Comparison of Childhood Trauma and Effects of the Support System among University Undergraduates: A Gender-Based Study

Kiran Fatima [1,*], Muhammad Hassan [2], Saqib Baloach [3], Muhammad Abdullah [4], Abdul Rehman [5], Taqdees Maryam [6].

ABSTRACT:

Objective: To assess burden of childhood trauma among undergraduates and to compare the association of childhood trauma between male and female students. The secondary objective was to compare the effect of social support system amid both genders.

Methodology: The questionnaire-based study was conducted among undergraduates of Medical, Dental, and Physiotherapy institutes of Ibn-e-Sina University, Mirpurkhas after obtaining ethical approval. The validated Childhood Trauma Questionnaire-Short Form (CTQ-SF) was used along with the social-support/resilience tool comprising of 28 items and 8 items respectively. For data analysis, SPSS version 32 was used. P-value < 0.05 was considered statistically significant.

Results: Total n=304 participants were included in study. There was total n=192 (63%) female and n=112 (37%) male students. Majority (n=185-61%) of students lived in hostel. Most of the students were from MBBS (n=107) followed by BDS (n=104) and n=93 from DPT. The burden of childhood trauma was found to be 33.9%. Significantly higher mean scores were observed on subscale of emotional abuse items in male than females at p-value 0.004, and 0.007. To observe the effect of social-support, females scored significantly better on reliance on family and friends (p=0.024) and on self-calming ability (p=0.055), while males more often reported actively seeking help (p=0.001).

Conclusion: Approximately one in three undergraduates had experienced childhood trauma. Male students severely affected by physical, emotional, sexual abuse and by self-harm ideation, while revealing weaker perceived family support than their female counterparts.

Keywords: : Adverse childhood experiences, Childhood trauma, CTQ-SF, Social support; Resilience.

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Introduction:

Childhood trauma (CHT) is a substantial public health concern, surrounded by physical, emotional and sexual abuse and neglect. Worldwide, millions of children affected by CHT and continues to shape their behavior and health long after childhood ends.[1] In USA, population-based survey revealed that approximately two-thirds of adults reported at least one adverse childhood experience (ACE) before 18 years of age and 17.3% reported four or more.[1] National level estimates confirm that specific adversity types, such as neglect, abuse and household dysfunction, remain common across demographic groups.[2] According to the systemic review and metanalysis amid university cohorts in UK discovered the burden of one or more ACEs at 55.4% and frequently reported subtypes of ACE are emotional abuse (27.0%) and emotional neglect (30.0%).[3]

The burden of ACE from Pakistan even be heavier due to limited evidences. The study conducted in Lahore Pakistan among medical students of public university unveiled extensive exposure to ACE and protective factors that shaped their mental and physical health.[4] Another qualitative study from Lahore, Pakistan in 2024 discovered that mental-health disorders, chronic health struggles, paranoia, social and emotional difficulties and below average academic performance are long-lasting repercussion of childhood adversity.[5] According to the cross-sectional survey by Fazal A in 2022 in Rawalpindi, Islamabad found that 74.7% of students had an ACE score of 1-3 and 24.7% had a score of 4-6, with females reporting a higher proportion of adversity than males 66.8% and 33.2% respectively along with the strong association amid ACE load along with the burden of depression and anxiety.[6] The recent study by Mehmood S in 2025 explored the association of ACE with mental health status of young adults revealed that 98% had experienced at least one ACE, with 82.4% reporting three or more.[7] In Karachi, ACE were significantly associated with self-harm ideation among university students, with emotional abuse emerging having a strong correlation.[8]

Gender appears to shape both the type of trauma experienced and its psychological sequelae. Data presented at the European Psychiatric Association 2023 Congress showed that childhood emotional and sexual abuse had a greater impact on women, whereas emotional and physical neglect were more damaging for men, underscoring gender comparison and adversity subtype must be considered together.[9] Similarly, a large survey of Chinese college students found that childhood sexual abuse was reported by a comparable proportion of male (39.42%) and female

1. Associate Professor Department of Medical and Dental Education, Muhammad Dental College.
2. Student Third Year MBBS. Muhammad Medical College. Mirpurkhas
3. Assistant Professor Department of Anatomy, Muhammad Medical College. Mirpurkhas.
4. Student Third Year MBBS. Muhammad Medical College. Mirpurkhas.
5. Student Third Year MBBS. Muhammad Medical College. Mirpurkhas.
6. Lecturer Department of Dental Education, Muhammad Dental College. Mirpurkhas.

**=corresponding author :*
Email: kiranbana291@gmail.com.

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(43.55%) students, yet men who had experienced contact or penetrative abuse had markedly higher odds of a subsequent suicide attempt than women with the same exposure.[10] Network-analysis work in Chinese university students likewise found that the symptom structure of complex post-traumatic stress disorder differed meaningfully by gender.[11]

Social support is one of the most consistently identified protective factors against the mental-health consequences of childhood adversity. According to the stress-buffering hypothesis, supportive relationships are especially protective during periods of high stress, and several recent studies confirm that social support mediates or moderates the relationship between adverse childhood experiences and adult anxiety, depression, and mortality risk.[12,13] Coping-strategy and family support in particular has been shown to buffer trauma-exposed individuals against future psychiatric symptoms[14,15] although the protective effect of family support may weaken under conditions of severe or repeated maltreatment, particularly for girls and women. Understanding whether male and female students draw on and benefit from social support differently is therefore essential for designing effective, gender-responsive interventions. Despite an expanding body of evidence, limited literature is available in rural Sindh, Pakistan, examined childhood trauma and its buffering by social support specifically gender-based analysis in undergraduate health professionals' (HPE) population who are under substantial academic and clinical-training stress, hence it was the rationale of the study to fill that gap.

Objectives:

To assess burden of childhood trauma among undergraduates HPE and to compare the association of childhood trauma between male and female students. The secondary objective was to compare the effect of social support system in both genders.

Methodology:

This comparative analytical action research was conducted among MBBS, BDS and DPT undergraduates of Ibn-E-Sina University Mirpurkhas (ISUM) from September-2025 till December-2025. The ethical approval was obtained from IRB-ISUM Ref# ERB 11/2025. Sample size was calculated with the help of standard formula of sample size N = Z2*P (I-P)/d2as n=291 by considering the 74.7% prevalence6 and 95% confidence interval with 5% margin of error as to assess the burden of childhood trauma among undergraduates of ISUM. The sample size was augmented to 350 as to achieve more significant findings and considering 20% of wastage.

With the help of non-probability convenience sample technique, a self-reported validated Childhood Trauma Questionnaire-Short (CTQ-SF) comprised of 28-item used to screen trauma caused by physical, emotional, and sexual abuse and physical and emotional neglect.[16-21] The CTQ-SF has consistently demonstrated structural validity and good internal consistency across diverse populations and cultural adaptations, including Chinese, Danish, Japanese French, and Dari (Afghan) samples.[16-21] A recent meta-analysis of 39 independent samples reported an average Cronbach's alpha of 0.891 for the total score.[17] The responses were rated on five-point scale (never/rarely true to very often true). An eight-item social-support/resilience instrument, rated on the same five-point scale, was administered alongside the CTQ-SF to capture perceived family/peer support, coping strategies, and help-seeking behavior.

Other demographic variables such as age, gender, residence, live in hostel, year and discipline of studying were included as the first section of questionnaire. The participants were assured about anonymity of data throughout the study and participants gave consent were included in this study.

Data was analyzed on SPSS version 32. To assess the normality of data Shapiro-Wilk test was used. Frequencies and percentages were calculated for categorical variables. Association between different variables was assessed through application of fisher exact test and Chi square where appropriate. To compare the mean of CTQ-SF across male and female cohorts independent T test was used. P value > 0.05 was taken as statistically significant.

Results:

Total n=304 forms were completed in all aspects from total n=350 distributed forms, hence response rate was 87%. The prevalence of childhood trauma was found to be 33.9%. There was total n=192 (63%) female and n=112 (37%) male students. Majority n=185 (61%) of students lived in hostel. Most of the students were from MBBS (n=107) followed by BDS (n=104) and (n=93) from DPT. Significantly higher mean scores were observed in 3 items of emotional abuse in male than females at on items such as reflecting outright rejection, feeling that their parents wished they had never been born (p=0.004), feeling hated by family (p=0.007), and being told hurtful or insulting things (p=0.027) -table-1. Higher mean scores indicate a greater frequency of the reported experience. Statistically significant difference was found in all items related to sexual abuse and male students reported significantly higher mean trauma scores than their female counterparts at p value 0.004. For physical abuse, where severe abuse requiring medical attention (p<0.001) and self-harm ideation (p=0.001) were both significantly higher among male undergraduates. Although the two most general emotional-abuse items (belief that one was emotionally abused; difficulty controlling emotions) did not differ significantly by gender. Male students also reported significantly greater difficulty trusting others (p<0.001) and significantly higher scores on both self-harm-domain items: prior self-harm or ideation (p<0.001) and engagement in risky behaviors (p=0.002). Only one item (I believe I was physically abused) did not reach conventional significance (p=0.132), and several low-self-esteem items (self-worth, relationship difficulties, anxiety, sleep disturbance, feeling misunderstood) showed no significant gender difference, suggesting that the psychological sequelae of trauma were broadly comparable between genders even where the reported trauma exposure itself differed-table-1.

To observe the effect of social-support, females scored significantly better on reliance on family and friends (p=0.024) and on self-calming ability (p=0.055), while males more often reported actively seeking help (p=0.001)-table-2

Female students were significantly more likely to rely on family or friends during difficulties (p=0.024) and to endorse having coping strategies such as talking to someone or using relaxation techniques to deal with stress (p=0.024) then male students. Notably, male students were significantly more likely than females to report actively seeking help or advice when struggling with personal problems (p=0.001), a finding that stands in apparent contrast to their lower scores on family-reliance and coping-strategy items and suggests that male students may turn to sources of support outside the immediate family or peer network.

Table No 1: Gender-wise comparison of childhood trauma domains (CTQ-SF), N=304.

Item	Subscale	Female Mean (n=192)	Male Mean (n=112)	p-value
I believe I was emotionally abused.	Emotional abuse	1.8177	1.7143	0.173
I thought that my parents wished I had never been born.		1.3958	1.7054	0.004*
I felt that someone in my family hated me.		1.5781	1.9196	0.007*
People in my family said hurtful or insulting things to me.		1.7292	2.0268	0.027*
I have flashbacks or intrusive thoughts about past events.		2.2344	2.1786	0.565
I have difficulty controlling my emotions.		2.4948	2.1875	0.232
I believe that I was sexually abused.	Sexual abuse	1.3281	1.6250	0.004*
Someone molested me.		1.3281	1.7857	0.000*
Someone tried to touch me sexually or tried to make me touch them.		1.3125	1.6964	0.000*
I believe I was physically abused.	Physical abuse	1.3490	1.5893	0.132
I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.		1.3698	1.8393	0.000*
I have harmed myself or thought about self-harm.		1.6563	2.1250	0.001*
I struggle with low self-esteem or self-worth.	Low self-esteem	1.9271	2.0089	0.866
I struggle to form or maintain close relationships.		2.4323	2.2613	0.475
I often feel anxious or worried without a clear reason.		2.2552	2.2143	0.645
I struggle with sleep (e.g., nightmares, insomnia).		2.2604	2.4196	0.132
I feel misunderstood or different from my peers.		2.0469	2.2679	0.219
I have difficulty trusting others.		2.9063	2.1161	0.000*
I have harmed myself or thought about self-harm.	Self-harm	1.4792	2.0714	0.000*
I engage in risky behaviors (e.g., substance use, reckless actions).		1.7031	2.1339	0.002*
*Statistically significant, independent-samples t-test, p<0.05.				

Table No 2: Gender-wise comparison of resilience / social-support items among female and male Health professionals Undergraduate N=304

Resilience / Social-support item		Gender		p-Value*
		Female N=192	Male N=112	
I feel that I can rely on my family or friends when I face difficulties.	Never true	57	29	0.024*
	Rarely true	46	13	
	Sometimes true	31	20	
	Often true	30	21	
	Very often true	28	29	
I have coping strategies (e.g., talking to someone, problem-solving, relaxation) that help me deal with stress.	Never true	58	23	0.024*
	Rarely true	41	19	
	Sometimes true	39	18	
	Often true	31	26	
	Very often true	23	26	
There is at least one person in my life whom I can trust and confide in.	Never true	40	18	0.454
	Rarely true	23	15	
	Sometime true	30	19	
	Often true	29	25	
	Very Often true	70	35	
When I am upset, I know how to calm myself in healthy ways.	Never true	19	18	0.055
	Rarely true	32	13	
	Sometimes true	51	19	
	Often true	42	36	
	Very often true	48	26	
I can stay positive and hopeful even during stressful times.	Never true	24	11	0.051
	Rarely true	37	25	
	Sometime true	47	14	
	Often true	36	33	
	Very often true	48	29	
I actively seek help or advice when I am struggling with personal problems.	Never true	45	15	0.001*
	Rarely true	34	17	
	Sometimes true	52	18	
	Often true	24	33	
	Very often true	37	29	
Chi square test				

Discussion:

This study was focused on exploring the burden of childhood trauma among health professionals' undergraduates in rural Sindh, and to examine whether the protective social -support system operated differently for male and female students. The prevalence of childhood trauma was 33.9% which was under globally reported prevalence. According to the survey conducted internationally discovered at least one ACE in approximately two third of adult population and 17.3% experiencing four or more severe ACE. 1 However, meta-analysis conducted in UK discovered 55.4% of university students experiencing one or more ACE.[3]

Alternatively, nationally reported prevalence of ACE amid medical students in Lahore and young adults in Rawalpindhi is substantially higher such as 52.6% and 98% respec-

tively due to variation of the study tools, settings and cutoff scores used in study settings.[5,6]

The comparatively lower burden of ACE observed in this study presumably indicate the conservative scoring suggested in CTQ-SF and legitimate variance across regions, student populations, instruments, culture, reporting mechanisms and social stigma, hence plausible explanation as reported by Fazal et al[6] is ACE remains the persistent and prominent features in the lives of Pakistani students.[5]

This study unveiled significantly higher mean scores among male students than female in all the subscales of ACE such as emotional, sexual, physical, low self-esteem and self-harm. Similar findings are observed in Chinese College student survey, stated ACE of sexual abuse amid women was 43.55% and in men was 39.42% followed by attempt of suicide and experienced penetrative abuse caused by emotional trauma,[11] this pattern is significantly observed in elevated score of self-harm in this study. Parallel results are found in the local study conducted in Karachi, which stated that self-harm is strongly corelated with emotional abuse among university students [6] and greater score was observed in male students having difficulties while trusting others, interpersonal mistrust, social rejections in emerging adulthood, which is closely related to the emotional maltreatment during childhood.[22,23] These findings are in consistent with the evolving evidences that ACE affects the gender differently. Western literature reported the contrary findings where women reported heavier burden of emotional and sexual abuse.[1] According to the data of European Psychiatric Association 2023 Congress depicted that though trauma in childhood has a similar psychiatric impact in both genders but the type of specific trauma has asymmetrical magnitude specifically sexual and emotional abuse have grave effects on female and physical neglect and emotional trauma affects male significantly.[9]

Female students reported significantly greater perceived family and peer support and use of coping strategies than males. These findings are in consistent with buffering role of social support against ACE to combat childhood adversity and highly documented.[12,13,16] Social support (from family, peers) repeated reported and discussed to mediate ACE and depression and trauma in emerging adults, this buffering effect reduce the associated mortality risk. [15]

Male reported less score for seeking social support for seeking advice for personal problems to battle ACE albeit of having greater burden of trauma in childhood in this study, it may be that the male population in this context seeking support outside family, or teachers, counsellors, culturally adapted cognitive behavioral adaptation, which have a beneficial effect to lower the depression and anxiety, mentoring and phycological counselling is available in this context of ISUM. The use of cross culturally validated CTQ-SF instrument and self-administration of anonymous question may improve the disclosure of sensitive experiences of the study population is the strength of the study. However, there are several limitations such as single centered study, the convenience sampling technique may limit to generalization of findings in other regions and population of Pakistan. There are chances of recall bias in cross sectional study design. It is recommended to conduct multicentered studies to enhance generalizability, standardized clinical mental wellbeing tools such as GAD-7, PHQ-9, GAD-7) may be added in future studies to link trauma exposure with clinical outcomes. Furthermore, qualitative Insights with focus group discussion and interviews can be added to strengthen supplement quantitative findings to contextualize gender differences in coping and support.

Resilience building workshop on mindfulness training and emotional intelligence are suggested for students with attention to gender differential needs.[24]

Conclusion:

Approximately one in three undergraduate healthcare students at this rural Sindh university had experienced childhood trauma. Male students carried a disproportionately higher burden of sexual abuse, severe physical abuse, targeted emotional rejection, interpersonal mistrust, and self-harm ideation than their female peers, while female students reported stronger perceived family and peer support and greater use of adaptive coping strategies. These findings highlight the significance of childhood trauma among undergraduate healthcare students in rural Sindh and underline the need for support systems that address the distinct needs of male and female students rather than assuming a uniform pattern of vulnerability and protection across genders.

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Authors Contribution	
Kiran Fatima	Data analysis, write up, proof reading, supervision
Muhammad Hassan	Conceived, data collection, development of questionnaire
Saqib Baloach	Supervision, proof reading
Muhammad Abdullah	Conception, Development of questionnaire, data collection
Abdul Rehman	Data collection, development of questionnaire
Taqdees Maryam	Literature search, write up