privacy and confidentiality will be protected, even though the data they have submitted may be utilized for publishing. Participants were told they may ask as many questions as they wanted. Participants were told that if they had any distress during or after completing the questionnaire, counseling or therapy would be offered. The evaluation instruments were then given to the participants.

### *Measures*

- 1) Demographic characteristics.

A self-report questionnaire designed to collect demographic information. This will be used to collect the basic information of the participants including gender, marital status, education, marks, religion, family system, abroad, witnessing terrorism, relationship with father, relationship with mother, and witnessing terrorism of the participants.

- 2) *PTSD Checklist for DSM-5 (PCL-5):*

PCL-5 there is a 20-item self-report test for PTSD (Weathers et al., 2013). From (0 = Not at all, 1 = A little bit, 2 = Moderately, 3 = Quite a bit, 4 = Extremely) the respondents stated how much each symptom had plagued them during the past month. Greater symptoms were indicated by higher summed scores severity. An empirically calculated criterion for probable PTSD is a score of 31 (Bovin et al., 2016). Cronbach's alpha the sample was.94. The Urdu version scale is used in this research the was translated by Sadia Saleem.

- 3) *Difficulties in Emotion Regulation Scale (DERS):*

Gratz and Roemer created the scale in the beginning. The Urdu translated version of DERS will be used in this research, that was translated by Saleem, (2019). DERS is made up of 36 items that are assessed on a 5-point scale and six subscales: (a) problems engaging in goal-directed behavior, (b) restricted access to emotion management tools, (c) refusal to accept emotional reactions, (d) trouble regulating impulsive behaviors while feeling unpleasant emotions, (e) emotional clarity, and (f) emotional awareness. Problems are indicated by higher subscale scores. Cronbach's Alpha was discovered to be in those components of emotion regulation, and the total score may be used to measure the overall complexity of emotion regulation. The total scale is 90. (Gratz & Roemer, 2004).

- 4) *Multidimensional perceived social support (MDSS)*

A 12-item self-report questionnaire called the MSPSS (Zimet, Dahlem, Zimet, & Farley, 1988) measures how people perceive the social support of their friends, family, and significant others.

Respondents stated how strongly they agreed that they were supported on a scale of (1 = very strongly disagree, 2 = strongly disagree, 3 = mildly disagree, 4 = neutral, 5 = mildly agree, 6 = strongly agree, 7 = very strongly agree). Higher summed scores showed more support. Cronbach's alpha was .92 for the overall score and .93 or .92 for the subscales in the present sample. (Zimet et al., 1988). The Urdu translated version of MSPSS will be used in this research that was translated by Rukhsana Kausar.

### Data Analysis

The Statistical Package for the Social Sciences (SPSS) 25 version was used to analyze the data. frequencies and Descriptive statistics were tabulated for socio-demographic characteristics of the respondents. Correlation was used to analyze the association between PTSD, DERS, and social support. Multiple hierarchical regression analysis was conducted using DERS as dependent variable and mediator analysis was used to analyze in order see the mediating role of social support between PTSD and DERS. In which we used the PROCESS macro (Hayes, 2013), which employed least squares regression to evaluate mediation, we explored whether social support mediated the connections of PTSD with emotion dysregulation. We bootstrapped the sample distribution of the indirect impact 10,000 times to facilitate normality, as advised by Hayes (2013). If the 95% confidence intervals for indirect effects did not cross zero, they were considered significant. Direct and indirect effects were standardized (converted to z scores) to facilitate comparisons within and across models.

## Results

**Table 1.** Demographic characteristics of participants (N=250).

Variable	<i>f</i>	%
Gender		
Male	125	50%
Female	125	50%
Marital status		
Married	4	1.6%
Engaged	20	8.0%
Unmarried	226	90.4%
Education		
Bachelor	220	88%

Master's	8
3.2%	
Others'	12
8.8%	
Marks	
Satisfactory	101
40%	
Somewhat	77
30.8%	
moderate	43
17.2%	
Somewhat unsatisfactory	17
6.8%	
Unsatisfactory	12
4.8%	
Religions	
1	20
20%	
2	45
45%	
3	35
35%	
Family system	
Nuclear family	143
57.2%	
Joint system	107
42.8%	
Abroad	

Yes	143
37.2%	
No	107
62.8%	
Witness terrorism	
Yes	70
28.0%	
No	180
72.0%	
Relationship with father	
Satisfactory	183
73.2%	
Somewhat satisfactory	27
10.8%	
Moderate	23
9.2%	
Unsatisfactory	10
4.0%	
Somewhat unsatisfactory	6
2.4%	
Relationship with mother	
Satisfactory	215
86.0%	
Somewhat satisfactory	19
7.6%	
Moderate	9
3.6%	
Unsatisfactory	3
1.2%	

---

Somewhat unsatisfactory

2

.8%

Note f= frequency, % = percentage.

**Table 2.** Mean and standard deviation of the participants for demographic characteristics.

Participants Characteristics		N=250		
		M	SD	Mini
<i>Max</i>				
Age			21.8	1.8
18	31			
Family income		81284	64281	10000
500000				
Birth order		3.0	2.1	1
10				
Siblings		4.6	2.1	1
13				

Note: M= mean, SD= Standard deviation, N= number of participants, Mini= minimum, Max=maximum .

**Table 3.** Descriptive statistics and reliabilities of the study variables.

<i>Range</i>					
Variable	<i>n</i>	<i>M</i>	<i>SD</i>	<i>α</i>	
<i>Mini</i>	<i>Max</i>				
PTSD T	250	17.3	12.6	.884	
.448	1.24				
MSPSS	250	58.3	15.8	.903	
4.38	4.29				
DERS T	250	91.7	21.3	.920	
2.13	3.252				

Note: PTSD T= Post traumatic stress disorder total, MSPSS= Multidimensional perceive social support total, DERS T= difficulties in emotion regulation total, N= total participants, M= mean, SD= standard deviation,  $\alpha$ =reliability of variables, Mini= minimum, Max= maximum. .

Three research variables: PTSD Total, Resilience Total, and DERS Total are shown in the table along with their descriptive statistics and reliability ratings. A sample of 250 people was used to measure these factors. PTSD M=17.3, SD=12.6 with the complete scale's Cronbach's Alpha coefficient was determined to be  $\alpha$ =.884. MSPSS M=58.3, SD=15.8 with the complete scale's Cronbach's Alpha coefficient was determined to be  $\alpha$ =.903. DERS M=91.7, SD=21.3 with the complete scale's Cronbach's Alpha coefficient was determined to be  $\alpha$ =.920.

**Table 4.** Correlation study of variable.

		1	2	3	4
5	6	7	8	9	
PTSD Total		–	.238**	.291**	.251**
	.300**	.254**	.252**	.410**	-.488**
DERS Nonacpt			–	.682**	.718**
	.466**	.781**	.406**	.784**	-.447**
DERS Goals				–	.707**
	.482**	.740**	.462**	.770**	-.403**
DERS Impul					–
	.529**	.807**	.557**	.824**	-.372**
DERS					Awar
	–	.497**	.585**	.673**	-.223**
DERS					Strat
	–	.495**	.832**	-.384**	
DERS					Clari
	–	.623**	-.266**		
DERS					Total
	–	-.510**			
MSPSSTotal					
	–				

Note: DERS Nonacpt= DERS Non acceptance, DERS Impul= DERS impulse, DERS Awar= DERS Awareness, DERS Strat= DERS Strategies, DERS Clear= DERS Clarity, MSPSSTotal= multi-dimensional perceive social support, \*\*= p<.005.

The table Displays correlation between PTSD, DERS and social support. PTSD were significantly positive correlated with DERS total ( $r = .41$ ,  $p < .001$ ), DERS non-acceptance ( $r = .238$ ,  $p < .001$ ), DERS goals ( $r = .291$ ,  $p < .001$ ), DERS impulses ( $r = .251$ ,  $p < .001$ ), DERS awareness ( $r = .300$ ,  $p < .001$ ) DERS strategies ( $r = .254$ ,  $p < .001$ ), DERS clarity ( $r = .251$ ,  $p < .001$ ) indicating that higher PTSD symptoms are associated with increased difficulties in emotion regulation. Conversely, a strong negative correlation emerged between social support and both PTSD ( $r = -.488$ ,  $p < .001$ ) and DERS components, suggesting that higher social support relates to lower PTSD severity and better emotion regulation skills.

**Table 5.** DERS would be predictor of social support and PTSD.

Model	SEB	P<
<i>B</i>		
<i>t</i>		
Step 1 (R= .22, ΔR2= .036)		
Gender	6.4	
.14	2.32	
.02*	Witness terrorism	
10.1	.18	
2.84	.005**	
Step 2 (R=.27, ΔR2=.038)		
Victim in family	6.8	
.13	1.97	
.04*		
Step 3 (R=.47, ΔR2=.193)		
PTSD total	.73	
.39	6.84	
.000***		
Step 4 (R=.58, ΔR2=.305)		
MSPSS Total	.52	
.41	6.30	
.000***		

Note: Note: PTSD=post-traumatic stress disorder, DERS= Difficulties in emotion regulation, MSPSS= multi-dimensional perceive social support. SEB= standardized error B, B= beta, t= T-test, P= level of significance (p < .05, \*\*p < .001).

The table displays the result of multiple hierarchical regression analysis. The first step of the regression included personal characteristics. At this phase, Gender (B=.14, t (249) =2.32, p<.02\*) and witness terrorism (B=.18, t (249) =2.84, p<.005\*\*) that both were significantly predicted of DERS. Step 2 introduced victims in the family (B=.13, t (249) =1.97, p<.04\*) it was also found to have a significantly predicated DERS, Step 3 introduced PTSD (B=.39, t (249) =6.78, p<.000\*\*\*) it was also found statistically significantly predicted DERS. The Final model incorporated social support (B=.41, t (249) =6.30, p<.000\*\*\*) it was found significantly predicted of DERS.

**Table 6.** Social support mediating the association of PTSD with emotion dysregulation.

	Independent Variable	Mediator	Dependent Variable
Indirect Effect	Indirect Effect	Mediator	Direct Effect
Effect	Effect 95% CI	Total Effect	
Variable (a×b)	Mediator CI	(a)	(b) (c)
DERS	Total effect		.39**
.36	(.22-.52)	.76**	
	MSPSS	-.71**	-.51**

Note: PTSD= (post-traumatic stress disorder), MSP= (Multidimensional perceived social support), DERS= difficulties in emotion regulation.

Table displays the mediating role of social support between PTSD and DERS. The mediation analysis used 5000 bootstrap and 95% CI. Our hypothesis that social support would mediate emotional dysregulation and PTSD was supported. Support accounted for 76.3% of the total effect. The result revealed a significant indirect effect of impact of PTSD on DERS ( $b=.36$ ). Furthermore, the direct effect of PTSD on DERS in the presences of mediator was also found significant ( $b=.39$ ,  $p<.001$ ). social support partially mediated the relationship between PTSD and DERS that indicates that social support plays a play mediating role between PTSD and DERS. Social support acts as a protective factor, buffering the impact of poor emotion regulation on the development of PTSD symptoms.

## Discussion

The study aimed to investigate the relationship between PTSD (Post-Traumatic Stress Disorder), social support, and DERS (Difficulties in Emotion Regulation) among students of the Hazara community in Quetta. From the above data, the study found a substantial inverse relationship between Hazara students' perceptions of social support and their PTSD symptoms. Higher degrees of PTSD symptoms are frequently associated with lower levels of social support. This suggests that the presence of PTSD may contribute to a decrease in the overall level of social support that an individual receives from their friends, family, and community. The negative correlation between PTSD and social support can have significant implications for an individual's well-being and recovery. Social support plays a crucial role in helping individuals cope with and manage traumatic experiences. The healing process can be aided by having a strong support system since it can offer emotional affirmation, useful help, and a sense of belonging. When individuals with PTSD experience a lack of social support, it can exacerbate their symptoms and make it more difficult for them to effectively cope with their trauma. On the other hand, having a strong support system can contribute to better mental health outcomes and a greater ability to manage and heal from PTSD. This result is in line with other research, which found that people who suffer greater trauma-related symptoms tend to seek less social support from their networks. The size of the social network vs the quality of social support: which is more protective against PTSD. Social networks that are supportive are crucial to the post-traumatic recovery process. A social network's variety may make it more resistant to PTSD. Participation in social activities and clubs can significantly reduce the chance of developing

PTSD. For the prevention and mitigation of PTSD, a deeper knowledge of how these networks work holds promise for enhancing psychiatric health(Platt et al., 2014).

The results of the study indicated significant positive correlation between PTSD and DERS, the positive relationship between PTSD and DERS shows that those with more severe PTSD symptoms also tend to have more trouble controlling their emotions. This result is consistent with other studies that have repeatedly demonstrated that people with PTSD frequently suffer with emotional regulation, which increases emotional reactivity, impulsivity, and difficulties managing uncomfortable feelings. The hypothesis was backed with the result of previous research of a Preliminary Investigation of the Association Between Posttraumatic Stress Symptoms and Difficulties with Emotion Regulation. The study included 108 undergraduate students from an urban college who represented a varied range of ethnicities. It has been demonstrated that the severity of PTS symptoms is associated with a lack of emotional acceptance, trouble focusing on goals when disturbed, challenges with impulse control, a lack of access to useful emotion management tools, and a lack of emotional clarity. Additionally, general deficiencies in emotion regulation related to the intensity of PTS symptoms when negative affect was considered. Last but not least, those who had PTS symptoms typical of PTSD reported having more trouble controlling their emotions. (Tull et al., 2007).

According to the current study, social support acted as a statistically significant mediating factor in the relationship between PTSD and DERS. According to the considerable mediating effect, social support can operate as a buffer or protective factor to lessen the effects of poor emotion regulation on the onset or escalation of PTSD symptoms. Individuals who have stronger social support networks may be better equipped to manage and cope with emotional challenges stemming from traumatic experiences, leading to a reduced likelihood or severity of PTSD symptoms. Social support may directly influence how individuals with difficulties in emotion regulation respond to and manage the emotional aftermath of traumatic events. This could manifest as receiving empathy, understanding, advice, or practical assistance from friends, family, or community members, which in turn helps individuals cope with their emotions more effectively and lowers the risk of developing severe PTSD symptoms. The hypothesis was backed with the result of previous research of Emotion Dysregulation and Social Support in PTSD and Depression: A Study of Trauma-Exposed Veterans. Social support and emotion dysregulation are transdiagnostic predictors of psychopathology (Aldao et al., 2010). They discovered that social support partially mediates the effect of emotion dysregulation on the symptoms of posttraumatic stress disorder (PTSD) and depression (PM =.10) using self-report data from 90 combat veterans (89.9% men) who participated in an outpatient treatment program for PTSD. When the source of support was taken into account, it was shown that support from friends and a significant other were more effective mediators of the effect of emotion dysregulation on depressive symptoms than support from family (PM =.01 and .08, respectively).The impact of emotion dysregulation on the signs and symptoms of posttraumatic stress disorder (PTSD) and depression is partially mediated by social support. (Cox et al., 2017). The mediating role of social support suggests that interventions aimed at improving emotion regulation and managing PTSD symptoms should also consider strengthening and enhancing social support systems. Interventions that foster the development of supportive relationships and provide resources for individuals to seek and receive help may have a positive impact on their overall mental well-being.

### *Conclusion*

Our Research sheds light on PTSD (Post-Traumatic Stress Disorder), social support, and DERS (Difficulties in Emotion Regulation) among Hazara students in Quetta. The study uncovered significant correlations and mediating effects that provide valuable insights into the mental well-being of this community in the aftermath of trauma.

The negative relationship between PTSD symptoms and social support emphasizes the Individuals with higher levels of PTSD symptoms tend to have lower levels of social support. This suggests that the presence of PTSD may contribute to a decrease in the overall level of social support

that an individual receives from their friends, family, and community. The negative correlation between PTSD and social support can have significant implications for an individual's well-being and recovery. Social support plays a crucial role in helping individuals cope with and manage traumatic experiences.

Furthermore, the positive correlation between PTSD and DERS highlights the challenges that individuals with more severe PTSD symptoms face in regulating their emotions. This aligns with existing literature and underscores the significance of addressing emotion regulation difficulties in the context of trauma recovery.

The study revealed that social support plays a play mediating role between PTSD and DERS. Social support serves as a protective factor, reducing the effect of ineffective emotion control on the emergence of PTSD symptoms.

### Limitation

The study utilized a relatively small sample size of participants from the Hazara community in Quetta (N = 250). Our research adopted a cross-sectional design, capturing data at a single point in time. This design limits our ability to establish causal relationships or infer the direction of influence between PTSD, social support, and DERS. Our research focused mostly on quantitative data, restricting our capacity to delve extensively into the Hazara students' lived experiences and narratives. Incorporating qualitative methodologies might give deeper understanding into the contextual complexities of PTSD, social support, and emotion regulation.

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