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Editorial

Torture is a horrific menace entrenched in the ranks of societies and states in many parts of the world. Since 1986, VAST has assisted refugees and newcomers who have endured torture, trauma, and political violence through counselling, documentation, education, and referrals. The United Nations, IRCT, Canadian Red Cross, municipal and provincial governments, and other organizations support us in our endeavors.

In our learning and growth trajectory, we understand that thriving for a world free of torture is a colossal challenge for humankind across the globe and beyond borders, and no single government or organization can succeed alone in achieving this cherished goal. To this end, a partnership between CSOs and academia can have lasting and collective impacts through mutually reinforcing and supportive actions. Forging a partnership with universities, academic institutes, and researchers is one such front, which can help influence policies and curricula. These influences on our social and collective thought go a long way in addressing and containing trauma, abuse, and violence.

VAST (The Vancouver Association for Survivors of Torture, in Canada), the School of Human Rights Pakistan, and Roots Pakistan, joined as collaborators with the National Institute of Psychology (NIP), a Centre of Excellence in Psychology of Quaid e Azam University in Pakistan to organize the 9th International Virtual Conference on "Trauma, Abuse, and Violence: Thriving for a World without Torture" on July 23rd, 2022. The Conference aimed to provide a premier interdisciplinary platform for social scientists, academicians, civil society organizations, and research scholars from all over the world to present and discuss the most recent innovations, trends, and concerns, as well as practical challenges, encountered, and solutions adopted in the fields of Trauma, Abuse, and Violence. It was heartening that the NIP's call for papers received an overwhelming international response, and 96 papers were presented from different countries and regions, which subsequently set the stage for forging partnerships with individuals and institutions of those countries.

This special supplementary issue of the VAT Journal carries the papers contributed to the 9th International Conference, alongside a few other papers matching the theme of the Conference. We understand the papers presented at the Conference will help expand the knowledge base around trauma, abuse, and violence, and the evidence presented will help inform national and international policies aiming at a world free of torture. VAT and VAST, working with stakeholders in different parts of the world, will continue working for a world free of torture and hope that one day our work will no longer be needed.

Farooq Mehdi and Frank Cohn

KEYNOTES




Aoa
Subha
Bakhair









KEYNOTE LECTURES

Global and Local Anti-Torture Movements

Frank Cohn, MSW

Executive Director, Vancouver Association for Survivors of Torture

The newly released IRCT's Global Rehabilitation Standards (2021), along with the revised Istanbul Protocol (2022) of the United Nations Convention Against Torture (1984), are powerful tools in the advocacy struggle against torture and against impunity for the perpetrators of these crimes against humanity. In addition to these and many more international platforms, many countries have their own national consortia, networks, or federations of torture treatment programs. In addition to the international scientific 'Torture' journal, since 2004, the newly released international human rights journal 'Voices Against Torture,' since 2021, brings to life the research, stories, and perspectives of survivors and those who work with them and the daily hard work on the groundwork of the more than 200 Torture Rehabilitation Centers around the world supports those who had to endure senseless violence because of their identity. Our small center in British Columbia, Canada, VAST, supports over 1000 clients per year from all over the world through individual counselling, support groups, community building, public education, activism, advocacy, and capacity building for and with survivors.

Preventing Torture in Police Settings: Insights and Reflections

Asir Ajmal

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While much has been written on the effects of torture, there is a paucity of psychological research on the prevention of police brutality and torture, especially with regard to Pakistan. There have been numerous attempts at police reforms, but nothing substantial or substantive has been accomplished in this regard. Systemic interventions have been few and far between. We need to examine several variables before we can better understand the status quo. I will attempt to answer some of the following questions in this keynote address:

- What kind of personality commits torture and abuse on helpless unarmed citizens? Are personality variables significant?
- What kind of personality is attracted to the police force?
- Does the recruitment process attract the ―wrong‖ kind of people?
- Is prior education an important variable in this regard?
- Can in-service training and capacity building help prevent or reduce police brutality?
- What about IQ? Is intelligence relevant?
- What situational factors contribute to torture in custody? Have we learnt nothing from Zimbardo’s classic prison experiment?

An in-depth look at forensic literature suggests that the above questions are extremely important. Interaction with senior police officials over the years seems to confirm that such is the case. The number of cases of abuse, brutality, humiliation and torture has been increasing and has reached pandemic proportions. There is extreme fear and distrust of the police, and all attempts to improve their image have been cosmetic and not backed by any serious attempt to address the above questions.

Prevention Programs to Confront Sexual Violence Victimization on South Asian University Campuses

Lawrence H. Gerstein and Aashna Banerjee

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Sexual violence is a form of direct violence (Galtung, 1969) often sanctioned, reinforced, and maintained by cultural (Galtung, 1990) and structural forms of violence (Galtung, 1969). Sexual violence disproportionately affects women and girls around the world; more than one in three women and girls experience this form of violence in their lifetimes (World Health Organization, 2021). Given this high prevalence rate, sexual violence prevention (SVP) programs offer a potential solution for reducing sexual violence perpetration and victimization. Many SVP programs have been created, implemented, and evaluated in the Global North (i.e., U.S., Canada), specifically on college campuses (Holtzman, 2019). Programs typically target this setting because college-aged women are at a higher risk for sexual violence victimization across social contexts (Cantor et al., 2020). These worldwide programs have relied on several approaches to SVP— risk reduction (e.g., Rozee & Koss, 2001), bystander intervention (e.g., Banyard et al., 2007), comprehensive (e.g., Senn et al., 2015), and emancipatory sexuality education (e.g., Raymond & Hutchison, 2019). These programs and approaches, however, cannot be applied to South Asia's sociocultural context without addressing threats to external validity (Heppner et al., 2015), construct equivalence (He & van de Vijver, 2012), and theory and intervention equivalence (Gerstein, 2021). Each of the frequently used SVP approaches has different theoretical mechanisms of change underlying their interventions and targets different gender audiences (e.g., bystander intervention targets all genders, risk reduction targets women). In this presentation, the authors will review the global strengths and limitations of different approaches to SVP. Further, given that most SVP programming is currently developed in the Global North, the authors will discuss how cross-cultural bias needs to be addressed before implementing such programs in, for instance, South Asia. Additionally, the authors will discuss the role of feminist liberation (Lykes & Moane, 2009) and peacebuilding (Galtung, 1969, 1990) theories when designing and implementing culturally relevant SVP programs for college-aged women in South Asia. Further, the impact of SVP program participants 'gender on the selection of SVP approaches and the development of gender-appropriate prevention strategies also will be discussed. Finally, several other implications will be shared, including the (a) potential mitigation of sexual violence victimization and perpetration on university campuses, (b) establishment of evidence-based clinical strategies to reduce sexual victimization and perpetration amongst college-aged students, and (c) creation of relevant programming to decrease sexual violence in South Asia.

Elderly Abuse and Need for Social Protection

Wajid Pirzada

CEO, Roots Pakistan-A Grassroots Development Action, and Dean School of Human Rights, Pakistan

Roots Pakistan is a nonprofit civil society grassroots development action registered under the Societies Act of Pakistan. One of its core programs centres on "Aging in Place and the Social Protection of the Elderly."

Roots Pakistan, through its evidence-based advocacy program, working closely with its partners in development in the country and the region, seeks to inform public policy for an over-arching social protection program built around cash transfers, insurance, and/or social pensions for the elderly.

We have succeeded in getting the Senior Citizen's Bill enacted by the Parliament of Pakistan, which has been lying unattended for almost a decade. To further inform this Act and to strategize the "Aging in Place of the elderly, their social protection is the center of our asks and advocacy program."

The United Nations' World Health Organization (UN WHO) estimates that the global population of people aged 60 will more than double from 900 million in 2015 to about 2 billion in 2050. The WHO considers elderly abuse an important public health problem. It further maintains that elderly abuse can lead to serious psycho-social and financial consequences like physical injuries, depression, cognitive decline, early death, and financial damage. Guided by a review of 52 studies around elderly abuse in 28 countries conducted in 2017, it reported that one in six (15.7%) people aged 60 years and more were subjected to some form of abuse

ILO (2022) Report – Social Protection Floor for Fair and Inclusive Globalization confirmed that social protection programs enable the beneficiaries to invest in their families and proactively engage in economic and social development-related activities. Therefore, investing in the elderly through social protection programs can help contain the risks around elderly abuse, to which this segment of society is highly vulnerable. Over decades, we have witnessed growing elderly discrimination and abuse across the globe, and this trend heightened during COVID Contagion 19. Such an unfortunate trend disrespects the right of older people to a dignified life.

Older people are the architect of 'Today' and custodians of knowledge and wisdom. The national government and societies are responsible for protecting older people's rights and ensuring their well-being and dignified life. Older women are relatively more vulnerable to abuse compared to their male counterparts, for they are more likely to experience inequalities, injustice, and poverty. On the 63rd Session of the Commission on the Status of Women (CSW63), non-governmental entities across the globe collectively voiced for universal pension as a key right of women. They argued that non-contributory social pension schemes have helped, in many parts of the world, e.g. Kenya, alleviate poverty in the ranks of older people. Further, these help arrest the growing trend of the elderly being discriminated against and abused and contain their exclusion from mainstream development.

HelpAge International estimates suggest that in four out of five South Asian countries, namely Bangladesh, Nepal, Philippines, Vietnam, and Thailand, less than half of the elderly population is hardly protected through pensions. This situation prevails even though, in these countries, social pension coverage has significantly increased since the 90s, with coverage rates: in Thailand (70%), Nepal (40%), Bangladesh (28%), Vietnam & Philippines. However, the region's national governments face challenges in further expanding the social pension programs. Women generally tend to be among the less paid segments of society; as such, their coverage through pensions is proportionately less.

Further, older women are relatively more vulnerable to abuse compared to their male counterparts, for they are more likely to experience inequalities, injustice, and poverty. On the 63rd Session of the Commission on the Status of Women (CSW63), non-governmental entities across the globe collectively voiced for universal pension as a key right of women. They argued that non-contributory social pension schemes have helped, in many parts of the world, e.g., Kenya, alleviate poverty in the ranks of older people and arrest the growing trend of them being discriminated against and abused and their exclusion from mainstream development.

In Pakistan, a very limited population is covered under the Employees Old Age Benefit (EOABI) program and that too who are insured under the EOBI Scheme, which is a kind of contributory pension. Benazir Income Support Program (BISP) and Bit ul Ma'al, too, extend some social protection to the marginalized and disadvantaged, but these are not specifically targeted at the elderly. Pakistan has no other elderly-specific social pension program, unlike India, Bangladesh, and Nepal. While Universal Social Pension ((non-contributory) programs have shown the best results in the region, the 'Near-to-Universal Pension' program of Thailand has also succeeded in reaching 96% of the poor.

As an evidence-based strategy, Roots Pakistan seeks 'Means-Tested' social pensions for the elderly as an entry point for the social pension scheme in Pakistan and to build on and systematically graduate for Universal Social Pension. Academia, civil society organizations, and public and private sectors need to work in unison to this end and build a social protection alliance for a more inclusive and informed social protection policy for older persons.

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Learned Helplessness as a Consequence of Traumatic Experience:

New Methodological Ideas of Study

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The trauma results from a stressful effect that has proved excessive to the psyche. The result of psychological trauma is the occurrence of various pathological conditions, including depression and anxiety. Learned helplessness is a state arising as a reaction to uncontrolled, mainly negative events, the avoidance of which is impossible, which are connected with the optimistic or pessimistic attributive style of explaining life events. In both cases, a person feels no longer safe and feels that he cannot control his own life and be confident in the future, and psychological and somatic symptoms manifest. Psychological include tension, anxiety, obsessive thoughts, apathy, the desire for solitude, or, on the contrary, fear of being alone and others. The analysis of contemporary psychological studies showed that the following points are distinguished as specific features of the learned helplessness of a person: changing the motivation of achievement, emotional, cognitive, and volitional spheres. The new methodological basis presented in this study combines three conceptual ideas: learned helplessness theory (Seligman), the theory about the cultural and historical development of the human psyche (Vygotsky), and ideas of transportive analysis (Klochko). This unique methodological combination allowed us to design the authentic questionnaire Subjective Assessment of the Learned Helplessness Genesis, which reveals the connection between learned helplessness and psychological trauma. Knowing learned helplessness's genesis and the influence of traumatic experience on its formation can help to identify and predict it easily and increase the effectiveness of psychological assistance.

A Multicultural Approach to the Study of Mental Health Literacy and Myths on Trauma Caused by Catastrophes

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There is scarce literature on Mental Health Literacy related to trauma, particularly in catastrophes. Besides, limited attention has been paid to the role of cultural differences in this context. This cross-cultural pilot study aimed to compare people's myths about trauma and catastrophes in two countries (i.e., Spain and Pakistan). With a snowball sampling stratified by age range, an online questionnaire on myths related to trauma after catastrophes was completed by 80 participants. Multivariate covariance analysis was conducted on the scores of the set of items of the questionnaire, and a Covariance Analysis was also carried out for each of the 25 items, applying the correction of Bonferroni for multiple comparisons. Participants were reasonably knowledgeable on how people are supposed to respond to catastrophes. However, some misconceptions still prevail, like the universal need for psychological therapy because of necessarily suffering from a psychological disorder or the obligation to confront, cry, talk, and show pain to overcome the situation or recover in a limited time. Significant cultural differences were found, with Pakistani participants showing a firmer belief in myths referring to the power of time to heal wounds, the identification between overcoming and forgetting, and the overprotection of children (all large effect sizes). Future educational materials on mental health literacy should concentrate their efforts on these specific misconceptions that differ among countries and/or cultures. The significance of these myths is culturally discussed.

Journey of Voices Against Torture, Pakistan

Editor-in-Chief, VAST

Former VAST Board Member, Vancouver Canada

Voice Against Torture (VAT) represents the first organized and systematic effort to combat serious problems of torture in Pakistan. It is an interdisciplinary forum for the struggle against all forms of torture and the treatment and rehabilitation of torture survivors and their families. Professionals from every sphere of life, doctors, psychiatrists, psychologists, physiotherapists, lawyers, social counsellors, human rights activists, social workers, and research and documentation experts, put in their efforts to achieve the aims and objectives. Torture prevails everywhere in our society. The despotic character of the socio-economic fabric uses torture as an essential instrument for its survival and for snuffing out any dissent. Globally thousands of individuals and families, including many refugees, suffer from torture, from home to workplace, streets, academic and religious institutions, and police stations and prisons. The impact of torture can remain on the body as long as the procedure has ended. The whole life of an individual is destroyed, and in turn, this goes on to affect their integration into society. VAT has focused on the core themes of dissemination of information; mobilizing public opinion; making doctors and the medical sensitized and informed about torture and its psycho-somatic sequels; mobilizing opinion among the community of scientists in such a way that they refuse to make instruments, which could be used in the process of inflicting torture; conducting research on all forms of torture, their effects and methods of treatment including rehabilitation; providing free medical facilities for the treatment of torture victims; providing specialized Centre where victims of any type could be referred from anywhere for treatment and rehabilitation; acknowledging and supporting the activities of other human rights organizations both national and international level.

Note: Historical background of Voices Against Torture Pakistan.

www.schoolofhumanrights.com , http://vat.vast-vancouver.ca/

RESEARCH PAPERS

Pandemic as a Trauma: Basic Needs Frustration, Learned Helplessness Emergence, Development of Addictive Behavior and Hypochondria

O.V. Volkova, O.A. Tsvetkova, A.V. Rupeka and A.Y. Shadrina

The article is devoted to the analysis of pandemic COVID-19 conditions, which can be considered extreme and traumatic for many reasons. Using methods of theoretical analysis, the authors developed a theoretical investigation model which demonstrates how the pandemic situation becomes traumatic and by what mechanisms an increase in maladaptive behaviors occurs in various groups of people. These conditions affect all levels of the need-motivational sphere of personality, forming a state of basic needs frustration. For people characterized with specific predispositions, the pandemic situation causes basic needs, frustration, learned helplessness, cases of addictive behavior, and signs of hypochondriac attitude to health. The novelty and practical significance of the study are in designing the investigation model that can be applied as an algorithm for mass psychological assistance to various categories of people during a pandemic.

Keywords. Trauma, learned helplessness, basic needs, addictive behavior, hypochondriac attitude to the state of somatic health, COVID-19, pandemic.

Introduction

Although humanity has repeatedly experienced various cataclysms, the COVID-19 pandemic became a shocking surprise for the world, which appeared not to be ready for it. Existing knowledge about the development of pandemics, various infectious diseases, and some familiarity with medical science with the causative agent of the pandemic was not enough to prevent the crisis. The world community has introduced unprecedented measures for prevention and precautions against the new coronavirus infection spread, and the World Health Organization has described the pandemic as a crisis.

The world and all mankind have undergone and continue to undergo such profound changes that it is very early to talk about ready answers to the issue. The situation has generated great research interest in various psychological aspects and consequences of this phenomenon (Ostrovskiy & Ivanova, 2020). The following question remains one of the most important: why has the COVID-19 pandemic become so traumatic for the whole world and affected everyone?

In the pre-pandemic period, the way of life organization had several specific features, among which we can underline external locus of control, external determination, and conditional stability of reality. The sudden, spontaneous, and uncontrolled changes are not in any comparison with the circumstances with which a person has been forced to face COVID-19, both at the somatic and mental health levels. Taking into account that traditional ways of coping with stress (by a person, as a self-organizing system, representing biopsychosocial unity) are not working now, and the problem has a global level, the scale of the tragedy simply cannot be overestimated. To analyze the situation deeply, it is important to study the major compounds of the "extremity" of the pandemic conditions. It becomes necessary to develop and substantiate a theoretical investigation model that includes both the process of transition from an objective pandemic situation into a traumatic situation and the basic mechanisms of such a transition (frustration of basic needs and the emergence of the learned helplessness state); and thereby justify the manifesting effects of maladaptive behavior in a wider range of people of different ages, namely: increased hypochondriac type of response to disease, increased various forms of addictive behavior during a pandemic.

Methodological Background: In psychological studies, the extreme situation is characterized by sudden emergence, the uncertainty of prognosis, the risk to life, and the disorganization of familiar behaviours. In a pandemic situation that has erupted at the global level, the observing conditions can be considered extreme. Such conditions, according to several authors (Alekhin & Dubinina, 2020), include life threats and related threats, virtual threats, informational stress, excessive load, the need for rapid mobilization of psychological and psychophysical resources, significant psychoemotional stress and deprivation, the inability to influence the situation fully, uncertainty of prognosis, the lack of ready-made decision schemes and socio-economic stress. Subjectively, these conditions are experienced as "excessive" or even "unbearable."

A concept that is closely related to extremity is mental trauma. Summarizing the various characteristics of a traumatic event, the following features can be distinguished:

- Event extremity.
- An external event leads to the destruction of the life-world model or the main personal structure at this stage.
- The inability of a person to build a new lifeworld or a new personal structure.
- Lack of resources to rebuild the new life-world model.
- Not being able to cope and even survive It.
- Loss of process experience dynamics, there is a stuck at some point and stagnation of the state (Magomed-Eminov, 2014; Vasilyuk, 1984).

According to many of these signs, with a certain predisposition of the person, the situation of a pandemic and self-isolation can act as traumatic. Such a diverse range of experiences and emotions does not pass without a trace, forming stable views, attitudes to the situation, and behavior. Not everyone can control their emotional manifestations and psychotic reactions in such conditions because anxiety about their health, fear of getting sick, and becoming helpless are normal human reactions. Many contemporary researchers agree that the pandemic has become a global stress-forming factor for various categories of people worldwide (Anjum et al., 2020; Chen et al., 2020; Rasskazova et al., 2020).

COVID-19 is another type of stress - its destructive form - distress, the collision that leads to a person's destruction or death. The only hope is the possibility of a reasonable, rational, systemic, technological approach to the pandemic problem, in which joint efforts of specialists of different professional fields will be able to change the polarity of coronavirus infection SARS-Cov-2 effects from "-" into "+": not baseless optimism, but the persistent search for a solution to a new problem in a new reality rapidly developing under the influence of a new coronavirus infection SARS-Cov-2.

The pandemic's extremity (complexity) affected the grounds for each personality: needs, values, and attitudes. First, this concerns the fact that everyone has experienced the frustration of basic human needs. One of the natural needs that every individual has is protection and a sense of security. Against the background of such a large-scale and unpredictable event as a pandemic, the psychoemotional tension of people is growing, the panic state is embraced, and the reaction to such stimuli can be completely different.

The mechanisms of psychological protection are manifested in a variety of ways. This can be directly related to the depth and multidimensional nature of the object itself (Pilyugina, 2020). Frustration refers to the impossibility of realizing or meeting a need. As a rule, frustration is a short-term emotional state that leads to the search and resolution of the conflict that a person experiences. However, this does not relieve the severity of the experience. In other words, a person perceives this obstacle as really existing. Not only the fact of frustration itself becomes traumatic, but also the duration of the frustration.

Frustration can be one of the components of the trigger mechanism for the occurrence of hypochondriacal disorder. Feelings of anxiety for one's health, and fear of missing something important overlapping with the psycho-trauma situation of a pandemic, can stimulate the development of a hypochondriac type of attitude to the disease when there is an imaginary belief in the presence of any pathology. It is more difficult to experience a state of frustration if it affects personality-based needs. Basic needs here mean needs; the dissatisfaction experienced by man as a crisis or even collapse affects the value and meaning foundations of life, making the frustration of basic needs a mechanism of mental trauma.

If frustration concerns personality-based needs and is experienced by the individual for a long time, various destructive phenomena arise that are associated with pathology, illness, or disruption of adaptation. One of these manifestations is the hypochondriac type of response to the disease. People with such a reaction seek treatment and, at the same time, do not believe in the success of the treatment prescribed by the doctor. Constantly concentrates on unpleasant, painful experiences and feelings and go into unnecessary details, describing their well-being (Chamkina et al., 2019).

Our observations reveal that in a state that can be noted as the general psychoemotional background of the population, there are clear signs of a psychological phenomenon, which was defined as a state of learned helplessness by American psychotherapist, founder of the New Positive Psychology Martin Seligman in 1970s (Seligman, 1975). Learned helplessness arises from long-term out-of-control events that cannot be overcome by any effort.

The degree of satisfaction or frustration of basic needs in ontogenesis (as a positive or negative experience of the individual) can predefine the degree of constructiveness or destructiveness of behavioral manifestations in a crisis. Following Magomed- Eminov (2009), we can agree that the whole variety of reactions to a crisis or extreme situation can be represented on a continuum: negative reactions (in the limit - disorder) - neutral reactions - positive reactions (overcoming, development, and growth).

A person experiences the state of need for frustration in a crisis, and the richness of reactions to frustration can also be described in this continuum. Research interest is currently caused not only by a negative pole but also by a positive one. However, in real requests for psychological assistance in pandemic conditions,

negative pole reactions still prevail, so some of them are in the prism of our investigation: the state of learned helplessness, addictive behavior, and hypochondriac type attitude toward the disease and health.

Purpose, Object, and Subject of Study

The pandemic conditions as factors leading to experiencing psychological trauma were defined as the object of the study. The subjects of the study are as follows: The frustration of basic needs during the pandemic, learned helplessness emergence, hypochondriac type of reaction to disease, and addictive behavior as consequences of this specific traumatic experience. The study aims to substantiate the theoretical model of considering a pandemic as a traumatic situation that frustrates a person's basic needs, which leads to the emergence of learned helplessness, as well as destructive behaviours such as addictive behavior and a hypochondriac type of reaction to the disease. Within the study, the following hypothesis was formulated: the frustration of basic needs in pandemic conditions affects the emergence of the learned helplessness state and the formation of addictive behavior and a hypochondriac type of attitude to the disease and health.

Research Methods

The following methods were used to build the theoretical model: theoretical and methodological analysis, modelling, abstraction, concretization, generalization, and interpretation of scientific data.

Discussion and Results

A number of researchers, considering the quarantine situation, cite the following factors that affect a person's mental state: the duration of quarantine, fear of infection, frustration and boredom, insufficient provision (products, clothing, medical services, household services, etc.), inadequate information (Fedosenko, 2020). All these factors affect the person in conditions of self-isolation as well. Under conditions of self-insulation or quarantine, all levels of needs described in Maslow's pyramid (Maslow, 2011) are frustrating. The first level (physiological needs) was frustrated by such factors as the prohibition of leaving home without extreme need, including for the purchase of food, and medicines, the possibility of visiting organizations and institutions that provide life, and even simple "household" issues (for example, when older people could not leave their homes and had to rely on the help of volunteers).

The second level (the need for safety) is frustrated both by the danger of infection due to the high contagiously and the rapid spread of infection and by the fact that the disease "entered" the homes of the closest social environment, posing a threat to life (constant reports on the disease and death, news highways on various media), even the house ceased to be safe. The third level of needs was frustrated by the ban on social contact, including elderly parents or relatives. The fourth level (the need for recognition and respect) was frustrated by such events as the transition to new ways of professional activity in remote work and incompetence in the tools necessary for it. The fifth, highest level in Maslow's concept (the need for self-actualization) was frustrated by the impossibility of self-realization in conditions of self-isolation using the usual methods.

Children of pre-school age who are not at direct high risk of COVID-19 disease face special conditions of deprivation: observance of the regime of self-isolation contributes to restriction of physical activity, conditions of stay in home deprive children of natural development of the leading age activity - games, the most effective mastering of which is possible in the process of communication with peers. The absence of systematic training in the graduate class creates the highest level of anxiety and uncertainty. The effects of quarantine and distance learning on children's mental and social health are described in their study by Luijten et al. (2021). Their empirical study shows that during the pandemic, the number of children with symptoms such as anxiety and sleep disorders increased, and the quarantine situation also negatively affected the social sphere by reducing social contact with peers (Luijten et al., 2021). From this point of view, the social layer of students is seemingly in a more secure situation. However, a remote form of the educational process contributes to the development of procrastination ("putting tasks on the back-burner"), limits the sphere of social communication, and restricts future specialists' direct adoption of practical experience. Lack of social skills is a risk of forming Internet-dependent behavior (Malyshev & Yakovleva, 2018). In a pandemic, when the Internet and social networks become the only way of communication for young people, this risk increases. The middle-aged population filters all the negative effects of the new coronavirus infection pandemic SARS-Cov-2: Threat or fact of unemployment, transition to form of remote work, social deprivation, need to learn new competencies, anxiety for family members of younger and older generations, exacerbation of conflicts in the family (if previously family members spent a certain limited time in collaboration, now the communication has entered the 24/7 mode, the results of which we can already find in data reflecting the increase in the number of divorces since the abolition of the self-isolation regime in many countries of the world). In addition, modern representatives of the working layer of the population have met with the phenomenon, which in western psychology and management is called the term "overlap" - when the boundaries between professional activity and the home environment are blurred, the working space and professional tasks are moved to the

territory, which is intended for rest, recuperation, intimate and personal relations, etc. All the above-mentioned conditions contribute to the highest level of psychological tension and increase susceptibility to stress effects, which are abundant in the modern information environment.

For employees in various areas, the pandemic situation significantly impacted the organization of labor. The transition to telecommuting required significant changes in the lifestyle of office employees, which affected the psychological and physical well-being of many of them (Xiao et al., 2021). The impact of the COVID-19 pandemic on human mental health in the workplace is covered by a review. Scientists agree on the need to take specialized measures to prevent mental problems for each professional field representative (Giorgi et al., 2020).

One of the most vulnerable professional groups to the stressogenic factors of the pandemic is health care professionals. The medical personnel working with patients in specialized departments have a high risk of negotiation, disorders of the emotional sphere and general maladaptation (Kuzmin et al., 2021).

Representatives of the third age group are also in special conditions. Above all, the older population is among the main risk groups for COVID-19. And this, apparently, a purely physical factor, promotes the formation of psychological vulnerability, which is shown in feelings of anxiety, concern, feeling of isolation and loneliness, lack of psychological flexibility in the development of new forms of life organization, communication implementation, and receiving services.

One of the key factors in all age groups is the type of personality, on which the type of human response to the disease depends more. The type of attitude to the disease, in turn, directly affects the style of behavior; people with a hypochondriac attitude to the disease choose a competing style of behavior since their own "I" has a priority for them (Bardadyn et al., 2019).

The pandemic situation is characterized as a situation of long distress and a high degree of uncertainty of control and prediction. The frustration of basic needs thus leads to phenomena of mental health violation reflected in many studies: anxiety, fear, apathy, stupor, emotional distress, depression, stress, poor mood, irritability, insomnia, symptoms of post-traumatic stress, anger, and emotional exhaustion, reduced mood, and irritability (Fedosenko, 2020). Disorders of the personality's emotional, cognitive, and motivational-will sphere, characteristic of dependent behavior, are also characteristic of the state of learned helplessness (Glukhova & Sheglova, 2009).

For the psychologically unstable person who has insufficient frustration tolerance, stress can become a trigger for the development of maladaptive forms of behavior, the most dangerous category of which is addiction. Addictive disorders are a form of disruption of a person's adaptation to the objective surrounding reality. In many scientific studies, "care" in addictive behavior is seen as a destructive reaction to traumatic events.

If to simplify the principle of addiction development, we can generalize that in conditions of experiencing conditionally negative emotions or with a deficit of positive ones, a person has an interest in using an addictive agent (substance or behavior) to change his psychoemotional background. If normally negative emotions motivate a person to change the conditions that frustrate the satisfaction of basic needs and to their ultimate satisfaction, then when "leaving" for the addiction, the problem situation is ignored. A person does not make efforts to overcome the problem and takes a passive position on his own future. In the meantime, frustration is growing; the need to change the psychoemotional state by using an addictive agent is increasing.

In this way, addictive behavior is formed and is developing, which begins with psychological dependence and, over time, leads to functional changes in the nervous system, physical dependence syndrome, and pathological attraction. We find such a mechanism for addiction development (Dmitrieva & Levina, 2012), as well as in many other authors studying the concept of an addictive personality. Most of them converge in understanding the essence of addiction as a form of avoidance of reality, arising initially as maladaptation, which, as the addictive disorder worsens.

The relationship between learned helplessness and symptomatic manifestations of hypochondriac attitude to the disease and health allows a person to assume the role of a patient, which entails a decrease in responsibility and removal of the daily duties of a healthy person while increasing attention to the care of others (Kolmogorova & Buikov, 2015).

The authors consider learned helplessness as a basis for the formation of dependent behavior on the example of tobacco smoking in adolescents (Gluhova & Sheglova, 2009).

Several examples of addictive behavior and the learned helplessness state development in pandemic conditions can be considered based on the general mechanism presented in Figure 1. As the most traumatic factors caused by the COVID-19 pandemic state of uncertainty, anxiety, and fear of the unknown, including fear for health and life, can be distinguished. This can strike at one of the basic needs - safety needs. A frustrated need for safety can cause long-term anxiety, which in turn leads to a general disruption of life.

Long-term experience as an unpleasant and depressive emotional state forces a person who does not have a sufficient level of development of coping behavior to

take a passive position regarding his own ability to influence events. A state of learned helplessness arises, while anxiety increases with it. A person is looking for external support in order to cope with this negative condition. Drinking alcohol and psychoactive substances with ataractic motivation as a way to relieve emotional tension can be a way to avoid anxiety and trigger the mechanism of addiction. It is also possible to take psychotropic drugs uncontrolled, which forms a violation called "drug dependence."

Another circumstance that requires adaptation to the current world situation is the transition of many States to a self-isolation regime. In such a situation, several groups of needs become vulnerable at once - primarily social, as well as the need for self-realization through usual routine activities, including professional ones. A long stay in conditions of lack of communication and uniformity of life can provoke a sense of boredom, apathy, a feeling of loneliness, and "emptiness" of life. According to many researchers, even in their usual lives, one of the most pronounced motivations for drinking alcohol is hedonistic - getting pleasure (Belousova & Fandej, 2015).

Many people, including those at a stage when it is not yet possible to say about the formed addiction syndrome, resort to alcohol consumption as a form of leisure organization. It does not require special efforts but leads to some emotional detente and helps to fill free time. In a situation where a person has a sharply limited ability to choose various activities, alcohol remains an affordable means of combating boredom. These factors can potentially both accelerate the course of formed or emerging alcohol dependence and serve as a trigger for the emergence of interest in alcohol for those who have lost their usual activities and have not been able to organize new forms of leisure. For young people, samples of narcotic substances are also characteristic of destructive satisfaction of the need for new impressions, the so-called "emotional hunger" (Patrikeeva et al., 2015).

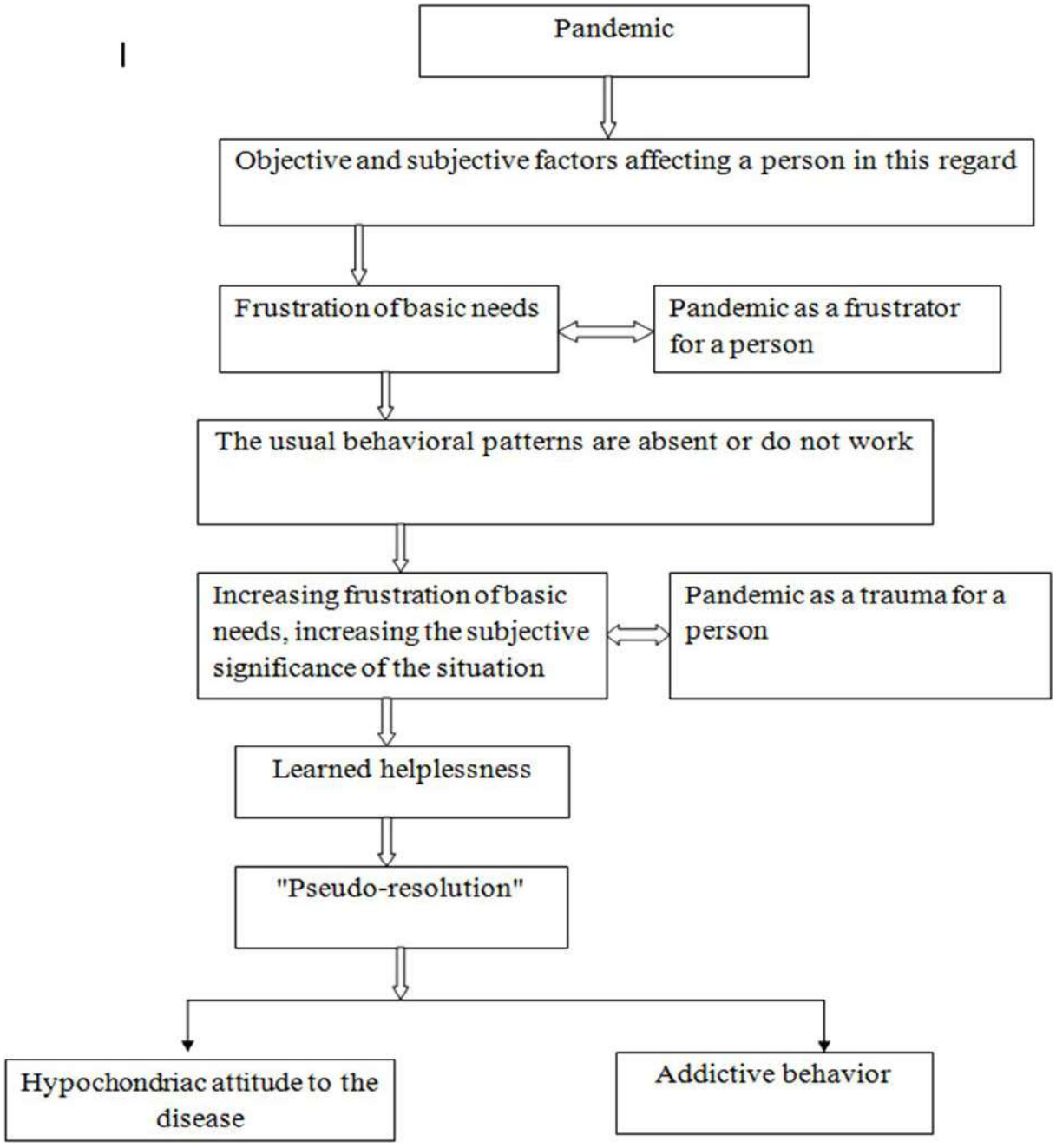
It is also important to say about another risk arising in the context of the frustration of basic needs caused by the pandemic. As new technologies evolve, new forms of dependent behavior emerge. Today, a large number of so-called "non-chemical" additions are distinguished. Among them, the most common is dependence on computer games, social networks, uncontrolled viewing of movies, TV shows, information on the Internet, and an obsessive desire to shop. These and other forms of behavior, which are accepted in society as a norm, can act as a destructive way of coping with negative emotions and develop according to the principles of the development of other addictive disorders. Internet technologies today have increased the opportunities for the development of ludomania, known long ago as dependence on gambling. Now making bets, playing a tote, and an online casino has become available to everyone using the Internet.

A pandemic, with its negative economic consequences, can become a factor that pushes a person to seek alternative earnings. An infantile personality is trying to find a way to enrich without labor - this acts as a motivation to start playing. And the winning and losing system forms pathological attachment and addiction syndrome.

Nowadays, we can only make assumptions about the possibility of developing addictive behavior in people in pandemic conditions since the formation of such violations occurs over time, often long. But already, researchers are convinced in practice that events in the world have influenced this problem. Alcoholism in pandemic-induced stress in people who chronically consume alcohol primarily increases cravings, including at the neurohumoral level (Clay & Parker, 2020). This makes possible the risk of remission failure among those who suffer from alcoholism and are in prolonged abstinence. The health system should be ready for an influx of patients with a drug profile as one of the consequences of the pandemic (Dubeya & Ghoshb, 2020).

Another important factor that can influence the disruption of remissions in persons with addictive disorders is the ban on mass meetings, namely group self-help. One of the most common and effective ways to maintain the remission of alcohol and drug-addicted patients is recognized by organizations of therapeutic community meetings of "Alcoholics Anonymous" "And Drug Anonymous." Attending face-to-face meetings, mutual support, and constant social contact allowed a person not to escape to change the structure of his motives and interests. The therapeutic community acts as a certain form of external support during adaptation to a sober life. This suggests that it is important to pay attention to a group of people in need of post-rehabilitation assistance in overcoming addictive behavior, seeking alternatives, or transforming familiar forms of psychological support for this category of patients. A Figure of the interaction of these phenomena is shown in Figure 1. Empirical implementation of this model on a sample of Russian students showed its viability (Volkova et al., 2021).

Figure 1
The mechanism of pandemic influence as a factor in the emergence of basic needs frustration, development of the learned helplessness state, hypochondriac attitude to the disease, and addictive behavior



Conclusion

As a result of theoretical analysis, an investigation model was built to demonstrate the transition from a pandemic situation into a crisis and trauma. In a fairly large number of cases, a person resorts to "pseudo-decisive" actions: strengthening the hypochondriac type of response or addictive behavior (both chemical and non-chemical. This approach does not allow now to consider the injuries of some professional groups (for example, doctors) who provide medical assistance but themselves need adequate psychological support programs. Special cases of traumatization of medical staff may require comprehensive psychological rehabilitation. We must admit that frustration develops at all levels of personal needs and manifests itself locally - in family and household spheres, and globally – in all spheres of human life.

This leads to effects such as learned helplessness and addictive behavior, often accompanied by a hypochondriac type of response in a wide range of people. These factors significantly reduce both the population's quality of life and mental health, indicating the need to introduce local psychological assistance to heal the resulting psycho-trauma. Recognition of both the fact of the trauma of a pandemic and frustration as the main mechanism of trauma allows you to translate psychological support from a situation of treatment and correction into a situation of complex prevention.

The developed theoretical investigation model is universal by its structure and can be used not only in regions and countries where the pandemic has already acted as a global trauma (China, Russia, the USA, EU countries, and other states that have encountered the pandemic sharply in 2019 - 2020) but also for those regions where the severity of the pandemic has not reached the level of mass traumatization (Coronavirus Statistics, 2022). This model allows both to urgently respond to the crisis that has arisen and to deploy preventive work at any stage in the development of a negative mass situation. It helps the mental health assistant to identify the targets of consulting and psychotherapeutic work more promptly in the mass nature of appeals. In the future, this model can be tested as an algorithm for psychological assistance to various categories of people in a pandemic.

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Psychosocial Predictors of Post-Traumatic Growth among Conflict-Related Sexual Violence Survivors: A Specific Strata of Congo

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Conflicted Related Sexual Violence (CRSV) includes all forms of sexual violence where state or non-state armed groups target political, ethnic, or religious minority groups during state collapse. It is highly prevalent in the Democratic Republic of Congo (DRC) and leads to the development of many psychological problems. The present study was based on a Cross-Sectional research design in which data was collected from 52 female survivors of Conflict-Related Sexual Violence between the age range of 20 to 61 years (M = 35 SD = 9.7) in the Democratic Republic of Congo during the period from June 2019 to February 2020. All participants were assessed through Posttraumatic Stress Disorder Checklist (PCL) (Weathers et al. 1993), the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996, Brief Cope (Carver, 1997, Life-Orientation Test-Revised LOT-R; Scheier et al., 1994), and **Multidimensional scale of perceived Social Support** (MSPSS; Zimet et al., 1988). Results showed that there was a significant negative correlation between post-traumatic growth with post-traumatic stress disorder and pessimism; a significant positive correlation with emotion-focused coping and optimism. At the same time, the relationship between post-traumatic growth with age, social support and problem-focused coping was non-significant. Additionally, the result of the hierarchal regression model showed that post-traumatic stress disorder, pessimism, optimism and motion-focused coping play an important role in predicting post-traumatic growth, with pessimism being the most significant predictor. This study highlighted that being optimistic and having a positive life approach play a significant role in the development of post-traumatic growth among survivors of Conflict-Related Sexual Violence.

Keywords. Post-traumatic growth, pessimism, optimism, coping strategies, post-traumatic stress, conflict-related sexual violence

Despite having the world's largest resources and many inimitable features, the Democratic Republic of Congo (DRC) has remained a fragile country for many years. It has struggled with wars, civil strife, d multiple rebellions since 1996 and slowly recuperating from political and economic instability. It has enormous challenges in terms of security/peace, decentralization, political/economic governance, and poverty. Despite some improvement in recent years, females are the most underprivileged part of this country, facing huge physical, mental, and psychosocial burdens. Sexual violence, specifically conflicted related sexual violence (CRSV), is the most threatening traumatic event that is highly prevalent in the Democratic Republic of Congo (DRC). Especially women and children are mostly a victim of it. Every second woman there had encountered rape and sexual violence at some level. It has devastating effects on survivors' psychosocial well-being and mental health (Linden, 2011; Scott et al., 2017). Their psychological pain is clearly depicted by the statement of the UN secretary general's special representative on sexual violence, which was referred to as the rape capital of the world. Sexual violence was used as a weapon of war in this country, and it has one of the world's highest rates of sexual violence.

Sexual violence, which may include kidnap, sexual slavery, sexual exploitation, and human trafficking – was a prominent feature of this conflict (Delic et al., 2017), whereby women are believed to have been targeted by civilians, locally-stationed military forces, foreign military forces and United Nations Peacekeepers (Jennings et al., 2009). Previous research revealed that survivors of CRSV develop the symptoms of depression, post-traumatic stress disorder (PTSD), anxiety, and suicidality (Johnson et al., 2010). This is because of the social stigmatization and rejection at the family and societal levels (Kelly et al., 2012). Further, the results of a study on 51 female survivors of sexual violence after 20 years of war in BIH depicted the long-term effects of conflict-related sexual violence. 57% of these survivors suffered from post-traumatic stress disorder (PTSD), 76% reported disrupted sleep, and 40% expressed frequent thoughts about death and dying (Mittelmark et al., 2017). In addition to these symptoms, some other most prominent and persistent emotional and psychological reactions of these victims are often intense fears of associated situations, generalized anxiety, humiliation, depression, increased substance abuse, loss of self-esteem, distrust of others, social isolation, hostility, fear of sexually transmitted diseases, guilt, self-blame and fear of sex or other sexual dysfunctions (Steketee & Foa, 1987; Ullman & Najdowski, 2010).

But these survivors do not always report the negative effects of these experiences. Rather they appear to be strong enough to take these events in an optimistic way and experience positive psychosocial outcomes in the form of PTG (Anderson et al., 2019). Post-traumatic growth is the art of living optimally despite having traumatic events in life. It brings permanent changes in the survivors' lives' psychological, cognitive, and spiritual aspects. Though the process of its development is initiated immediately after the experience of trauma, the actual growth occurs after some time of trauma experience when survivors start reflecting on their trauma at a cognitive level and giving meaning to his/her experience. However, it was highlighted in the literature that both positive (PTG) and negative outcomes (PTSD) of any trauma could emerge at the same time as a separate entity (Solomon & Dekel, 2007); and there is several psychosocial factors which involved in the development of PTSD and PTG among survivors of traumatic events. A study on Bosnian refugees who settled in the USA revealed that coping plays a very significant role; for example, avoidance coping strategies are associated with greater distress and negative outcomes compared to healthy coping strategies (Ai et al., 2003; Lazarus, 1993). Optimistically inclined people can derive a sense of benefit from adversity to a greater extent than pessimistic people, and that optimism can be generalized and remain stable over time (Prati & Pietrantoni, 2009; Saboonchi et al., 2016). So these emotional, social and spiritual resources act as buffers in managing trauma. But there are limited studies that focus on growth following interpersonal events such as CRSV. There is one such study in which a sample of 104women survivors of CRSV from Bosnia and Herzegovina was studied to determine the relationship between post-traumatic growth with symptoms of post-traumatic stress disorder (PTSD), coping (COPE), and optimism. And it was found that coping strategies play a significant role in the development of PTG.

As deliberated above, the female strata of Congo are mostly affected by CRSV, leading to the development of several mental health consequences that need to be addressed for these women's overall well-being. In this milieu, the present study was designed to determine the various psychosocial predictors, such as PTSD, age, gender, coping, locus of control, and social support, which are helpful for the growth of PTG among these survivors.

Method

Sample

The present research was a cross-sectional study in which a purposive sample of 52 female survivors of conflict-related sexual violence was collected from the Democratic Republic of Congo. The sample obtained comprised females with an age range between 20 to 61 years (M = 35 SD = 9.7). Further, details about sample characteristics are explained below in Table 1.

Table 1

Demographic characteristics of the sample (N=52)

Variables	**Categories**	***f (n=52)***	**%**
Age	Below 45	43	82.7
	Above 45	9	17.3
Marital status	Single	6	11.5
	Married	46	88.5
Family setup	Joint	40	76.9
	Nuclear	12	23.1
Education	Un-educated	18	34.6
	Educated	34	65.4
Employment Status	Employed	38	73.1
	Un-employed	14	26.9
SES	Poor	37	71.2
	Better	15	28.8
Ethnic Affiliation	Christian	34	65.4

	Others	18	34.6
Time-CRSV	Less than 1year	14	26.9
	More than 1 year	38	73.1
History of Trauma	Yes	42	80.8
	No	10	19.2
Part of SSG	Yes	19	63.5
	No	33	36.5

Table 1 shows that all the participants were females ($N = 52$). Majority of them were married ($n = 46$), educated ($n = 34$), employed ($n = 38$) and living in joint family system ($n = 40$). Maximum participants were Christians ($n = 34$) and belonged to poor socio-economic status ($n = 37$).

Instruments

The following instruments were used to measure the various study variables.

Posttraumatic Stress Disorder Checklist (PCL; Weathers et al., 1993). It is a 17-item self-report checklist of PTSD symptoms based closely on the DSM-IV criteria. Respondents rate each item from 1 = "*not at all*" to 5 = "*extremely*" to indicate the degree to which they have been bothered by that symptom over the past month. Thus, the total possible scores range from 17 to 85. Estimates of internal consistency (Cronbach's alpha) range from .94 to .97(Weathers et al., 1993). Test-retest reliability has been reported as .96 at 2-3 days and .88 at one week (Ruggiero et al., 2003).

Post-traumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996). The PTGI is a 21-item self-report scale for assessing psychological growth following a traumatic event; in this case, framed in the context of participants' experiences of CRSV. The PTGI includes five subscales: new possibilities, relating to others, personal strength, spiritual change, and appreciation for life. Items range from 1= "I *did not experience this change as a result of my crisis*" to 6 = "*I experienced this change to a very great degree as a result of my crisis,*" and total scores on the PTGI range from 1 to 126, with higher scores reflecting greater perceived growth. It is a reliable instrument with Cronbach's alpha for the PTGI total score was .96 and ranged from .66 to .90 for subscale scores.

Brief COPE Scale (Carver, 1997). The Brief COPE (Carver, 1997) is a self-report questionnaire used to assess several different coping behaviors and thoughts a person may have in response to a specific situation. The Brief COPE was developed based on concepts of coping from Lazarus and Folkman (1984). The scale comprises of 28 items and fourteen subscales: Active coping (items 2 and 7), use of instrumental support (items 10 and 23) planning (items 14 and 25) was classified as problem-based coping. Self-distraction (items 1 and 19), denial (items 3 and 8), substance use (items 4 and 11), use of emotional support (items 5 and 15), behavioral disengagement (items 6 and16), venting (items 9 and 21), positive reframing (items 12 and 17), humor (items 18 and 28), acceptance (items 20 and 2), religion (items 22 and 27), self-blame (items 13 and 26) falls into emotion-based coping (Macdonald, 2011). Internal reliabilities for the 14 subscales range from .57- .90 (Carver, 1997), and reliability for each subscale ranged from .75 to .82 (Jacobson, 2005). It is a Likert-type scale with responses varying from 1 = 'I have not been doing this at all to 4 = = '*I have been doing this a lot*.

Life-Orientation Test-Revised (LOT-R; Scheier et al., 1994). The LOT-R is a 10-item self-report measure of dispositional optimism and pessimism. Three items in the scale capture optimism (Cronbach's α = .70), three capture pessimism (Cronbach's α = .74) and the four remaining items are fillers and are not scored. Scores were calculated in their original unidimensional format. Respondents rate each item on a scale from 0 "*strongly disagree*" to 4 "*strongly agree*." A total score is calculated by adding the inverted pessimism score to the optimism score. Cronbach's α for the total score is .73 for the Serbian population (Jovanović & Gavrilov-Jerković, 2013; Scheier et al., 1994).

Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988). This scale **is** used to measure participants' perception of support that they get from family, friends, and significant others. It is a 12-item self-report questionnaire with a 7-point Likert scale where 1 denotes *very strongly disagree* and 7 denotes *very strongly agree*. It contains three subscales, and each contains 4 items. The total mean score can be generated by adding the score of all 12 items and dividing it by 12. A mean score of 1 - 2.9 means low support, 3 - 5 means moderate support and 5.1 - 7 is considered high support. In the present study, MSPSS showed good reliability with Cronbach's alpha of .94.

Procedure

Multi-level procedural steps were carried out in this study; the researcher got formal permission for the use of scale through email and approval from the Ethical committee of the Psychological Research Wing, GHQ. Participants with a history of CRSV from various Villages in Congo were approached. A short-info care session was given to all the participants with the aim of explaining the purpose of the study and obtaining their verbal consent. Data was collected through a language translator.

The collected data was entered on SPSS-24 and analyzed. Descriptive Statistics were carried out to describe the mean, SD, frequencies, and reliability coefficients. Further inferential statistics involved Pearson Correlation, regression analysis, and *t*-test.

Psychometric Properties of scales

The reliability of all the scales used in this study was tested using coefficient alpha reliability, and it was found that all the scales were reliable, which is shown in Table 2.

Results

Table 2

Coefficient Alpha Reliability of Measuring Variables and their Subscales (N=52)

Variables	***n***	***M***	***SD***	***α***
PCLT	52	44.73	12	.917
PTGI	52	69.04	8.16	.771
PFC	52	17.58	2.33	.454
EFC	52	52.87	7.62	.686
MSPSS	52	61.90	18.94	.952
OPT	52	8.73	2.58	.540
PES	52	10.87	2.71	.464

Note. PTG = Post Traumatic Growth Inventory; PCLT = Post-Traumatic Stress Disorder Checklist; PFC = Problem Focused Coping; EFC = Emotion-Focused Coping; MPSST = Multidimensional Scale of Perceived Social Support; PES = Pessimism; and OPT = Optimism.

Results show that the value of alpha of all scales ranges from .917 to .454; all represented good values of reliability except two sub-Scales (PFC of Brief COPE and PES of LOT-R) which have satisfactory reliability. This indicates that the data collected in this study has produced reliable results (Heiman, 2011) and could be used for further analysis. The reliability of subscales of the LOT-R was low. The reason behind it is that this scale was composed of 10 items; among them, three items in the scale capture optimism, three capture pessimism, and the four remaining items are fillers and are not scored. As the length of the scale is related to the reliability of the scale, so less number of items might affect the reliability. Another possible reason was the lack of cross-cultural validity of these measures.

Table 3

Frequencies and Percentages of Main Variables (PTSD & PTG) Among CRSV Survivors (N=52)

Variables	**Categories**	***f (n=50)***	**%**
PTSD	Above mean	20	40
	Below Mean	13	26
PTG	Above mean	28	56
	Below Mean	6	12

Table 4

Correlation Coefficients of PTG with PTSD, Problem Focused Coping, Emotion Focused Coping, Social Support, Optimism, Pessimism and Age Among Survivors of Conflict-Related Sexual Violence (N=52)

Variables	1	2	3	4	5	6	7	8
1. PTG		-.401**	-.007	.522**	-.038	-.607**	.377**	.169
2. PTSD			-.135	.536**	-.054	-.342*	-.245	.295*
3. PFC				.030	-.205	-.032	.215	.235
4. EFC					.104	-.336*	-.192	.214
5.MPSST						.169	-.158	-.181
6. PES							-.473**	-.049
7. OPT								-.191
8. Age								

Note. PTG = Post Traumatic Growth Inventory; PCLT = Post-Traumatic Stress Disorder Checklist; PFC = Problem Focused Coping; EFC = Emotion-Focused Coping; MPSST = Multidimensional Scale Of Perceived Social Support; PES= Pessimism; and OPT = Optimism. ***p* < *.01; *p* < *.05*.

Table 4 shows the Correlation Coefficients of PTG with Various study variables. Results revealed that PTG was significantly negatively correlated with PTSD and PES, meaning that survivors of CRSV who have PTSD and Pessimism tend to have poor PTG. Whereas it was significantly positively correlated with EFC and OPT to indicate that survivors who used emotionally focused coping and were optimistic would have high PTG. Further to this, no significant results were reported with other variables such as age, social support and problem-focused coping.) was non-significant.

Regression Analysis

In order to test the hypothesis that PTSD, PES, EFC and OPT will predict PTG among survivors of CRSV, Hierarchical multiple regression was calculated.

The results showed that post-traumatic stress disorder accounted for about 16% (F (1, 50) = 9.59; $p < 0.05$). In step 2, pessimism was added to the model and the total variance explained by the model was 41% (F (2, 49) = 17.09; $p < 0.001$), explaining that an additional 25% change is caused by pessimism. In the nest model, emotion-focused coping was added which resulted in variance of about 48.5% (F (3, 48) = 15.1; $p < 0.001$). Finally, the addition of optimism. To regression model at stage 4 explained variance of 58.2% i.e. additional 9.7% of the variation, and this change in R^2 was significant (F (4, 47) = 16.36; $p < 0.001$). Therefore, it can be inferred that pessimism is the most significant (β = -0.532, $p <$ 0.001) negative determinant of post-traumatic growth among survivors of conflict-related sexual violence. Although all four variables together account for 76% of the variance in PTG, pessimism is the most significant as it explains 25% of the variance.

Table 5

Hierarchal Multiple Regression Analysis to Explore Psychosocial Predictors of Post Traumatic Growth Among Survivors of Conflict-Related Sexual Violence (N=400).

Variables	***R***	***R²***	**Δ *R²***	***B***	***SE***	***β***	***t***	***p***
Model 1	.401	.161	.144					
PTSD				.273	4.07	.401	3.09	.003
Model 2	.641	.411	.387					
PTSD				.149	.079	.219	1.87	.066
PES				-1.68	.369	-.532	-4.55	.000
Model 3	.697	.485	.453					

PTSD				.042	.085	.062	.495	.623
PES				-1.50	.355	-.475	-4.23	.000
EFC				.353	.134	.330	2.63	.011
Model 4	.763	.582	.546					
PTSD				.142	.083	.209	1.71	.095
PES				-.616	.420	-.195	-1.46	.149
EFC				.455	.126	.425	3.62	.001
OPT				1.25	.382	.418	3.29	.002

Note. R^2 = amount of variance explained by IVs; ΔR^2= additional variance in DV; *B* = Unstandardized Coefficient; SE= Standard Error; β = Standardized Coefficient; *t* = Estimated Coefficient.

*$p < 0.05$; ** $p < 0.01$.

Discussion

The present study aimed to explore the psychosocial predictors (PTSD, age, gender, coping, locus of control, social support) of PTG for the sample of CRSV survivors from DRC. The result of the present study showed that both positive (PTG=56%) and negative outcomes (PTSD=40%) of CRSV emerged as separate entities and these findings are in line with previous research (Anderson et al., 2019; Johnson et al., 2010; Kelly et al., 2012; Mittelmark et al., 2017; Solomon & Dekel, 2003; Steketee & Foa, 1987; Ullman & Najdowski, 2010). Past studies from various other countries displayed similar findings where survivors of CRSV experienced positive outcomes as well as damaging effects of these experiences (Anderson et al., 2019; Ullman & Najdowski, 2010).

Moreover, the present study's results found a strong negative significant relationship between PTGI with PTSD and pessimism, indicating that people experiencing PTSD and having a pessimistic approach towards life will tend to have low PTG and vice versa. Many studies have found similar results (Prati & Pietrantoni, 2009; Saboonchi et al., 2016).

Essentially, optimistically tending people can derive a sense of benefit from adversity; to a greater extent than pessimistic people, and that optimism can be generalized and remains stable over time (Saboonchi et al., 2016). The present study also reported a significant positive value of Pearson correlation for the relationship of PTG with EFC and Optimism. Therefore, it can be inferred that survivors with emotion-focused coping and an optimistic approach toward life have post-traumatic growth, which is also supported by previous literature (Anderson et al., 2019; Solomon & Dekel, 2007). For example, Anderson et al. (2019) reported that if these survivors adopt optimistic ways and have an overall positive approach toward life, they can experience positive psychosocial outcomes in the form of PTG. Additionally, the result of the hierarchal regression model to explore the role of PTSD, pessimism, optimism, and emotion-focused coping in predicting PTG among survivors of CRSV showed that these variables do play a role in predicting PTG. All four variables together account for 76% of the variance in PTG, with pessimism being the most significant as it explains 25% of the variance. The values suggest that pessimism is the most significant (β = -.532, $p < 0.000$) determinant of PTG among survivors of CRSV. However, PTG is not significantly related to age, social support and problem-focused coping. There are many reasons for it, such as the cognitive makeup of the population. These discoveries are compatible with previous studies (Anderson et al., 2019; Saboonchi et al., 2016; Prati & Pietrantoni, 2009), which reflected that psychosocial, cultural and spiritual capitals are strong buffers in the management of psychological trauma. Along similar lines, a study on survivors of CRSV from Bosnia and Herzegovina showed the same findings where coping strategies played a significant role in the development of PTG (Anderson et al., 2019). The findings of the study prove that pessimism is the most significant predictor of PTG among survivors of CRSV. In addition to pessimism, PTSD, EFC and optimism also play a part in the development of PTG. A recent systematic review conducted by Guggisberg et al. (2021) on 41 articles

research articles published between January 2010 and October 2020 focusing on post-traumatic growth following sexual victimization depicted that recovery from sexual victimization is probable with the help of various strategies used by these survivors, such as thoughtful introspection to link with themselves helped them to grow. Therefore, it is important to provide psychological help to cope with pessimism among survivors. Changing their life approach (from pessimism to optimism) and treating the PTSD of survivors of CRSV can be positively effective in their life. Therefore, the survivors of CRSV need to seek psychological help for the development of PTG.

Limitation of Study

While the present study is unique in studying this important issue in Congo, it has some limitations that must be addressed. For example, a small sample limits the generalizability of findings, so future studies with a large and more diverse sample are recommended. Secondly, the use of self-report processes to collect the data is another drawback of the current study, so the study must be replicated by using mix method approach. Thirdly, scales were not available in the local language and were administered with the help of a translator, which is also considered a potential limitation and highlighted the need to adapt these measures in the local context of Congo. The low internal consistency of a few measures might also signify a lack of cross-cultural validity of these measures.

Declaration of patient's consent

The authors certify that informed consent was obtained from all participants using consent forms. The form briefly explains the purpose of the study and ensures that all information will be kept confidential. Furthermore, they were assured they could choose to participate in the study and refuse whenever they wanted. The participants were allowed to ask questions and gave consent once their queries were resolved.

Disclosure statement

The authors have reported no conflict of interest.

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Impact of Direct and Indirect Trauma Exposure: Moderating Role of Coping Self-Efficacy and Perceived Social Support

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The present study was conducted to understand the impact of direct and indirect exposure to war trauma on active security officials of police who participated in the war on terror. The study also investigated the role of perceived social support and coping self-efficacy and their interaction on enhancing or impending PTG among the population. The study was cross-sectional in design. The sample comprised 400 active-duty police officials who participated in the war on terror and were directly and indirectly exposed to trauma exposure. Hypothesis based on existing literature grounded the path analysis assessing the role of coping self-efficacy and perceived social support and their relationship with war trauma and post-traumatic growth. Non-probability purposive sampling technique was used. Post-Traumatic Stress Diagnostic Scale (Foa et al.,2016), Post Traumatic Growth Inventory (Tedeschi & Calhoun, 1996), Comprehensive Trauma Inventory (Hollifield, 2002), Coping Self-Efficacy Scale (Chesney et al., 2006) and Multi-Dimensional Scale of Perceived Social Support (Zimat et al.,1988) were used in the study. All scales were used in Urdu to understand better and avoid cultural biases. The results revealed that perceived social support and coping self-efficacy moderated the relationship between exposure to trauma and post-traumatic growth. Findings have concluded that direct exposure to war trauma was more intense than indirect exposure, and the population with direct exposure scored high on stress and post-traumatic growth. So, findings of the study confirmed that stress and post-traumatic growth could be experienced together, and variables like coping self-efficacy and perceived social support moderate the relation between war trauma and post-traumatic growth.

Keywords. Trauma, post-traumatic growth, perceived social support, coping self-efficacy

Important events which are traumatic in nature can produce long-lasting effects on the exposed population are war, personal (violent) assault (e.g., sexual assault and physical attack), being hostage or kidnapped, being in prison, torture, being a victim of terrorist attack, exposure to sever car accidents and natural disasters (Angel, 2016). Law enforcement officials tend to be exposed to a high frequency of potentially traumatic incidents during the war. The dichotomous distinction among these events involves witnessing threat or harm to others and experiencing threat or harm directly to oneself. Previous research suggests that different types of trauma exposure can develop varying levels of negative post-traumatic responses, including post-traumatic stress and disorder related to stress (PTSD) symptoms and positive outcomes such as post-traumatic growth (Park et al., 2022). With the goal of better-assisting officers experiencing post-traumatic stress, enhanced knowledge regarding this psychological response to the development of PTG is necessary. Post-traumatic stress disorder (PTSD) and many other mental problems are common in the population exposed to tragic events, especially war. Previous studies have found that individuals with higher and direct exposure to trauma experience higher levels of distress than indirect and low levels of trauma exposure. Studies have confirmed that unexpected, sudden, and extreme tragedies may cause the exposed population to post-traumatic stress disorder and anxiety (Gori et al., 2021). The severity of the distress can be measured by the symptoms like feelings of chronic sadness, worthlessness, and loss of interest in interaction with other people (Montalvo-Ortiz et al., 2022).

Trauma exposure can be a precondition for severe psychological reactions like post-traumatic stress, but not all individuals who face trauma suffer from severe psychological disorders. In recent years the identification of positive changes after trauma exposure has attracted scientific exploration, especially with regard to direct trauma exposure (Tedeschi et al., 2017). Studies have found that some people maintain psychological stability when they face trauma, whereas others bounce back or thrive and experience meaningful complete positive change, which includes many positive consequences like a positive change in social interaction, improved relationships with others, improvement in personal strength and self-assurance and an increased sense of appreciation of life and change in priorities of life. There are many studies that have reported post-traumatic growth in survivors of trauma (Shuwiekh et al., 2018). Tedeschi and Calhoun's (1996) model of post-traumatic growth is a comprehensive approach to this area of study, and the model explains the co-existence of post-traumatic growth and stress in survivors of trauma. The model also explains that many factors can contribute to and predict either one or both consequences. There are factors that can be positively associated with one out of two

outcomes but negatively with the other (Calhoun & Tedeschi, 2014).

Perceived social support plays an important role in the aftermath of trauma and can save an individual from adversities, and their presence can produce positive changes (Chasson et al., 2022). Perceived social support is the person's belief that they are loved and cared for,

Esteemed and a part of communal obligations. Research has proved that supportive interactions among people are protective factors against the negative consequences on health because of life stressors. Coping self-efficacy is the belief that reflects control of personal actions and a personal and future view that is more optimistic. Coping self-efficacy also plays a protective role and leads to growth after trauma (Tedeschi et al., 2018; Taku et al., 2021).

Research has begun to identify variables that affect the relationship between trauma exposure, post-traumatic stress, and post-traumatic growth. These variables may be conceptualized as social and personal strength factors. Studies on social factors suggest that veterans who have a strong perception of being supported suffer less from stress and other mental adversities like PTSD after trauma. Personal strength factors like coping self-efficacy also play an important role in diffusing the effects of war trauma and preventing PTSD (Acquaye et al., 2018). The process adopted in the face of adversity can affect the development and intensity of stress. The use of avoidant coping shows a link with increased PTS symptoms following trauma, but on the other hand use of active coping relations plays an important role in the development of PTG (Hokes & Adams, 2022). A significant part of the studies about the impacts of direct and indirect war trauma exposure and factors that play an important role in positive change after trauma exposure has been done in countries of the west, but very little work has been done in Pakistan. The present study is unique as it is the first study in Pakistan conducted on the impact of direct and indirect exposure to war trauma among police officials who played an important role in the war against terror. The study has investigated the lying relationship between war trauma, stress, and post-traumatic growth and the role of contributing factors of growth like coping self-efficacy and perceived social support.

Method

Sample

The sample included 400 active-duty police officials. The age range of the sample was from 21 to 56. To be eligible for participation in this study, the criteria were having direct or indirect exposure to trauma during the war on terror and from 1 year on post-deployment in peaceful areas.

Instruments

Post-Traumatic Stress Diagnostic Scale (PDS-5). PDS-5 is a 22-item 5-point Likert-type scale which was developed by Foa et al. (2016). The Urdu version was unavailable, so the scale was translated into Urdu and adapted culturally. The alpha reliability of the scale for the sample was (.93).

Post Traumatic Growth Inventory (PTGI-SF). PTGI-SF was developed by Tedeschi and Calhoun (1996); translated Urdu was available. The inventory was used as a measure of post-traumatic growth. A score of the alpha reliability of the current scale for the sample was .91. The scale has 10 items. Participants rated their responses on a 6-point Likert-type scale.

Comprehensive Trauma Inventory (CTI-104). CTI-104 was developed by Hollifield (2002) and has been used to measure war-related trauma. The Urdu version was unavailable, so the inventory was translated into the Urdu language and culturally adapted. Participants rated their responses on a 5-point Likert-type scale. The scale's alpha reliability score for the sample is .91.

Coping Self-Efficacy Scale (CSE*).* The CSE scale (developed by Chesney et al., 2006) was used to measure self-efficacy. The available Urdu version was used. The scale has 26 items with 3 subscales. Participants rated their responses on 0 to 10 rating scale. The scale showed (.93) reliability for the sample.

Multi-Dimensional Scale of Perceived Social Support (MSPSS). The MSPSS was first developed by Zimet et al. (1988), Urdu version was available. It is a 7- point Likert-type scale consisting of 12 items questioning the source and the level of social support.

Procedure

A cross-sectional study was conducted. Approval was taken from the ethical committee of NIP (National institute of Psychology). Data was collected after receiving permission from concerned authorities, and informed consent from the participants was taken. All participations were given information about the purpose of the study; personal identity information was not taken. Assurance about the confidentiality of the data was provided, and it was clarified that data would be used for research purposes only. Participants were asked to respond to the items by selecting an option resembling their situation, feelings, or behaviors more closely. There were no right or wrong answers.

Results

AMOS and SPSS 21 version (Statistical Package for the Social Science) was used for the analysis. The response rate of the study was 97%. A structured questionnaire collected demographic information. In table 1 difference

between direct and indirect exposed individuals has
been described.

Table 1

Differences between Direct and Indirect Trauma Exposed Population on Intensity of War Trauma, Post Traumatic Stress, Post Traumatic Growth (N= 400)

	Exposure								
Variables	Direct (n = 200)		Indirect (n = 200)		t	p	95 %CI		Cohen's d
	M	*SD*	*M*	*SD*			LL	UL	
WT	30.78	16.4	8.73	7.8	17.05	.00	19.50	24.59	1.70
PTG	33.63	7.6	29.91	8.28	4.66	.00	2.15	5.29	0.46
PTS	25.34	17.1	9.26	7.0	12.26	.00	13.50	18.66	1.22

Note. CI = Confidence interval, LL = Lower limit; UL = Upper limit.

Table 1 shows differences between respondents with indirect and direct trauma-exposed populations. Individuals with direct trauma exposure showed high scores on war trauma intensity, post-traumatic stress and post-traumatic growth compared to individuals with indirect trauma exposure.

Table 2

Correlation between Study Variables (N = 400)

Variables	1	2	3	4	5	M	SD
1. War Trauma	-	.70**	.28**	.15*	.28**	19.75	16.9
2. Post-traumatic Stress		-	.11	.07	.19*	17.30	15.3
3. Coping Self- Efficacy			-	.57**	.38**	92.03	29.7
4. Perceived Social Support				-	.72**	58.77	15.8
5. Post-Traumatic Growth					-	31.77	8.1

**p < .05; **p < .01.*

Table 2 shows the descriptive statistics and Pearson correlation of the variables. The results showed that the correlation between trauma related to war, post-traumatic stress and growth is positive. Coping self-efficacy and Perceived social support showed a significant positive relationship with post-traumatic growth. Perceived social support and coping self-efficacy were marginally positively correlated with PTS. War trauma and PTS were positively correlated, and PTS and PTG also showed a positive relationship. In Tables 3 and 4, results of moderation between study variables are provided.

Table 3

Moderating Role of Perceived Coping Social Support in Contributing Post-Traumatic Growth After Trauma (N=400)

	Post Traumatic Growth				
	Model 1	Model 2			
	B	*B*	*LL*	*UU*	*p*
Constant		36.64***	29.23	42.04	.00
Perceived social support (Moderator)	-	-2.61***	-4.59	-.64	.00
War trauma (Predictor)	-	-.27***	-.44	-.99	.00
Perceived social support x PTG	-	.04***	.01	.01	.00
R^2		.13***			
F		9.42***			
ΔR^2		.02			
ΔF		6.16			

*$p < .05$; **$p < .01$; ***$p < .001$.

Table 3 shows an analysis of moderating effects of perceived social support on war trauma and post-traumatic growth. Moderation is found satisfactory for perceived social support. Findings suggested a significant increase in post-traumatic growth aftermath of exposure to trauma in the presence of perceived social support.

Table 4

Moderating Role of Coping Self-Efficacy in Contributing Post Traumatic Growth after Trauma (N = 400)

	Post Traumatic Growth				
	Model 1	*Model 2*			
	B	*B*	*LL*	*UU*	*p*
Constant	-	30.42***	25.28	35.07	.00
CopingSelf-Efficacy (Moderator)	-	-2.16***	-4.59	-.64	.01
War trauma (Predictor)	-	.22***	.44	.90	.01
Coping self-efficacy x PTG	-	.03**	.01	.09	.00
R^2		.30***			
F		30.55***			
ΔR^2		.01			
ΔF		4.32			

*$p < .05$; **$p < .01$; ***$p < .001$.

Table 4 shows an analysis of moderating effects of coping self-efficacy on war trauma and post-traumatic growth. Moderation is found satisfactory for coping with self-efficacy. Findings suggested a significant increase in post-traumatic growth in the aftermath of exposure to trauma in the presence of coping self-efficacy.

Discussion

This article aimed to investigate the relationship between war trauma, post-traumatic growth and post-traumatic stress and confirm the moderating role of perceived social support and coping efficacy with growth. The present study is the first one to investigate the impact of direct and indirect trauma exposure on police officials who participated in the war on terror. Additionally, studies have investigated the underlying pathway from stress to growth and highlighted the role of contributing factors of growth, like perceived social support and coping self-efficacy. Results are consistent with the findings of the studies in the literature. A literature review concluded that different factors play an important role in promoting growth (Henson et al., 2021). Overall, findings suggest that direct trauma exposure affects officials' well-being more than indirect trauma exposure. Conversely, the presence of perceived social support (social factor) and coping self-efficacy (personal strength factor) during the coping process can bring positive changes like growth. Findings are inconsistent with previous literature, as previous studies have inferred that the relationship between stress and growth in the aftermath of trauma can be affected by factors like perceived social support and coping self-efficacy (Cox, 2017; Finstad et al., 2021).

The findings also confirmed that stress and PTG are positively correlated. The confirmation of the association between stress and growth is in line with the previous studies. Previous research has confirmed this association in different cultures (Yaun et al., 2021). Present findings have confirmed that a higher level of stress is associated with a higher level of growth and have confirmed the co-existence of stress symptoms and growth is possible, which is in line with previous research on adolescent survivors of the Wenchuan (China) earthquake (Zhou et al.,2015). More ever, the negative effects of trauma, like stress after trauma, may buffer positive effects like growth in the aftermath of trauma. The study has confirmed that using positive factors like perceived social support and coping self-efficacy is a shield against the negative consequences of a traumatic event like war. And especially war against terror was not a traditional war. The active-duty officials of police who had direct exposure to trauma in this war showed high levels of post-traumatic growth and scored high in stress as well. The result proves the fact that what does not kill u gives you strength. And belief in self (coping self-efficacy) and perception of being helped results in positive change like growth. Findings are persistent with previous research (Taku et al., 2021).

The study findings concluded that trauma exposure results in stress which can end in PTSD or growth. The moderating role of perceived social support and coping self-efficacy positively predicted growth in a population exposed to war trauma. The use of positive factors to cope with trauma leads individuals to think positively about the trauma and produce feelings of personal strength which turn into post-traumatic growth and reduces the chances of PTSD after math of war trauma exposure. The findings are consistent with the previous findings in the area (Zhou, 2018).

Limitations & Implications

The study's cross-sectional nature of the study and utilization of the self-report measures, and use of the purposive technique for sample selection are the study's limitations. The use of random sampling and longitudinal study design provides better qualification for the generalization of the findings, but due to time limitations and complex samples, it was not possible to conduct the longitudinal study. Findings have implications for soldier fitness programs, psychological intervention planning and health care programs for the active-duty officials of police who had faced tragedies during the war on terror.

Conclusion

Despite the mentioned limitations, the study's contribution is new knowledge to previous theoretical and empirical knowledge related to direct and indirect trauma exposure, PTS and Post-traumatic growth, and the underlying mechanism and role of perceived social support and coping self-efficacy. The results have demonstrated that more consideration is required to be given to enhance the role of the contributing factors of growth, like perceived social support and coping self-efficacy. These factors may foster post-traumatic growth in individuals, target stress, and reduce the chances of PTSD. The study highlights the implication of increased clinical efforts to improve coping self-efficacy and perceived social support, which moderates the relationship between growth and stress. Additionally, helping the war trauma survivors and helping them to buffer and achieve more positive attitudes towards traumatic events.

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Oncological Diagnosis Statement, as a Traumatic Situation: Ways of Psychological Prevention and Correction

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One of the urgent problems of contemporary psychological practice is assistance to patients in overcoming the traumatic situation associated with the statement of an oncological diagnosis. As a disease, cancer does not threaten the psyche or personality of a person, but the adoption of the diagnosis entails the onset of a personal crisis, can become a serious stress load, and lead to post-traumatic stress disorder. An uncertain or unfavourable prognosis of the course of cancer aggravates the patient's condition. Factors affecting the degree of injury to cancer patients were identified as follows: age, nature of tumors localization, disease stages, used methods of treatment, somatic state, degree of psychological compensation, and personality traits. Experiences of physical and psychological discomfort during the crisis inevitably lead to changes in the personality of the cancer patient. The main objective and subjective manifestations of this kind of change were determined: asthenia, anxiety-depressive states, fears, character and pathological reactions, deprivation of goal setting, change in self-esteem, decrease in personality activity, the frustration of basic human needs and meaning of life, leading to an existential crisis, violation of social contacts and change of behavioral stereotypes.

Keywords. Psychotrauma, oncopsychological study, cancer, cancer patient, personality crisis

The review of contemporary studies in the field of oncopsychology confirms the existence of specific conditions for preventing (overcoming) psychodrama during oncodiagnosis statement, which allows for establishing target guidelines for overcoming the traumatic situation in cancer patients (Balatskayaa, 2020; Gapova & Danchenko, 2020).

The number of people with cancer grows annually, and their average life expectancy rises due to the development of contemporary medical care in the field of oncology; therefore, attention to this category of people increases on the part of not only the professional medical community but society as a whole (Ulybina & Volkova, 2021).

Scientists have established that cancer itself does not threaten the psyche of a person or personality, but the adoption of the diagnosis and attitude toward it entails the onset of a personal crisis (Kolosova, 2017). Diagnosis and cancer treatment can significantly impact the patient's physical, psychological, social, and existential well-being. Cancer in clinical psychology is considered an example of an extreme and crisis situation: the detection of oncopathology in a patient can become a serious stress load and lead to post-traumatic stress disorder (Zagoskina et al., 2017; Balatskaya, 2020). Moreover, in the case of an oncological disease, not only the cancer patient suffers but also his closest social environment.

Theoretical Background

When studying the consequences of cancer on the human psyche, most scientists are based on the theory of post-traumatic stress disorder (Frolova, 2007; Gapova & Danchenko, 2020; Ivashkina et al., 2020). The cancer patient's life is characterized by a sharp change in the social situation of development, restriction of the type of activity leading to age, social deprivation and isolation, changes in the family structure, and frustration with the need for independence. Prolonged hospitalization is associated with a change in psychological indicators, such as anxiety, self-esteem, level of claims, motives and reactions, and ways of experiencing communicative and emotional difficulties (Shchepanovskaya, 2018).

Experiencing physical and psychological discomfort and the course of a life crisis in a person with cancer inevitably leads to personal changes (Vagaitseva, 2015; Yankova, 2015). Personal traumatization of a patient with cancer has the following specific objective and subjective manifestations:

Difficulties or deprivation of a person's long-term goals, a decrease in personality activity, and frustration with basic human needs and the meaning of life (Gapova & Danchenko, 2020; Holt, 2015).

Existential crisis: solving existential problems can lead to both positive (spiritual growth) and negative (spiritual decline) personality transformations (Bourdon, 2017).

Various fears: fear of amputation, disability, loss of social connections, fear of neglect by society, social isolation (Gapova & Danchenko, 2020), fears of cancer recurrence and spread (Mehnert et al., 2013; Holt, 2015), fear of death; the appearance of these fears can cause a

significant disruption of social functioning and affect the well-being and quality of life.

Distortion of microsocial and behavioral stereotypes due to the patient's long stay in medical institutions (Gapova & Danchenko, 2020).

Pessimism, asthenia, depression, somaticized, aggressive reactions, and high risk of suicide after diagnosis statement.

A change in self-esteem and attitude towards own effectiveness reflects the subjective idea about oneself in a situation of changing opportunities (Shiryaev & Vasilyeva, 2016).

Scientists distinguish risk factors that greatly affect the degree of traumatization among patients having an oncological diagnosis.

Age

It was noted that young age is a factor that increases the risk of personal injuries. In comparison with adults, children do not have enough experience to constructively express emotions; in addition, they do not understand what is happening to them, do not always have enough information about the disease, and cannot describe the spectrum of their own feelings and experiences, do not have enough resources to cope with feelings, caused by the disease, with emotional tension, overcome the sense of mental discomfort - their traumatization will occur to a greater extent (Dmitrieva, 2022).

Tumor Localization Pattern

In patients with non-localized diseases (for example, malignant lymphomas), the acceptance of the disease is increased in duration, and the denial of the disease is also more pronounced compared to patients with localized tumors (Poroshina et al., 2017).

The Stage of the Course of the Disease

The lower the spread stage of the disease, the higher the likelihood of partial or complete rehabilitation, a prognosis is more favorable, and a lesser degree of personal trauma occurs (Gapova & Danchenko, 2020). The regularities of the psychological trauma degree by stages of treatment are also highlighted: the strongest - at the diagnostic stage, post-operative stage: asthenia, resource exhaustion, hypochondria, the formation of an inferiority complex during a crippling operation - all this leads to psychological trauma (Shiryaev, 2016).

Treatments Used

For example, with chemotherapy treatment, patients have a lower level of emotional stress and anxiety than with the transplant method (Hain, 2015). The level of psychological trauma is lower in patients who have the option of choosing a treatment method (therapeutic, surgical).

Somatic State

The level of experiencing trauma is higher in patients feeling physiological manifestations of the disease. The determining role in the trauma caused by the disease is the presence of postoperative stoma in the patient (Khain, 2015), emotional instability forms in this category of persons; there is a decrease in self-esteem, an increase in the level of auto-aggression, social maladaptation (Semke et al., 2008). Due to the increase in the duration of emotional acceptance of the disease in patients with non-localized diseases (for example, malignant lymphomas), they have a greater degree of disease denial compared to patients with localized tumors, which entails an increased risk of injury (Poroshina et al., 2017).

The Degree of Psychological Compensation and the Use of Constructive Coping Strategies

Among the coping strategies, the following can be distinguished as situationally used: Flight-avoidance, positive reassessment, planning a solution to the problem, distancing; and strategies not correlated with the situation: Self-control, search for social support, confrontation, and taking responsibility (Alexandrova, 2019).

Awareness of the Disease and the Depth and Validity of Knowledge about the Disease

The degree of traumatization of the personality is determined by the oncopatient's assessment of the disease severity. In this case, the severity must be considered in two aspects - objective and subjective. Objective severity (due to the complexity of quantifying the severity of the disease, scientists are invited to give an objective assessment based on the criteria of mortality, probability of disability, and loss of ability to continue usual life). Subjective severity is an "internal picture of the disease" the concept of the disease, nosology, reflects the patient's ideas about the disease at three levels: cognitive - knowledge about the disease, methods of treatment, forecasts of recovery, etc., relational - processing information regarding their unique situation, awareness of own emotions; and behavioral - formation based on the above behavioral patterns reflecting coping behavior (Zinchenko et al., 2014).

The Characteristic Features, Personality Traits, and the Actual Personality Type of the Patient

These are highlighted on the basis of studying the accentuations of his character (Grigorieva & Chalov, 2015). Patients of an anxiety type (according to the classification of A.E. Lichko) are extremely vulnerable; they show excessive suspicion and concern about the

course of the disease, methods of treatment, the competence of the attending physician, and the adequacy of his effects. Patients with cycloid accentuation respond most adequately to the disease. Psychasthenics demonstrate the greatest intensity of experiences, which affects the appearance of secondary somatic symptoms. Persons with schizoid accentuation are most susceptible to self-isolation; those with epileptoid accentuation are more likely than others to manifest aggression and suicidal behavior (Gnezdilov, 1996).

The attitude of Personality to Disease

At the same time, a maladaptive type of response to the disease and, accordingly, a high degree of trauma is recorded in the presence of semantic emptiness, a negative assessment of the present moment of life, a narrowing of the future perspective, as well as a violation of the goal-setting function of the self-determination process (Sotnikov, 2015).

Relation to Disease in the Reference Group (social factor)

A high level of psychological stress is associated with such characteristics of the cancer patient as disability (due to the narrowing of the spectrum of social ties of the patient, deterioration of the financial situation), the absence of a spouse/spouse (the partner often encourages the patient to seek medical or psychological assistance) (Holm et al., 2013).

When adapting to a difficult life situation, both subjective assessments (how the patient perceives it) and objective circumstances that help or prevent adaptation are important. The purpose of psychological support for the oncopatient in adapting to the disease is to improve the quality of life (at any stage of the disease): ensuring physical and psychological comfort, overcoming deprivation of communication, and satisfying the spiritual needs of the patient (Alexandrova, 2019).

Discussion

A review of contemporary studies in the field of oncopsychology confirms the existence of current conditions for preventing (overcoming) psychotrauma during oncodiagnosis. They are as follows.

Orientation to personal merits and positive personal resources of the patient. Important is the system of the patient's ideas about cancer, reactions to the disease throughout the entire period of the disease, and the possibilities of adaptation to the disease (Sharova, 2017). The situation of cancer is associated with a personal crisis; when effectively overcoming it, life priorities, goals, and existential problems are reassessed, positive personal changes entail the emergence of new meanings, and positive changes in the patient's personality can also cause, for example, post-traumatic growth (Costa et al., 2016).

Optimization of disease response types, change in non-constructive attitude to disease, maladaptive type of disease response, adaptation to disease, and increased motivation for treatment and recovery (Zinchenko et al., 2014).

Inclusion in communication with the patient in a social environment, which consists in expressing sympathy, being close by, support from family and friends, from the staff manifested in honesty, presentation of available information, positivity and sympathy, participation of the patient in meetings of support groups (Richardson et al., 2019).

Changes in society in attitudes towards cancer and social stereotypes regarding malignant tumors are broadcast by society, and attitudes toward oncological diseases have developed in specific socio-cultural conditions (Ulybina & Volkova, 2021).

Honest accessibility informs the patient about the diagnosis, disease, and prognosis of recovery already at the diagnostic stage, finding opportunities for the patient to actively discuss the effectiveness of treatment (Vagaitseva, 2015). At the same time, it is important to determine the strategy for informing the patient about the diagnosis - solving the ethical issue (Usmanova et al., 2015).

Training patients in the use of constructive coping strategies and decreasing the level of alexithymia, the situation associated with cancer is a manifestation of extreme stress level, and personal resources are activated, which helps the patient reorient himself in the application of coping strategies (Sharova, 2017).

Reducing the level of social frustration, maintaining the patient's integration into family and social life, realizing the need to maintain social status and professional functions, and returning to the usual way of life (Balatskaya, 2020).

Conclusion

Taking into account correctional and preventive goals, it is possible to outline the main guidelines for overcoming the traumatic situation by means of psychological assistance to cancer patients:

Ensuring the collaboration of medical structures, psychological services, and society, in the course of support of cancer patients, from the diagnostic stage.

Individualization of psychological support routes for cancer patients.

Popularization among the population of modern scientific studies on effective methods of treating cancer, and progressive developments in this area.

Overcoming social stigma toward cancer patients by eradicating stereotypes about personal guilt in the occurrence of the disease, its infectiousness, and social and personal inferiority of cancer patients.

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Phenomenological Analysis of Attachment Patterns and Emotion Regulation Strategies in COVID-19 Trauma Survivors

Sana Wakeel and Saadia Dildaar

Abstract

The COVID-19 (coronavirus) pandemic was the worldwide public health crisis of the twenty-first century. The present study aimed to explore lived experiences of trauma survivors. So being focused on the most prevalent trauma of that time of COVID-19, individuals who directly got infected with the deadly virus, such as survivors of COVID-19, were selected as the sample of the study. The impact of COVID-19 on their attachment patterns and emotion regulation strategies was explored. Semi-structured interviews of four (Male=2 and Females=2) survivors were conducted. The non-probability purposive sampling strategy was used for sample selection. Analysis of transcripts was done using Interpretative Phenomenological Analysis (Smith et al., 2009). [31] Themes included manifestation of COVID-19 (psychological reactions; physiological symptoms; challenges during COVID-19; change in life due to COVID-19; and other's perception and attitude towards victims); attachment patterns (premorbid attachment patterns and impact on attachment patterns during COVID-19); and coping strategies (problem-focused coping, emotion-focused coping and religious/ spiritual coping) have emerged. It was expected that COVID-19 would bring negative changes because the global pandemic happened suddenly and unexpectedly, took many lives in a short time duration, and left people in a state of crisis and threat, but unexpectedly, the results revealed that COVID-19 had brought positive changes as well. In conclusion, COVID-19 greatly impacts attachments, relationships, emotions, and overall life. Gender differences were also observed in trauma survivors. Further research should focus on developing pre-planned therapeutic interventions in such sudden and unexpected scenarios.

Keywords. COVID-19, Trauma Survivors, Attachment Patterns, Emotion Regulation Strategies

Introduction

The COVID-19 (coronavirus) pandemic of 2019 has been declared one of the worst pandemics of the twenty-first century. By the end of February 2020, the Coronavirus had entered Pakistan, and a complete lockdown was imposed on 23rd March 2020, resulting in the closure of industries, offices, and educational institutions. WHO (World Health Organization) has classified the COVID-19 disease epidemic as a pandemic (WHO, 2020). [35] Pakistan had around 260,000 confirmed cases of COVID-19 as of July 23, 2020, with roughly 5,700 deaths (CSSE, 2019). [9] The pandemic was perceived as a truly traumatic event in some circumstances, and some studies have found that it added to the development of PTSD in the global population (Masiero et al., 2020; Rossi et al., 2020). [21] [30] PTSD (post-trauma stress disorder) is a mental disorder that develops after being exposed to a traumatic or stressful incident and is classified as a Trauma and Stress-related Disorder (American Psychiatric Association, 2013).

PTSD causes severe distress and disability in survivors, family members, frontline respondents (police, public health and medical specialists, and others), and even common individuals. A higher level of PTSD (Post Trauma Stress Disorder) is associated with experiencing or witnessing COVID-19. Infectious illness epidemics cause a specific sort of psychological trauma that can be classified into three stages (Liang et al., 2020). Immediately experiencing and suffering from symptoms and traumatic treatment is the first stage in which respiratory failure, difficult respiration, altered consciousness states, threatened death, tracheotomy, and other serious traumas are common in individuals who have severe COVID-19 symptoms (Xiao et al., 2020). [36] The physical, emotional, and cognitive links that bind us to one another are referred to as attachment styles (Bowlby, 1969). After birth child starts understanding and relating to people through which attachments form (Cozolino, 2008).

According to the growing body of literature, the way we operate in our world at the social level after trauma; is a tremendously complex issue (Bowlby, 1969). [5] [6] People with secure attachments have effective regulation of their negative emotions and are more optimistic about dealing with complex situations when they confront threatening or stressful situations (Nielsen et al., 2017). In contrast, people with insecure attachments have difficulty in emotion regulation (Jurist, 2005). The emergence of the

attachment system is the key to the emotional, controlling approach, due to which we learn to approach trustworthy others when we confront a threatening situation. According to growing evidence, people tend to seek attachment representations when confronted with real or symbolic threats (Mikulincer & Shaver, 2003).

Emotion regulation is the process of increasing, maintaining, or decreasing one or more than one constitutes emotional reactions, whether unconscious or conscious (control or automatic) (Gross, 1998). COVID-19 patients experience significant stress and physical symptoms during the whole disease crisis. Treating mental health requirements is critical, and the psychological aspect of people cannot be undermined. Therefore, in practice, the first step is to gain a thorough grasp of the psychological challenges that patients are experiencing (Yan et al., 2021). Psychiatric symptoms and comorbidities related to infectious COVID-19 were assessed in the review research. People who got an infection and those who didn't get an infection were studied. PTSD and depressive symptoms were higher in COVID-19 patients. Symptoms of psychiatric patients also became severe during the pandemic (Vindegaard & Benros, 2020).

The COVID-19 epidemic severely affects mental health worldwide; however, individual reactions may differ. During a pandemic, that participants who had anxiety, cyclothymic, and depressive features in their temperaments had a higher emotional impact. At the same time, certain personality characteristics served as protective factors against mental distress, such as male gender, security, and avoidance-based patterns of attachment (Moccia et al., 2020). [25] In recent times, as COVID-19 has been the most prevalent trauma worldwide. Millions of lives have been significantly altered, and a global, multilevel, and demanding coping-adjustment process is going on (Feeny et al., 2000).

COVID-19 has caused dramatic changes in the life of those who have experienced it themselves. Given the prevalence, there is a need to raise awareness about the challenges experienced by survivors of COVID-19. Therefore, the goal of this study was to look at if there is any impact on the attachments of survivors and how survivors have coped with the worldwide trauma to see if the theoretically expected patterns emerge. Little has been done to describe emotional strategies, and further research should be done to better comprehend various adaptive strategies. Therefore, the present study was done keeping in mind the following objectives:

- To explore the lived experiences of COVID-19 survivors concerning their attachment patterns and emotion regulation strategies.
- To explore different attachment patterns that COVID-19 survivors have developed and the impact of COVID-19 on attachment patterns.
- To explore different emotion regulation strategies used by COVID-19 survivors.

Method

Sample

The sample of the present study was comprised of four COVID-19 survivors (Male=2, Female=2) from Lahore, Pakistan. For the selection of the non-probability sample, purposive sampling strategies were employed. Willing individuals with a minimum age range of 20 years or above who were diagnosed by accurate laboratory test at least one month after the traumatic event's termination were included in the sample (according to DSM-V criteria for PTSD). Individuals with physical disabilities were excluded. Those who were not tested positive by the authentic laboratory were excluded. Those who had less than one month's duration since trauma termination were also excluded.

Procedure

The research was conducted appropriately by taking approval from the Board of Studies, Government College University, Lahore. To make the study more culturally validated according to Pakistan, an interview schedule was developed for the present study with the help of relevant theories after a thorough review of the literature. After peer review, it was approved by an expert. The final draft was constructed after expert review. The approved interview schedule was administered to four (04) participants, two males and two females. Each participant signed written informed consent, and they were assured that their confidentiality wouldn't be compromised, and information would be used only for education and research. Participants were asked open-ended questions related to their attachment patterns and emotion regulation strategies about COVID-19 during the survival period of illness. Phenomenology as a qualitative research design was used to explore the in-depth experiences of COVID-19 survivors. Interviews were recorded in audio tape format. Audiotape interviews were transcribed, and meaningful interpretation verbatim was done by thoroughly analyzing the content (line by line) several times. Coding and themes were generated based on an ideographic approach, and then clusters were made based on theme coherence. Data were analyzed, and themes were formed using interpretative

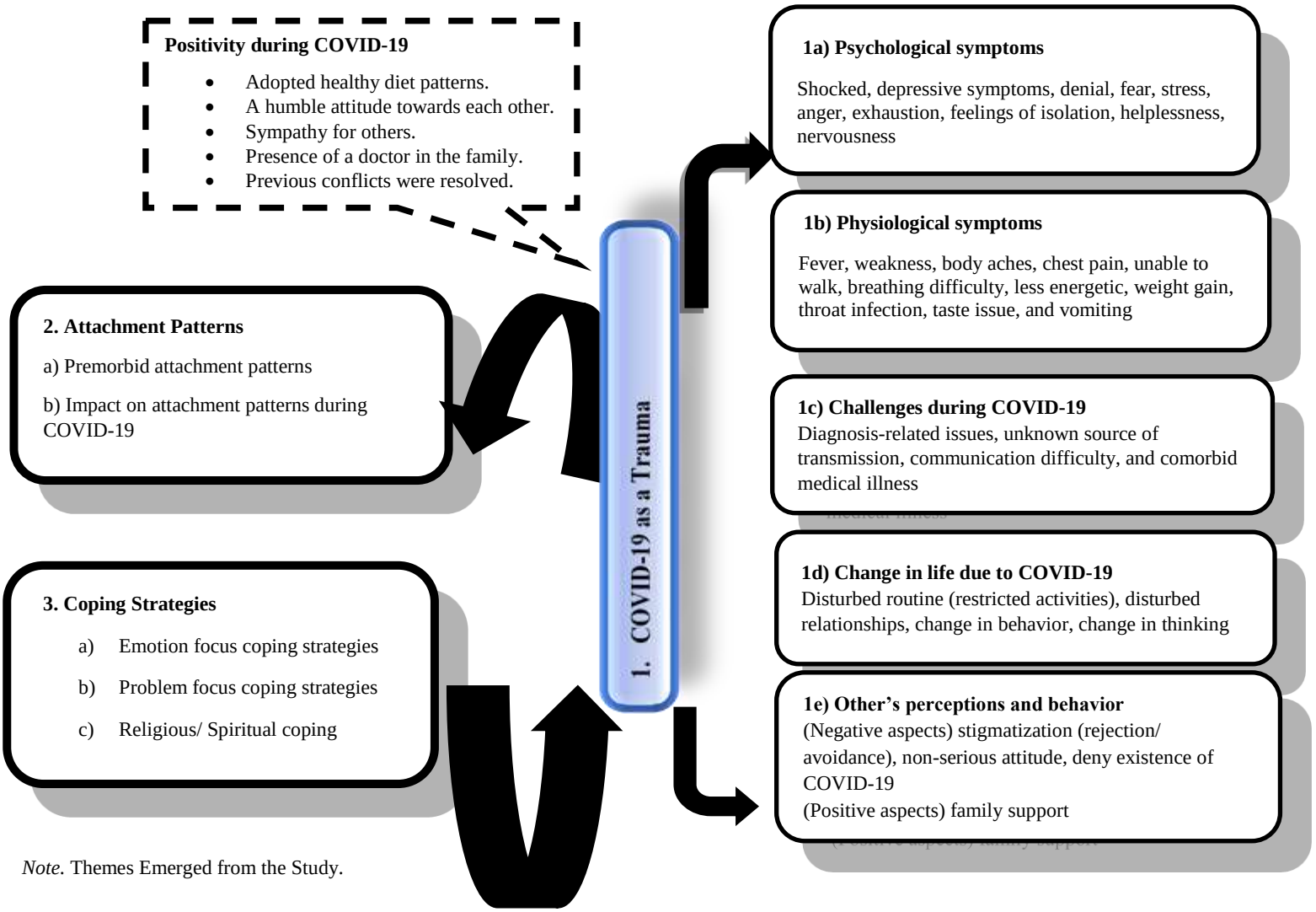
phenomenological analysis. Throughout the process, the researcher had to get down to the participants' level to comprehend their life experiences from their perspectives. Several steps recommended by Smith and Osborn (2007) were followed for data analysis. Ethical considerations were followed during the whole study.

Findings

This study aimed to explore the phenomenology of attachment patterns and emotion regulation strategies of COVID-19 trauma survivors by using interpretative phenomenological analysis. Four main superordinate themes include manifestation of COVID-19 as trauma, pre-morbid attachment pattern, impact on attachment patterns during COVID-19, and coping strategies (see Figure 1).

Figure 1

Figure Represents the Major Themes Emerged from the Study.



Note. Themes Emerged from the Study.

Manifestation of COVID-19 as Trauma

The COVID-19 (coronavirus) pandemic is the main global health crisis of the twenty-first century and the most challenging condition we have confronted since World War II. COVID-19 is experienced as traumatic by everyone. All the participants have reported many psychological symptoms or reactions due to COVID-19. Psychological symptoms were more prominent in individuals immediately after being tested positive. As one of the survivors of COVID-19 has reported, *I was shocked when I got tested positive for covid. Everyone got tested, but only mine was positive. Truly speaking, I was shocked… I said, sister! Everyone got their test negative, I just tested positive.*

Female survivor participants also reported fear as *I had felt weak even afterward… means a sense of fear; you can say… like before eating anything, before going anywhere outside, I always thought that I might not feel something weird again… I just don't want to go through this trauma again.* Male participants have experienced fewer psychological symptoms as compared to females. The most common symptoms in male survivors were stress and fear. A male participant reported that *it was like I was not much worried about my health, I was more worried about my mother's health because she was also having symptoms and when she got tested, it was also positive, which means… I was worried about her that she might not get severe symptoms.*

Even knowing that it will recover in two or three weeks or having a closed loved one suffering from a similar situation couldn't lessen the distress level in people due to COVID-19 who once tested positive. For example, a female COVID-19 survivor has reported that *it's very difficult… Although my husband also had covid, we were together, but weird like means… I…, couldn't understand what had been happening in life, it felt like… we knew that it was covid, nothing much to worry about… it would be recovered in 14 days, everything, but no…, it was a very depressing phase.*

Other psychological symptoms that female survivors experienced during COVID-19 include mood swings, depression, fear of testing, fear of COVID-19, fear of death, boredom, anger, distress, nervousness, loneliness, isolation, sleep disturbances, and loss of interest. Physiological symptoms that participants reported include fever, weakness up to the level where one is unable to walk independently, body aches, muscle stiffness, less energetic (reduced stamina), fatigue, tiredness, chest pain, breathing difficulty, stomach issues, damage of the immune system, vomiting and taste issues which resulted in the loss of interest in food. For example, participants have reported that *I had a fever and much weakness (FS1, Pg. 1, 5). I had such severe body aches like my hand…I was unable to straighten my arms, or if I was laying even during rest, I was having pain.*

Male survivors have reported that *I had a high fever, didn't feel hungry at all…and severe weakness. Taste issues were very common, even though I still feel…my taste issues were chronic and still going on. I had lost my taste. Else for one month, I had fatigue and weakness. After that, it recovered.*

The most widely spread COVID-19 has come with many challenges for people all over the world. The most common challenges participants have reported related to the diagnosis and transmission of the coronavirus. As a female survivor of COVID-19 has reported, I didn't know *I had covid.*

Comorbid medical illness was another challenge during the COVID-19 pandemic. If someone was already having some medical issue, it was making them more vulnerable to getting COVID-19 and more chances of difficult survival through it. A female survivor participant has reported that *I am asthmatic, so whenever any patient, you know…used to come. So it was like if they are dying, patients, they die, but it was like … when I had an asthmatic attack for the very first time, then I…I felt how humans have craved for one to breathe.*

The COVID-19 pandemic has changed the life of every single individual, but it has strongly changed the life of those who suffered themselves and whose close family members have suffered. As the participant has reported, *I didn't talk to anyone; even I was not talking with my friends; they used to call me… sent text messages to me, I didn't receive their calls, I was much depressed, I had a fear inside me, I was not able to speak.*

Another participant has reported suffering due to a change in environment, restricted activities, and inability to communicate; *my husband has separated my room…even though he didn't allow my daughters to see me, for 14 days, no one was allowed.*

Change in thinking and behavior related to acceptance and precautions, respectively, was also reported by participants after having self-experience. *I would say we should stay safe. Right… and means if any patient came to you, and told you something about himself, then you should understand his feeling of that time.*

Everyone has denied COVID-19 since its emergence. People in Pakistan also have been stigmatizing those individuals and families where the presence of the coronavirus was confirmed. Most of the individuals had felt rejection, avoidance, and hesitation by society and the community at large. A female survivor participant has reported that *People hesitate.* Another female survivor has also reported that *other people who live around you*

when they get to know that you have had covid, don't want to meet you to save themselves…don't come close to you.

Male participant has also reported that people perceive COVID-19 as unreal, and due to this unacceptance of facts, they also don't take precautions. *People don't believe that covid exists; when you tell them that patient has covid, they wouldn't believe…they would say that it's just a breathing issue or any other disease, it's a cough…so people don't take it seriously.* In the meantime, there was also a positive response from some people. Their family members have fulfilled their needs and were provided with support and care by their close family members.

Positive Aspects of COVID-19

Negativity was spread everywhere during the COVID-19 pandemic. Despite all the negative facts, it was very difficult to look towards positivity to maintain strength and consistency, but there were still some people who took out positivity from this negativity. Increased sympathy for others, humble attitude towards other people, improved relationships, resolved conflicts, family support, increased family time, emotional support as well as care, healthy diet patterns, and gratitude for having family doctors and availability of medical care are some pandemic-related positive aspects that people have reported during interviews.

As a male survivor participant has also reported about family support, *there was nothing something like this in my family…they all took much care…don't know about others that how did they have coped…because we had a family system like…that you had to take care of others… So…you cannot end these social values.*

Premorbid Attachment Patterns

Psychological and social relationships of participants with different individuals were explored from their early perceptions before COVID-19. Most participants have reported secure attachments with others, while few have reported insecure patterns of attachment. The death of parents or absence of parents made it difficult for the participant to cope with the stressful situation of COVID-19.

Participant 1. *(Survivor, Female).* She has reported a secure attachment with her parents but closer to her father. Moreover, her attachment to her mother increased with age. She was a very desirable child, most awaited and pampered by her parents. She was never scolded by her parents. She has a somewhat insecure relationship with her husband. She also did not have a congenial relationship with her in-laws. She has a small limited social circle and few friends but strong bonding and emotional sharing with them. As she has reported, *I was the only sister, so my family history is…that my father…he doesn't have any sister…so he wished for a daughter… then I was born…so my life was…I was much pampered…my parents have never scolded me… so far my mother…when we were in our childhood, she used to beat us… but now when we've grown up, we have increased love for my mother. So far my husband… when he is being complied then… Right…otherwise conflicting).* Relationship with friends and family was reported as, *I have just two friends since my school… generally, I have a good bonding with each person but my best friends…they are just two.*

Participant 2 *(Survivor, Female).* She has reported a secure attachment with her parents but is closer to her father. Her father died due to a heart attack some months ago before COVID-19. She missed her father a lot. Her father's death made the COVID-19 situation even more stressful for her. She found her husband very loving and caring as well. She was very social and liked to spend time around people. She has a good relationship with everyone, including relatives and friends. *My friendship… was with my father… (Father died a year ago) so I had a difficult time (crying)… Just after that, I got covid… Alhamdulillah! I'm also good friends with my mother but now when I go home… I don't feel the same thing… My husband is very nice, and caring, he took much care of me.* Relationship with friend and family was reported as *everyone is very nice. My relationship* is also very good with everyone.

Participant 3 *(Survivor, Male).* The participant has a secure attachment with his parents. He used to share all his emotions with his parents. He has a huge social circle and good relationships with friends, relatives, and family at large. Relationship with parents was reported as, *very nice…very nice with both of them… Normal as father and son, mother and son have…same like that… I used to share my emotions with my parents.* Relationship with friends and family was reported as, *I have good social circle…and very nice attachment with friends…and with family… it is also very nice.*

Participant 4 *(Survivor, Male).* The participant has a secure relationship with his parents. He used to share everything with his parents. He used to be very friendly with everyone. He also has a good relationship with friends and family at large. Relationship with parents was reported as, *I have very good attachment… as I have been living in the hostel, but I have very nice attachment with them, if there is anything, I used to share with them… Always.* Relationship with friends and family was

reported as, *with the grace of God…with everyone…I have a good connection… very friendly with everyone.*

Impact on Attachment Patterns During COVID-19

The newly emerged COVID-19 epidemic profoundly influences the psychological health of individuals and society at large. Some participants have experienced a negative change in attachments, while others have reported a positive change in attachment during COVID-19. A female survivor participant has reported that her attachment to friends changed during COVID-19:

Before COVID-19, *I had just two friends at my school; generally, I have good connections with every other person but so far, my best friends… they are just two, I have a very strong bonding with them means… They wouldn't call me any day… I feel like if there is something wrong… I just can't live without talking to them.* During COVID-19, *I didn't talk to anyone… even I didn't talk to my friends… they used to call me… message me… I didn't receive their calls… I was this much depressed.*

Although social distancing was the need of the hour during COVID-19, some emotionally detached themselves from their loved ones during that time, which showed that COVID-19 impacted their attachment styles as well. As another female survivor participant has reported, Before COVID-19, I have good friendships with my mother too… my brother is also very good, very nice. Alhamdulillah! Everyone is very nice. I have a good relationship will everyone.

During COVID-19, *my mother used to call me from Sialkot, then… I didn't want to talk to her… I have like strange… I was feeling like that… like a strange feeling… that my… I don't want to talk.*

Some people suppress their emotional expressiveness when they confront stressful situations, while others express themselves. For that purpose, they seek attachment with a close family member when confronted with a stressful situation. It also happened during COVID-19. As the participant has reported, *I would just say no one should have covid… and in case one has… family should be around him.* Results showed that survivors, who had a secure relationship with their partners before COVID-19, have approached their partners for emotional regulation in times of distressing situations as in COVID-19 illness as well. In contrast, attachment avoidance was observed in those who previously had somewhat insecure relationships with their partners. They did not approach their partners for emotional regulation during times of COVID-19.

Participants have reported that they have been struggling to manage their relationships due to all of the stressors that were present during COVID-19. For example, a female survivor participant has reported a secure relationship with her husband before COVID-19 as, *Alhamdulillah! Thank God, how much I would thank God, it won't be enough. My husband is very nice… very caring. Alhamdulillah! I have a good understanding of my husband. I used to share everything with him without any kind of hesitation.*

Partners were a source of relief, and mutual understanding was seen during a COVID-19 crisis if the relationship between partners was secure previously. *My husband took much care of me. He has provided me with everything in the room. I had my husband with me so when he was coming to my room, he would say, I sit here. I used to say just give fruits that he use to bring for me. He would say, I may set your room. So, he used to open the door and stand aside… has been watching over me… he would ask for video calls… then watching over me on a video call that how am I.*

On the other hand, another female survivor participant has reported a somewhat distant relationship with her husband before COVID-19 as, *so far with my husband… it's like… when he complies… then right… otherwise angry… my personality is as I used to say that… when I gave my 100% to someone… he should do the same for me… but not everyone owns a personality like this… he is like that… though he is sometimes caring when being with his family, he behaves in a way that… he would completely go into ignorance phase… and then I would be angry… which further aggravate arguments.*

Spouses were not a source of relief during COVID-19 if the previous relationship lacks security, understanding, and reciprocity. *My husband also had covid… we were living together but strange means… This means I wasn't able to understand what has been happening in life… he was with me during the whole*

COVID-19 duration but even then, I had been feeling like life has just stuck… nothing seemed well.

Coping Strategies

Coping strategies are ways to deal with the situation that is being experienced by an individual. The most common coping strategies that the participants reported during and after the stressful situation of COVID-19 include i.e., Problem focus coping strategies, Emotion focus coping strategies, and Religious/ Spiritual coping strategies. People have used problem-focused strategies to deal with the stressful situation of COVID-19. Their perceptions about COVID-19 have also changed after surviving it or seeing their family members going through that difficult situation and suffering. Problem-focused coping strategies were also increased after self-experience. As the participant has reported that, *masks, sanitizers, we used to have masks, and sanitizers daily… all the time… other than that, social distancing… tried to keep us at a distance as much as we could… this was the care, nothing else.*

Participants have also reported seeking out medical care and following the doctor's instructions properly. Family doctors were also a source of comfort for many people. People have also developed an increased sense of gratitude and realized the importance of medical healthcare providers. Some people also became conscious of their dietary patterns and immunity. They started having a healthy diet and increased their intake of fruits. I have had fruits etc.

Although, due to taste issues, it was difficult to have a healthy intake healthy diet and maintain a proper diet, participants tried to eat properly to boost up their immunity; a female survivor participant has reported that, *although I have eaten a lot… I didn't want to… but still, I was eating because I knew that I would have to do my job afterward… then there… in the hostel, you know… it's not possible… if you get it you may eat… otherwise, you have to order food from a restaurant.*

During quarantine, it was difficult to spend time. So some individuals use social media and mobiles and try to engage in other activities to cope with their stress. As a female survivor participant has reported, *I have been laying… have been using social media… but I didn't want to… I've just watched TikTok sometime.* A male survivor participant has also reported that *I used to spend most of my time on the internet. Nothing much… it was just… watched videos on my mobile phone etc.… Right… or if at home, taking part in communication/gossip.*

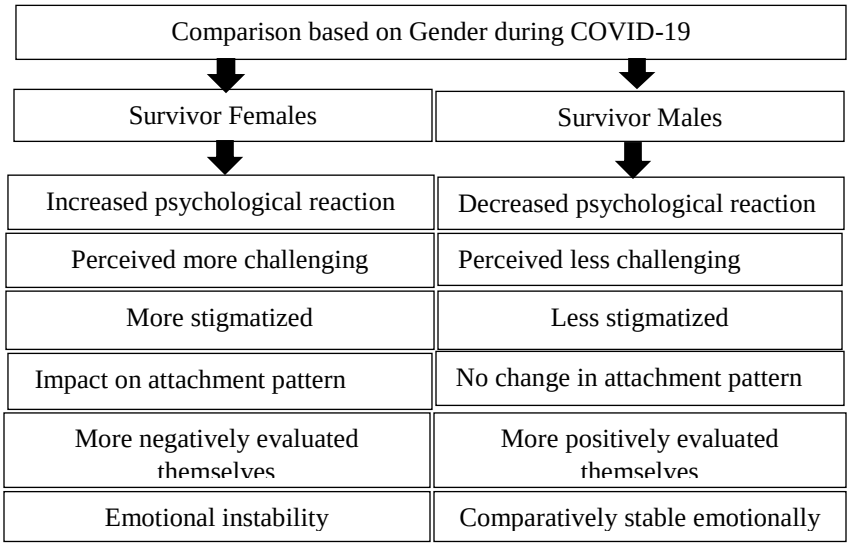
During COVID-19, some participants reported feeling very down emotionally besides illness. So, they seek emotional support from their families to regulate their emotions in that stressful situation. Some participants have also suppressed their emotions because they do not want to make their loved ones stressed about them. Emotional, expressive suppression was reported by survivor participants as, *No! I didn't talk to anyone… I didn't tell my parents… means my mother… she is a hypertension patient of hypertension… so I didn't want her to know… and being only child… if everyone knew that, then I might be recovered but something would have happened to them that's why… I didn't tell my parents.*

Family support and medical support were also available, which helped in emotional coping during the stressful situation of COVID-19. As a male survivor, the participant has also reported that *we have kept himself strong mentally and emotionally… this disease is like that… if you panicked, you would be caught more into it; that's why we didn't panic… other than that, family support was present… and some doctors were very supportive, so we were mentally relaxed).*

Participants have also used religious coping to cope with stress. Muslims immediately turn toward God in times of stress, and we seek help from him when the situation becomes out of control, and we feel helpless. In the COVID-19 pandemic, many people have also felt helpless. As a female survivor participant has reported about spirituality and religious practices, *said prayers… read Holy Quran… etc. Alhamdulillah! Thank God… not much I can say that… level of trust I have in God… I believe that God always gives ease with difficulty… same happened during covid days.* COVID-19 was novel for everyone and proved stressful due to its influence on people's lives. Some people try to cope with the situation, while others become emotional whenever stressful events happen in human life.

Figure 2

Gender Differences between Survivor Females and Males during COVID-19 Pandemic.



Note. Differences based on Gender during COVID-19.

Discussion

The crisis of COVID-19 has wreaked havoc on people's minds. Governments have been imposing various measures to preserve social distance to combat the pandemic. However, compliance and coping are influenced by a variety of interpersonal factors. Therefore, this study aimed to explore the phenomenology of attachment patterns and emotion regulation strategies of pandemic survivors.

COVID-19 has adverse effects on the mental health of all the participants. All participants have reported that they have experienced various psychological symptoms not only during illness but continuously afterward, i.e., stress, anxiety, depression, fear, helplessness, exhaustion, anger, and many others. Hao et al. (2020) conducted a study on COVID-19 patients in the recent past. The outbreak had a higher psychological impact on COVID-19 patients than it did on psychiatric patients or the control group (healthy individuals). Among them, half of the patients were experiencing severe PTSD symptoms. People who had been infected with COVID-19 had significantly higher levels of depressed mood, physical symptomology, and anxious behavior.

The pandemic of the recent COVID-19 disease is a global health emergency. Along with the immediate impact on the health providing system and patients, this pandemic has the potential to negatively damage millions of people's mental health (Bleil et al., 2021) All participants reported that they were low on psychological health during the pandemic and illness. Everyone has experienced psychological distress, but victims of COVID-19 were more afraid of transmitting the virus to their loved ones and making them ill as well. Yan et al. (2021) [37] conducted qualitative research in which the psychological difficulties of COVID-19 survivors were derived from three themes as: mental distress behind the wall, living in limbo, and psychological pressure of being a carrier throughout an illness crisis.

Participants have reported that they were more stressed and afraid of the situation after being first-time victims of COVID-19. Everyone has reported that stress, anxiety, and fear were long terms and they always prayed that they may not be caught COVID-19 ever again. Mental distress persisted even after recovering from COVID-19. Psychological factors like stress have been linked to the higher incidence of viral respiratory infections; these findings could have more than a theoretical value, as they could directly alter the immunological response to COVID-19 (Pedersen et al., 2010).

Literature validated results as a study on COVID-19 patients was undertaken a year ago. According to the findings, COVID-19 patients were found to have high levels of post-trauma stress (PTS) and depressive symptoms. Own poor health, females, and family

members of COVID-19 victims were all linked to a higher vulnerability of poor mental health (Vindegaard & Benros, 2020).

Physiological symptoms were shown to be common in conjunction with psychological problems. Participants have reported that they have experienced physical symptoms during the disease and a few months after recovery, such as fever, severe weakness, taste issues, throat infection, body aches, stomach problems, chest pain or difficulty breathing and immune deficiency, etc. The World Health Organization also lists respiratory symptoms such as cough, fever, and breathing problems as symptoms of COVID-19 (WHO, 2019). [35] Similar symptoms were reported by participants.

The COVID-19 pandemic was very challenging for everyone, both at the individual and national or international levels, but it was even worse for those who contracted the virus. The most commonly reported challenges for survivors were related to diagnosis and transmission of the coronavirus, presence of prior medical illness, and in the case of caregivers, increased level of responsibilities and inability to understand patient's needs were challenging. All the participants have reported diagnosis-related issues.

Both positive changes (healthy diet patterns, sympathy, and helping behavior for others) and negative changes (change in daily life/ routine activities, real or threatened loss of loved ones, increased responsibilities, workload, and so many restrictions) were reported by participants during a COVID-19 pandemic. Supporting each other and taking care of each other in times of crisis were also reported as social values learned from the culture of our country, which people have implemented during COVID-19 in Pakistan. Resilience studies showed that most people can overcome these obstacles and that some experiencing growth and good transformation. Even though adversity has obvious negative consequences, adverse experiences might likely provide opportunities to develop adaptive techniques that foster resilience and growth when faced with stress (Bleil et al., 2021).

During this novel disease of COVID-19 stigmatization of COVID-19 victims individuals and families was also very common in Pakistan. As indigenous research was conducted to investigate the stigma faced by patients (who were admitted to hospital) with the COVID-19 disease in the city of Pakistan, Lahore. Patients reported pervasive feelings of stigma, particularly regarding public perceptions and disclosure. According to the findings, rejection, stigma at the social level social, harsh, demeaning attitudes by other people, confidentiality beaching, lacking respect/trust, and the influence of diagnosis (COVID-19) were the main themes that emerged from the qualitative responses (Imran et al., 2020).

Given the fact that attitudes like stigmatization have plagued the response to the COVID-19 pandemic in some places (Marcinko et al., 2020). [Bowlby (1969) stated that in addition to separation from an attachment figure, the "attachment system" can be triggered by factors such as illness, fatigue, pain, hunger, and vulnerable environmental situations. Therefore, attachment patterns were also focused on in the present study. Participants have reported that they have developed insecurities regarding their attachment figures during COVID-19. Therefore, they used to hide their distress related to health and general life.

Emotional suppression was practiced by everyone. Children used to hide their emotions from their parents and vice versa. It can be supported by previous literature, as Bowlby (1969) [5] claimed that illness can trigger attachment behavior, and attachment insecurity was associated with high health anxiety (Reiser et al., 2019). Anxiety related to health is a key predictor of maladaptive reactions to illness outbreaks (Asmundson & Taylor, 2020).

Some participants hid their feelings and emotions intentionally, while others had difficulty communicating. Previously evidence was found through research conducted in Italy, as stated: certain characteristics of attachment patterns are associated with an increased vulnerability of mental distress in reaction to a COVID-19 epidemic, giving an idea that this could be a significant protective of precipitating factor in certain individuals (Moccia et al., 2020).

Participants have reported having post-traumatic mental suffering even after recovering from COVID-19. Post-trauma stress (PTSS) was reported at 7% in the general population in individuals exposed to the COVID-19 pandemic in China. The disease's direct effects could cause it, the procedures necessary to contain it, or even indirectly through having contact with directly affected persons (Liu et al., 2020).

During COVID-19 many people have also experienced a disturbance in their relationships. The COVID-19 outbreak has caused serious and long-term relationship issues. People were unable to fill the communication gap created by their illness and the pandemic. Participants have also reported that they had difficulty in communication during the illness duration. Studies showed that attachment avoidance among partners was linked to decreased problem-solving compatibility and family dimensions. Findings suggest that the characteristics of the spouses with whom individuals had to live with during the COVID-19 pandemic will

influence the impact of a pandemic on the functioning of their relationships (Overall et al., 2021).

Participants whose family was not supportive and those who were not living with their real parents during COVID-19 had more difficulty in regulating their emotions. Some females have reported that their in-laws were not supportive and were more stigmatized due to COVID-19 illness. Victim blaming was also very common during COVID-19, which further made victims suffer. It's also possible to see how, even if they're necessary to stop the spread of COVID-19, measures like social distancing, curfews, and home isolation can exacerbate attachment anxiety and insecurity (Bartolucci & Magni, 2017). [

The emotional control strategy was also very common in dealing with COVID-19. Participants also have emotional expressions during COVID-19. They have not shared their distressing emotions about the traumatic situation (such as COVID-19) with their parents, which was hard to manage because their in-laws were also non-supportive.

The COVID-19 pandemic was traumatic for almost everyone, and it has also affected the attachment behavior of the participants. Premorbid attachment patterns have well explained the behavioral actions of the participants during their illness and pandemic situation. Styles of attachment may be considered among the primary factors leading to regulations of emotions in stress-causing situations, such as when confronted with the stress of COVID-19. Different emotional reactions to both negative and positive life experiences were observed in individuals with various styles of attachment, as well as different ways of dealing with them. Individuals who said they had trouble controlling their emotions (poor regulators) exhibited increased anxiety, sadness, and PTSD (Mikulincer & Shaver, 2014).

Literature supported results as a study found that insecure attachment was connected to psychological problems via the pathways of low expectancy of support and poor regulation of emotions (Cloitre et al., 2008). [8] Various challenges greatly impact the psychological health (both relationally and emotionally) of individuals, couples, and families. In recent times of COVID-19, there has been an underlying sense of anxiety and uncertainty exacerbated by conflicting signals about health and safety (Stanley & Markman, 2020). [32]

Through attachment theories, one can understand attachment patterns and behavioral reactions as a result of COVID-19. Attachment theory is a technique for describing how people interact with one another. Humans are social creatures with an inherent system that drives us to seek comfort from others when we are stressed or in need (Bowlby, 1973). [7] When a person is confronted with a real or imagined threat, the attachment system becomes activated, causing the person to re-establish intimacy and connection to regain a sense of security (Mikulincer & Shaver, 2014).

Participants have also reported that they had extreme difficulty in communication during illness due to COVID-19. Various challenges greatly impact the psychological health (both relationally and emotionally) of individuals, couples, and families. In recent times of COVID-19, there has been an underlying sense of anxiety and uncertainty exacerbated by conflicting signals about health and safety (Stanley & Markman, 2020).

When people are confronted with a terrible situation, they begin to make sense of it. On the survivor's side, searching for meanings actively from their experiences is part of the coping process. “Why I?” “Why at this time?" and "What is the learning part in this event?" can be examples of this meaning’s search (Crossley, 2000). Similarly, participants reported the pandemic's situation when they tested positive for COVID-19.

Emotional management was also a big challenge for COVID-19 survivors during a worldwide pandemic. Due to the novelty of the situation of COVID-19, people were unable to understand their situation. Emotional suppression was also very common during COVID-19. Most of the participants were unable to understand the situation of COVID-19 and hence, had difficulty in assessing and regulating emotions. Similarly, Ehring and Quack (2010) investigated emotion control issues in trauma survivors. As a result, the intensity of post-traumatic stress symptoms was linked to all variables assessing emotion regulation difficulties. The variable "lack of emotional clarity" produced the most conclusive results.

In the traumatic situation of COVID-19, participants were overwhelmed by helplessness, so religious and spiritual coping was very commonly practiced. All the participants were Muslims who share the belief that ALLAH Almighty is watching over them and protecting them. They also believed that illnesses and recovery come from God, so religious practices were also a source of relief during that time. Culture and religion significantly influence trauma recovery (Tuval-Mashiach et al., 2004).

Conclusion

People have used different coping strategies to deal with the traumatic, unusual, difficult, and stressful situation of COVID-19. Using a phenomenological method, this study gives a complete and in-depth comprehension of the lived experiences of COVID-19 survivors while highlighting the pandemic's impact on their attachment patterns, and emotion regulation strategies. A positive mindset, healthy bonding with others, positive self-reflection, and coping strategies are extremely significant for psychological growth in any crisis such as a COVID-19 pandemic.

Implications

In the practical domain, this study suggests that psychological interventions should be combined with medical treatment in such situations rather than just being bound to medical interventions alone for the treatment of physical illness as of COVID-19. It will be helpful for counselors, students, and clinicians who have been dealing with people who have experienced trauma to understand the phenomenon. Further, it can help clinicians and counselors to clarify understanding and decision-making on whether explored factors should be included in the therapeutic process while implementing interventions for trauma survivors.

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Reconceptualizing Severe Traumatic Stress Reactions of Children and Young People: A Resilience Perspective

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Children and Young People (CYP) who experience severe traumatic stress through terror-related exposure are reported to have interconnected educational, social, and physical healthcare demands that characteristically receive a lack of attention. The nature of these challenges has been defined as wicked problems as they conventionally resist pragmatic or technical solutions due to the complexity of their appearance. Wicked problems are habitually more distinct within a vulnerable population of CYP who are exposed to a diverse scope of risk factors that increase the development of severe traumatic stress. To illustrate, the context of the present theoretical paper aims to focus on Pakistan's Army Public School terror-related incident, in which a multitude of risk factors, including the disorganization of education, witnessing the significant loss of life, the perceivable deficiency within Pakistan's psychosocial health system and stigmatized attitude towards mental health integrated themselves into the immediate environment of CYP who were exposed to the attack. In alliance with Bronfenbrenner's ecological theory, an interaction between proximal and distal elements within an individual's environment can significantly influence the emergence of protective and risk factors that interplay with each other to either escalate or reduce the probability of a disruptive outcome, such as severe traumatic stress, following CYP's exposure to trauma. Applying this research to the outlined wicked problem, the following theoretical review aims to address the outcomes that may have been overlooked before proposing a multidimensional intervention that can enhance the resilience of those impacted by future terror-related exposure through alleviation, protective and prevention strategies.

Keywords. Children and young people, severe traumatic stress, Pakistan, resilience, ecological theory

Children and young people who experience mental health challenges are reported to have interconnected educational, social, and physical healthcare demands that are unable to be addressed (NHS Digital, 2021). These challenges have been defined as wicked problems (Termeer et al., 2015), as they characteristically resist pragmatic or technical solutions due to the complexity of their appearance (Geuijen et al., 2016; Head & Alford, 2015). In particular, wicked problems are habitually more distinct within a vulnerable population of young people exposed to diverse risk factors that increase the development of mental health issues. To illustrate, the context of the present review aims to focus on the shooting-related terror attack which transpired on December 16th, 2014, at an Army Public School in Peshawar, Pakistan.

Through the heinous methods employed by the Tehrik-i-Taliban, 132 children lost their lives, and 121 children were critically wounded. Furthermore, the majority claimed to have experienced severe traumatic stress reactions as a result of the attack (Hussain et al., 2019; Kazmi & Ali, 2015). This was demonstrated by Khan et al. (2018), who found that out of the 205 children that survived the incident, 154 (75.2%) were reportedly exhibiting post-traumatic stress disorder symptoms such as intrusive imagery, hyper-arousal, and avoidance, at a severe level. The event was recorded as having the highest number of child fatality cases in the world because of a single terrorist attack. This incident was substantially covered across national and international media outlets and led to the employment of high-level security measures in all educational institutions across Pakistan, generating extreme tension and fear among children and young people.

Pastrana et al. (2020) argue that despite exhibitions of terror-related attacks, which introduce suffering to families and generates an increased risk for children and young people to encounter psychiatric distress and developmental challenges (Masten & Barnes, 2018; Tol et al., 2013), there is also evidence to suggest that a significant proportion of children can sustain their psychological distress and therefore advance through a normative developmental trajectory (Majumder et al., 2018). This specific population of children who are exposed to severe trauma but ultimately recover in response is known to have formed resilience (Rosshandler et al., 2016). In alliance with Masten and Narayan (2012), children and young people who develop resiliency display high standards of mental health functioning following the traumatic event and, in addition, may even thrive and adapt further to meet future adversities (Southwick et al., 2014). Furthermore, the research literature has defined resilience as an inherent personality attribute that can be determined by the

availability of protective factors within an individual's environment (Luthar, 2013). Applying this research to the outlined wicked problem, the following review aims to address the outcomes that may have been overlooked at the time of its occurrence whilst proposing a multidimensional approach that can enhance the resilience of those impacted by future terror-related exposure through alleviation, protective, and prevention strategies.

Pakistan has been the center of continued efforts against terrorism for the past two decades. While the intensity of terrorist movements has fluctuated over the years, the nation itself has endured more than 100,000 fatalities, including 50,000 children and their families (Portal, 2018). As a result of the Army Public School terror-related incident, a multitude of risk factors, including the disorganization of education (Mufti et al., 2019), witnessing the significant loss of life (Khan et al., 2019), the perceivable deficiency within Pakistan's psychosocial health system (Mian & Chachar, 2020) and stigmatized attitude towards mental health (Sandhu, 2012) integrated themselves into the immediate environment or microsystems of those exposed to the attack. Following the Army Public School terror-related incident, pertinent evidence-based interventions were unable to be effectively allocated by governmental and community levels (Stoltenborgh et al., 2015), other than the short supply of mental health professionals and non-governmental organizations that had sufficient training to respond to disasters that showed equivalent levels of similarity. The Institute for Economics and Peace (2022) could provide a plausible explanation as to why the government and community levels failed to implement extensive prevention strategies. Presently, Pakistan is ranking tenth in the list of countries with reportedly high volumes of disaster events that occur in the form of natural disasters, terrorism, and political turmoil. With a child population that surpasses 95.4 million (UNICEF Pakistan, 2021) and an economic loss in the approximate region of $126.79 billion (equal to Rs. 10762.14 billion) due to the impact of terrorism (Zakaria et al., 2019), it is evident that government and community levels are unable to meet the great demand for equal distribution of financial aid.

An additional challenge that was identified by Abdullah et al. (2015) that prevents children from receiving adequate psychosocial care is the current establishment of Pakistan's disaster management institutions existing at their premature phases. Although operations that are currently active, such as the Command, Control, and Communication Centre, anchor their attention on the advancement of coordination amongst the sector-level subunits, the subsequent production of their attempts maintains a deprivation of collaboration between distinct sectors within disaster management (Khan & Hassan, 2012; Qasim et al., 2017; Shahbaz, 2019). To demonstrate, Sarwar et al. (2016) claim that the foremost duty of disaster management organizations is to manage the outcome of natural disasters and, as a result, are left unequipped to produce significant contributions toward the governance of man-made disasters.

Furthermore, whilst the response and planning strategies to combat acts of terrorism are solely supervised by representatives of law enforcement (Rafique, 2019), recovery and relief strategies, due to inferior comprehension and resources, are impotent when considering implementation unless governmental and community levels are integrated and fortified (Rafique et al., 2016). Considering this and as previously identified, the non-governmental organizations currently functional within Pakistan largely utilize themselves through independent means (Ali, 2016; Ashraf & Ismat, 2016). As a result of operating in isolation, Ali and Iqbal (2021) suggest that barriers endure whilst attempting to integrate with supplemental public and emergency firms within the disaster response network, which therefore limits children and young people's access to services that support potential symptoms of severe traumatic stress. It is essential from this understanding that for this wicked problem to be effectively addressed to prevent future occurrences, the complexity of children's needs requires a multidimensional approach.

To address this requirement, it may have been beneficial to reconceptualize those exposed to severe traumatic stress from a resiliency framework (Kent et al., 2013; Masten, 2015). In alliance with Bronfenbrenner's ecological theory, an interaction between proximal, such as family, institutional settings and neighbours, and distal elements, such as national government, wars, and economic status, within an individual's environment can significantly influence the emergence of protective and risk factors that interplay with each other to either escalate or reduce the probability of a disruptive outcome following children and young people's exposure to trauma (Bronfenbrenner, 1992). Applying this to the current paper, children and young people are considered to progress in a manner that represents the interactions they engage with in their environment or social settings (Bronfenbrenner, 2005; Bronfenbrenner & Bronfenbrenner Ceci, 1994). The ecological theory proposes that this process of interaction occurs between four distinct systems. To illustrate, the first and arguably the most influential sphere that children and young people interact with is referred to as the microsystem, which includes family, health services, religious organizations, and academic structures. Resiliency progression is also affected by the next sphere, known as the mesosystem. This system represents how the different

sections of children and young people's microsystems collaborate with each other. It also describes the associations or scarcity of such cohesiveness between children and young people's microsystems, such as the relationships between home and work or school environments. Successive to this is the exosystem level, which emphasizes the effect of individuals and locations where children and young people may not interact closely but can still have a significant impact on them, such as government agencies, mass media, the economic status of the household, etc. The final level of the ecological model is the macro system which is situated in the outermost area of the framework and comprises the largest, most remote set of individuals, organizations, and values, including cultural attitudes and ideologies, which have a cascading influence on children and young people.

In the current context and as a result of Pakistan's substantial economic decline through terrorist activity, Shahbaz et al. (2013) reported that the sharp incline of employment became more evident, which caused it to be a predominant factor in explaining the shortfall of spending power utilized within a child's microsystem. This process can be exhibited through the incorporation of Pakistan's economic system into the outer spheres of children and young people's exosystem, which produced a cascading effect into the interacting microsystems that encompassed the child's family and school environments (Bronfenbrenner, 1979). Consequent to the irreversible impact orchestrated by previous efforts of terrorism, which led to a reduction in financial aid, non-governmental organizations instead aimed their concentration on developing psychosocial interventions which targeted children and young people's school environment, which resides in the microsystem (Qouta et al., 2012).

Psychosocial interventions that are tailored toward children who have been exposed to terrorism are available in abundance (Brown et al., 2016; Tol et al., 2014), and the majority of them initiate their programs for restorative purposes so that potential psychiatric disorders and their symptoms are prevented whilst optimal health and development are promoted (Kangaslampi et al., 2015). Through these methods, the objective is to improve a child's resilience by being attentive to individual features, which include essential coping tactics, problem-solving competence, and effective cognitive-emotional synchronization (Peltonen et al., 2012). Fernando and Ferrari (2016) additionally emphasized the importance of strengthening social support and family resources within a child's microsystem to successfully acquire these resilience-based skills. Despite these efforts, research that attends to intervention implementation has yet to address resilience as a principal outcome within the population of vulnerable children and young people and instead upholds symptom reduction as their leading outcome to attain (Graham et al., 2017; Salloum & Overstreet, 2012).

To demonstrate this, the Coping-Enhancement Protocol, which was utilized on a population of terrorism-affected Israeli children, concentrated on elevating resilience, coping strategies, and optimal emotion modulation by implementing practices of sharing and reorganizing traumatic material, psychoeducation, and narrative-based play tasks (Hamiel et al., 2013). Following its inclusion, the protocol was concluded to be most effective in symptom reduction rather than resilience building (Berger et al., 2016). A further display of how interventions can be integrated into the school environment of a child's microsystem is through Class-Based Interventions (CBIs). As observed in the research literature, CBIs have been widely administered for terrorism-affected children who reside in low-and middle-income countries (Jordans et al., 2016). Similar to the aforementioned protocols, the influence of CBIs within a child's school environment intends to encourage resilience that elicit innate coping strategies to prevent potential mental health issues. The efficacy of CBIs can be attributed to their cost-effectiveness and, as a result, is becoming a growing area of intervention implementation in many southeast Asian countries (Newnham et al., 2018). Despite this salient feature, the research identified that although mental well-being and post-traumatic stress-related symptoms had been alleviated through CBI interventions in response to terrorism, many children and their parents reported that their natural recovery had been undermined (Tol et al., 2013). In other LMIC countries, including Palestinian territories and Nepal, it was found that the introduction of CBI methods was not associated with improvements in PTSD, anxiety, or depression symptoms (Morina et al., 2017). The lack of potency when interventions were applied in other LMICs could have been explained by the lack of attention given to the psychological connectedness between a child and their immediate family within a certain cultural context (Cassidy & Shaver, 2018; Kim & Choi, 2014).

The importance of this connectedness, which employs the nonverbal methods of touch (same gender), empathy, and hugs in maintaining severe traumatic stress symptoms and building resilience, was found through a local NGO called Horizon that participated in psychological engagement with the children and families who were directly exposed to the APA terror-related attack in the city of Peshawar, Pakistan (Hoven et al., 2020). Although the WHO (World Health Organization, 2013), typically advises against utilizing such methods due to the lack of evidence that psychological debriefing or intervention has promising benefits in reducing symptoms of traumatic stress (Davies, 2020; Roberts et

al., 2019), Horizon found that the majority of children often favoured direct participation through the debriefing techniques of nonverbal communication within counselling sessions that employed empathic touch. As a result of this, Horizon concluded that it was more constructive to support the child's psychological resilience in association with their immediate family environment before addressing and implementing measures at the school level of a child's microsystem.

Taking this into consideration, most of the research which promotes family-based trauma interventions has been conducted in the west (Cooper, 2016). This translates into a limited comprehension of child trauma and its management from a non-western frame of reference. As a result, it can be considered irrelevant for application within the cultural and religious contexts upheld by Pakistan (Shukla et al., 2012). Successive to the Army Public School terror-related incident, it was therefore perceivable that an urgent demand existed for culturally sensitive measures to increase the level of understanding of the severe traumatic stress reactions of the children so that reliance-based interventions could be developed. In acknowledgment of its religious context, Pakistan is considered an Islamic state and is listed as the second most populous Muslim country in the world after Indonesia (Zaman, 2018). Following its partition with India (Khan, 2017), the practice of Islam has been deeply rooted in Pakistan's history and has since remained a significant factor regarding the country's policymaking and the society's widely held beliefs revolving around mental health (Naveed et al., 2017).

Although basic acceptance of psychological distress is on the rise within Pakistan, the standard that continues to be practiced is for parents to either consult with religious community leaders or to keep their issues private from their children (Ali & Gul, 2018). To illustrate this process from children and people's macro system, and more specifically from Pakistan's cultural perspective, the development of mental health is believed to be associated with supernatural causes which originate from witchcraft and the evil eye (Choudhry et al., 2018; Sharma et al., 2020). For this reason, barriers to developing resilience are formed and are used as an internalized reason for parents' inability to access mental health outlets in Pakistan. Furthermore, Ciftci et al. (2012) claim that parents often consider mental health as a punishment from God and, as a result, aim to perform more religious actions, such as prayers, to treat the disease instead of communicating their exposure to psychological distress to their children. This generates an increase in individual restraint from inquiring and ultimately accessing mental health outlets. In light of this, the lack of awareness within the family level of the microsystem may influence the child's overall perception of mental health services which creates a further barrier to potential access (Rana & Sharma, 2013). In support of this statement, Ali (2016) revealed that because of the lack of awareness that exists within the immediate family environment, children and young people reported that they had limited or no knowledge of family-based therapy, such as family-based cognitive behavior therapy and admitted to referring themselves to general physicians or conferring with friends if they experienced mental health concerns rather than their family members. In recognition of Horizon's research, drawing upon the religious and cultural contexts established within Pakistan can help further understand the reasoning as to why the children of the Army Public School disaster responded so effectively to the nonverbal techniques of empathic touch. This approach may have encouraged psychological connectedness and, thus, the initial stages of resilience to develop through the form of comfort, which informed the child that their trauma was being acknowledged, a form to which the children may not have previously been exposed.

In acknowledgment of Pakistan's cultural contexts, another model of resilience that could of having been applied when considering treatment interventions for those exposed to the Army Public School terror-related attack is the constructivist self-development theory (McCann & Pearlman, 1990). It was introduced as an interdisciplinary personality theory that expresses the impact of a traumatic event on the individual's overall development. Through the unification of psychoanalytic (Eagle, 2013), social learning (Rosenthal & Zimmerman, 2014) and cognitive developmental (Kazi & Galanaki, 2019) construct coupled with constructivist thinking (Mahoney & Lyddon, 1988), the constructivist self-development theory may be a useful tool to uphold whilst considering future occurrences of terror-related incidents in addition to what could have been incorporated shortly after the Army Public School attack. Its effectiveness can be perceived by including an individual's cultural and social context in which the traumatic event occurred. Through this lens, the constructivist self-development theory accentuates the importance of the developmental approach by claiming that the individual's early stages of development are central to their current methods of communicating with the self and others. Within these early stages, the closeness of the child-caregiver dyad forms an essential part of establishing innate resilience toward their exposure to the traumatic material. Therefore, if the child can establish a secure base or attachment with their caregiver, they are more likely to integrate coping strategies that act as a resilient barrier when experiencing thoughts or feelings that could threaten the integrity and protection of the self.

Taking the multitude of risk factors presented within the Army Public School children's macrosystem, exosystem, and microsystem into consideration, perhaps the most practicable strategy to utilize for future terror-related events is to apply horizontal integration within Pakistan's existing primary health care system, which would aid in strengthening the current system, instead of constructing a parallel mental health care structure. The implementation of this intervention would mean uniting professionals, services, and organizations that would otherwise function independently. Horizontal health care can be constructed again through the facilitation of the ecological model and could be used to organize and assess relationships between community infrastructures and between the community and the wider macrosystem to measure economic and other resources that have a role in determining the resilience of children and young people.

Despite the lack of qualified clinical psychologists and psychiatrists that exist within the psychosocial health system (World Health Organization, 2009), Pakistan is known for its cohesive Community Health Workers program (Khalid et al., 2022). This network of community health workers is often regarded as essential in enhancing access to mental health outlets so that individuals can achieve health-related goals. As previously mentioned, the constrictions in Pakistan's finance distribution due to terrorist activity create an expectation for community health workers to do more without securing the appropriate aid (Rahman et al., 2019; Scott et al., 2018; Zakaria et al., 2019). In response to this, the Lady Health Worker Cadre and similar groups were formed (Hafeez et al., 2011) to supply the required primary health care resources that promoted health, elimination of disease, therapeutic and rehabilitative services in addition to assistance in family planning within the individual's community level. Community health workers receive the necessary amount of training, including 18 months of coaching and 12 months of practical experience. These community health workers are chosen from their communities, which benefits the proposed intervention implementation as they have a greater understanding of society and are each accountable for supervising 200 individuals.

In support of integrating various support systems, each community health worker would be aligned to a particular government health establishment, from which they would be provided with sufficient coaching and a small allowance. In recognition of their influential status, the proposed intervention would also aim to incorporate a networking system between community health workers and religious leaders within the community to achieve a holistic and horizontal healthcare system. As explored, the ecological theory is an application framework of investigation to assess children and young people's resilience. Research repeatedly reports that resilience development has strong associations with proximal and distal factors (Ungar et al., 2013). The utilization of this framework in unison with children and young people in Pakistan would validate the importance of the influences existing in their microsystem, mesosystem, exosystem, and macrosystem upon their resilience. Findings can then be integrated into the development of future policies and intervention construction as the ecological model can stipulate where these areas will have the largest impact on building children's and people's resilience to future man-made disasters. Suppose the identified factions were trained in providing mental health services through the recognition of risk and protective factors in association with the ecological model and the recommendations of the constructivist self-development theory by emphasizing the role of a secure attachment between traumatized children and young people and immediate family members. In that case, it could become a very effective system in delivering mental health resources within the affected community. With the government and community levels acting in unison with the religious community leaders and community health workers, an integrated framework of support and understanding could exist, despite the limited financial resources, to employ alleviation, protective, and prevention methods through a constructivist self-development theory lens that would encourage the growth of resilience in children and young people within Pakistan.

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Integrative Free Associative Dyadic Mapping: mindfulness-based graphic notation to promote clinician self-regulation

Luke Felczak

Introduction

The experience of torture, according to Jean Améry, moves a person beyond the borders of death to a place of Nothingness (1980). Améry's observation appears to be consistent with the general clinical finding that dissociative symptomatology is a core feature of post-traumatic impairment as a consequence of torture (Başoğlu & Mineka, 1992; Saporta & van Der Kolk, 1992; Somnier et al., 1992; Ray et al., 2006; van der Kolk & McFarlane, 2006; Steele & van der Hart, 2009; Carlson et al., 2012; Dalenberg & Carlson, 2012; Courtois & Ford, 2013). If torture represents the phenomenological presence of the Cruel Other that leaves a survivor profoundly disconnected from the flow and rhythms of their own moment-to-moment experience, then perhaps the antidote to the dis-ease of torture may have something to do with the presence of a Loving Other – a presence that leaves a person more (and not less) connected to the flow and rhythms of their subjective phenomenological experience. Accordingly, if torture drives a person beyond the borders of ordinary death to a place of Nothingness, then perhaps "the rehabilitation of torture survivors" may have something to do with exploring what Abundance there exists beyond the borders of ordinary life. According to the Somatic Experiencing (SE) approach to trauma-therapy, this may represent the ideal meta-pendulation that heralds the resolution, integration, and re-calibration of the human nervous system in response to either extreme or normative traumas (Levine, 2010). In this regard, trauma therapists may need to become aware of and integrate, as needed, the clients unconsciously dissociated psychosomatic process, which can be readily transferred to the clinician in the course of their practice (McFarland, 2004; Diamond, 2020).

As a relatively inexperienced trauma-therapist, I wanted to write this paper to clarify an approach I have been finding helpful in my clinical practice at the Vancouver Association for Survivors of Torture (VAST). I have found this approach to be effective as a way to self-regulate and manage dissociation-related transference before, after, as well as between client sessions. Combining concepts and practices from sensorimotor Psychotherapy (SP) (Ogden et al., 2006), somatic experiencing (SE) (Levine, 2010), expressive arts therapy (EXA) (McNiff, 1992; Knill et al., 2010), Zen Buddhism (Suzuki, 1970), as well as reparenting skills (ACA WSO, 2021), I would like to describe an approach that I would call Integrative, Free-Associative, Dyadic Mapping (IFAD-Mapping). I wanted to share this approach because I thought other clinicians might find it helpful in their own clinical practice. IFAD-Mapping combines the following elements, with a special focus in this paper on the fourth and final element, mapping:

Integrative - IFAD-Mapping incorporates the mindful awareness of present-moment experience. The SE approach outlines five (5) aspects of phenomenological experience in its SIBAM model (i.e., sensation, imagery, behavior, affect, and meaning) (Levine, 2010). Similarly, the SP approach outlines five (5) core organizers of phenomenological experience (i.e., cognition, emotion, five (5) sense perception, movement, and bodily sensations (Ogden et al, 2006). For a complete description of the SIBAM model in SE please see Levine (2010). For a complete description of core organizers in the SP approach, please see Ogden et al., (2006).

Free-Associative - In IFAD-Mapping, the present-moment experience remains person-centered and is allowed to change and shift based entirely on the locus of attention of the person tracking and mapping their own phenomenological experience. There seems to be an interesting relationship between the stream of consciousness and the stream of phenomenological awareness. From my experience, I cannot deepen my phenomenological awareness of experience into every object of conscious awareness. Instead, I notice in myself a semi-intentional, semi-accidental process of selection and choice. One that is perhaps based on my convenience, comfort, familiarity, curiosity, the degree to which I want to challenge myself, as well as the ambiguous felt sense of "this feels right," this feels right for me to notice right now, to become aware of this, and not something else.

Dyadic - The experience of tracking and mapping in this method occurs in the felt presence of the Loving Other. When engaging in IFAD-Mapping "by oneself," this is

done in the imagined and/or evoked felt presence of the Loving Other (ACA WSO, 2021). When engaging in IFAD-Mapping in individual psychotherapy (a work in progress, I hope), the skilled helper or therapist can become the image of the Loving Other and so help elicit, if available, this foundational image in their clients.

Mapping - More importantly, however, and perhaps in modest innovation of other mindfulness-based therapeutic approaches, such as SE and SP, is that IFAD-Mapping is a "graphic" approach. This means that the present-moment tracking of phenomenological experience is also graphically recorded, in real-time, using what I consider to be a relatively basic and evolving graphic notation. There are several good clinical reasons for adopting a graphic notion when tracking present-moment experience: Employing a "complex" language- and symbol-based notation in this way is likely to engage higher cortical functions alongside subcortical emotional and sensory-based neurophysiological information-processing (Halford et al., 2010; Steffan et al., 2022)

This notation is likely to be experienced as a novel. Because no one writes or thinks ordinarily in this way, this notation may generate novel neural connections and evolve extant neural networks across the adaptive/triune brain (Steffan et al., 2022).

Recording phenomenological experience in graphic notation requires a participant to resolve several choice points. Again, this is likely to engage higher cortical functions alongside subcortical emotional and sensory-based neurophysiological information-processing (Halford et al., 2010; Roy, 2017; Steffan et al., 2022), as well as potentially slow down the experience of experience.

Phenomenological experiences can sometimes feel ambiguous or "too close." Engaging in a graphic notation can help resource these challenges by structuring and externalizing the perception of "internal experience."

This method produces a written artifact that can be assessed and analyzed in a variety of ways (e.g., in terms of recurring patterns, in terms of present or emergent resources, and so on.)

IFAD-Mapping Session and Notation

First, I will outline the basic steps to engage in an IFAD-Mapping session. Then I will explain the notation I've been using while doing my own IFAD-Mapping. To start, you will need a place where you feel comfortable. Dōgen (2013) suggests the following:

"…a quiet room is suitable. Eat and drink moderately. Cast aside all involvements and cease all affairs. Do not think good or bad. Do not administer pros and cons. Cease all the movements of the conscious mind, the gauging of all thought and views [the gauging of all internal sensations, complex imagery, movement, and emotion as well] …have no designs..." (p. 81) [Brackets my own].

If you already have a meditation or mindfulness-based practice, you may choose to settle down as you would for your usual practice. Next, you will need some paper and some multi-colored pens. I like using 14" x 17" unlined sheets. But this kind of paper is not necessary. The ordinary paper will do. I also like using eight (8) or more different colored pens. But again, this is optional. Lastly, you will need anywhere from 2 to 60 minutes. For me, session length depends on several factors. How much time do I have between client sessions? How much time do I have before or after my clinical workday? Whatever the session length, as a general rule, if I am able to, I like to conclude a session at a place that "feels good" or "feels right" to my felt sense at a place where I feel stronger or calmer than before.

As you will be doing your sessions "alone," to begin the session, you will need to first elicit the presence of the Loving Other. This complex image (i.e., complex, because not necessarily visual, or not only visual) of the Loving other may be different for different people. And there are several ways to evoke or elicit this complex image. This may be accomplished with a short loving-kindness meditation, imagining the presence of an especially kind and loving person from any time in your life, or imagining a pet or a place in nature that helps you feel unconditionally welcome or secure (ACA WSO, 2021). For an example of loving-kindness meditation to elicit the presence of the Loving Other, please see ACO WSO (p. 36-37, 2021)

Once you have elicited the presence of the Loving Other, you can begin mapping your phenomenological experience when it feels right. To do this, you begin by asking yourself, what am I noticing right now? This will be your first and recurring choice point. And according to this notation, and in consonance with the SIBAM model of SE, there are five (5) possible responses:

S – Internal physical sensations

I – Complex images, including five (5) sense perceptions

B – Behaviours, including movement impulses and actual movements

A – Affects, including emotions, mood, energy level, and the quality of orientation to time and space

M – Meanings, including cognitions, thoughts, and beliefs (Levine, 2010)

So that is your first step: to attend and orient your attention to one object or atom of present-moment

experience and decide if it is an S, I, B, A, or M. The second step, and second choice point, is to describe in a word or sentence, or brief illustration, the kind, category, or quality of the atom of experience you are attending to. For me, the notation is written in a column from left to right. And I find it helpful to have lists of words handy to describe common physical sensations and emotions. Here are some examples of the notation for each category of phenomenological experience:

S: tightness in my midback, around the spine

I: the sound of a songbird outside

B: the impulse to rub my eyes, and rubbing my eyes

A: panicky

M: I should take those plates to the kitchen

As a third step and fourth step, and as the third and fourth choice points, you can add a quality and/or quantity descriptor to the atom of experience you are attending to. For example, is the experience pleasant (P), unpleasant (UnP), or neutral (N). And on a scale of one to ten (1 → 10), is it a one (1), low intensity, or a ten (10), high intensity, or maybe somewhere in between? For example:

A: panicky (UnP) (4)

If you are practicing SE, when you have contacted an atom of phenomenological experience, and if it is pleasant, you are invited to stay with that experience and enjoy it. If it is unpleasant, you are invited to just notice it and see what happens next (Somatic Experiencing International). If this feels right to you, you can incorporate these elements of SE into your own mapping practice.

Sometimes, when mapping, I incorporate all and sometimes only some of the elements of the notation. It depends on the session, and every session is different. Don't worry; there is no wrong way to do this. This particular notation is just an example. You may even find that adding to it or subtracting from it might be helpful to you. For example, sometimes I will include the following symbols of notation because I have found them helpful. They seem to jive well for me in terms of my own mindfulness-based practice, as well as where I am in my SE training:

Nm – met need

Nu – unmet need

Bi – behavioral or movement impulse

Bm – behavioral or movement action

∞ - horizontal pendulation

R – familiar resource

NR – new or emergent resource

The invitation is to work with the basic SIBAM notation organically, giving yourself the freedom to customize your notation in a way that feels right and makes the most sense. Additionally, I will use my different colored pens, and sometimes pastels, while mapping. Sometimes a shape, an image, or a diagram will spontaneously emerge for me, and I will take a few moments, or maybe a couple of minutes, to sketch the image. If the image feels especially resourceful or otherwise charged or interesting to me, I will continue to explore it once I have concluded the IFAD-Mapping session, using the expressive arts therapy approach (Mcniff, 1992; Knill el al. 2010).

So, in summary, a single line of mapping may look something like this:

S: Chilly Feet (N) (2)

Table 1

The Four Basic Choice Points in IFAD-Mapping, Including Descriptions and Examples

Choice-Point	Description	Example
#1	Categorize the atom of experience	S
#2	In a word or short sentence, describe the atom of experience	Chilly Feet
#3	Evaluate if the atom of experience as pleasant (P), unpleasant (UnP), or neutral (N)	(N)
#4	Evaluate the intensity of the atom of experience (1 →10)	(2)

I now want to briefly discuss a separate class of physiological phenomena that I also track and map during an IFAD-Mapping session. This class of neurophysiological phenomenon is important because they typically indicate either the discharge of sympathetic nervous system (SNS) activation or the activation of the parasympathetic nervous system (PNS). These neurophysiological phenomena include yawning, stomach gurgling, flatulence, goosebumps, trembling or shaking, burping, a spontaneous deep breath (i.e., the reptilian breath), waves of sensation along the limbs, giggling and laughter (Somatic Experiencing International). In my experience, this separate class of SIBAM phenomena frequently recurs even during a short IFAD-Mapping session. And so, for the sake of simplicity and flow, I note these phenomena and also their frequency in this way:

Yawning I I I I

Stomach Gurgling I I I

Goosebumps I I

Trembling in abdomen I I I I I

So, for example, I haven't yawned four times in a row, but I did notice yawning four times in the session. I noticed my stomach gurgling three times in the session, and so on. For me, it feels good to observe and witness myself returning to these anchors of neurophysiological self-regulation throughout the session, as well as to track the dynamic balance between SNS and PNS activation.

Sample IFAD-Mapping Session Map

Now, I will provide below a sample mapping of a ten-minute session. Because we are all different, a ten-minute session may look quite different for you than it does for me. This is because our nervous systems are different, and this difference will inform each of our unique capacities to experience and track and map our own experiences. There is no right or wrong; no need to worry. The idea is to be curious, to explore, and, if possible, to enjoy being open to your own experience.

Ten-Minute IFAD-Mapping Session – Session Map

Yawn I I I I I I I I I R

Deep Breath I I I

S: my feet are chilly (Un) (3)

S: watery eyes (N)

B: leaning back in my chair

S: spacious breathing

M: I wonder if I'll finish this paper tonight

S: tightness, achiness in tops of shoulders (UnP) (2)

M: stay with the unpleasant sensation and see what happens

S: tension in mid-back

Stomach Gurgling, I I

M: This article/paper does not have to be perfect, or completely consistent, or completely R comprehensive

S: more warmth in feet (N → P) ∞

B: pulled shoulders back

B: sat more upright and more aligned

S: less tension in mid back ∞

Burps I

That was about a ten-minute IFAD-Mapping session. Once I complete the session, if I have time, I just take a look at the session map and notice things that catch my eye. These may include shifts or pendulations in my moment-to-moment experience. These may also include any resourceful atoms of experience or recurring patterns that might indicate some under-resourcing. I often make some post-session notes for myself on the map, as I have already done in the above example. Doing so helps me orient to this post-mapping analysis. Also, the colors I chose throughout the session are chosen randomly. With that said, however, I usually note SNS and PNS

activation in blue pen. Again, I don't know why; it just happens that way.

Lastly, there are several Zen concepts, as presented by Suzuki (1970) in his popular work, Zen Mind, Beginner's Mind, that I want to briefly touch upon here since they have contributed to my understanding of the IFAD-Mapping process:

Nyu nan shin – "a soft or flexible mind" (p. 110)

Nin – "constancy" – The unchanging, effortless ability to accept things as they are (p. 86)

No gaining idea – the attitude that this practice is not a means to something else (paradoxically, not even a means to self-regulation), but an end in itself. Or perhaps the means is the end. "When you do not try to attain anything, you have your own body and mind right here [!]" (p. 26-27) [brakets my own]

Everything is just a tentative form and color

Innumerable activities – IFAD-Mapping is a practice that "contains innumerable activities and includes the various activities of life. We study them…." (p. 125)

To see things as they are – "The true purpose is to see things as they are, to observe things as they are, and to let everything go as it goes" (p. 33)

Big mind – "Many sensations come, many thoughts or images arise, but they are just waves of your own mind. The activity of the big mind is to amplify itself through various experiences. With big minds, we accept each of our experiences as if recognizing the face, we see in a mirror as our own." (p. 34-36)

One thing after the other – "Here there is no time or space. We do things one after the other. That is all." (p. 30)

Conclusion

So that is a brief introduction to IFAD-Mapping. I look forward to continuing my SE certification and deepening my understanding of somatic psychotherapeutic work. I am eager and enthusiastic to further develop and evolve this method of practice and notation.

By taking the time, effort, and awareness – before and after client sessions – to graphically record and map the discrete units of present-moment and moment-to-moment phenomenological experience, the intention is that unconscious dissociative coping mechanisms can be readily transferred to the clinician in the course of their practice (McFarland, 2004; Diamond, 2020), can be gradually and safety titrated back towards greater and more integrated neuro-physio-phenomenological awareness. In the presence of the Loving Other, the hope is that corrective experiences that re-integrate and re-connect the capacity to be "present for experience" can remedy the survival-based dissociation that often becomes entrenched in survivors and possibly transferred to their clinicians. Such that in the space beyond the borders of death and Nothingness and the Abundance beyond the borders of life, perhaps new or familiar tolerability, possibility, and hope can as yet co-emerge.

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Relationship between Adverse Childhood Experiences and Aggression among University Students

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Adverse childhood experiences (ACEs) are stressful or traumatic events that include a variety of forms of abuse, neglect, violence between parents or caregivers, and other types of serious household dysfunction. Most children face different kinds of abuse, such as physical abuse, sexual abuse, and verbal abuse but few comprehensive studies found adverse childhood experiences in Pakistan. This study examines the relationship between adverse childhood experiences and aggression among university students. Co-relational research design is used through a survey method. The sample includes 400 undergraduates from Rawalpindi and Islamabad universities aged between 18-27 years. The participants were recruited through a convenient sampling technique. The childhood experience Questionnaire (ACE) and Buss-Perry Aggression Questionnaire (BPAQ) were used. Data were analyzed using Statistical Package for Social Sciences. Results suggest a significant positive correlation between adverse childhood experiences and aggression (anger, physical aggression, hostility, verbal aggression) among university students. There is no significant difference between gender and adverse childhood experiences. Moreover, there is a significant difference between gender and aggression. The study offers implications for a university wellness center and therapist working to deal with such students' inability to manage their aggression in the Pakistani context.

Keywords. Adverse childhood experiences, Aggression

In Pakistan, most children face different kinds of abuse, such as physical abuse, sexual abuse, and verbal abuse. Sahil, an NGO working on child protection, reported that almost 2960 cases have been reported in newspapers related to child abuse. 51% of the victims were girls, and 49% of the victims were boys. Cases of abuse were reported from all provinces, federal, Azad Jammu Kashmir, and Gilgit Baltistan. Most of the culprits were acquaintances or parents, service providers (molvi, teachers, shopkeepers, and drivers) (Sahil, 2020). In 2019, 2846 child abuse cases were reported, whereas, in 2020, 2960 child abuse were reported. There is a 4% increase in cases in 2020. This shows that more than 8% of children are abused in Pakistan daily (Hassan Abbas, 2020).

In Pakistan, abuse can occur at every socioeconomic level, ethnic group, religious group, cultural background, and educational level. These abuses can be overcome through awareness, especially in educational settings. In Pakistan, the more vulnerable age to child abuse were the children in the age bracket of 6 to 15 years (Sahil, 2020). Adverse childhood experiences are the events when a child experiences the involves stress or trauma, which include verbal abuse, physical abuse or sexual abuse, neglect given by parents or guardians and any kind of violence between held during childhood, any kind of substance abuse taken by parents (Springer et al., 2003).

According to statistics around the globe, every year, almost one billion children aged between 2-17 years' experience any form of violence (Hillis, 2016). A survey conducted by the CDC across 25 states of the USA in 2021 reported that 61% of individuals had experienced one type of adverse childhood experience (Centers for Disease Control and Prevention, 2021).

The consequences of adverse childhood experiences were discussed in research conducted in Turkey, which shows childhood maltreatment has many consequences such as short-term well as long-term consequences of adverse childhood experiences at all stages of life, including psychological, economic, and physical effects, with particular emphasis on relationships with mental illness (Yumbula et al., 2010). These experiences play a significant role in shaping their life. Adverse childhood experiences include all types of abuse and neglect, including parental maltreatment, any member's prison, and domestic violence. Also, divorced or mentally ill parents could cause trauma to the child.

Adulthood traits such as difficulty forming relationships, paranoia, insecurity toward others, and introversion can be seen because of unhealthy and/or distant relationships with the family, internalization of this relationship model, and insecure attachment issues in childhood (Renn, 2002). Having actively learned about all of this violence through social interaction, the person may develop an aggressive personality or even start engaging in violent behavior themselves. Aggression and anger are included in the diagnostic criteria for PTSD in the DSM-V manual. It lists "irritable behaviours and angry outbursts" as symptoms of PTSD (Ross, 2015).

Aggression and violence among humans are serious public health issues. Aggression is usually seen to be multi-factored. Genetic variables, the prenatal environment, obstetric problems, the rising environment, biological factors, and mental illnesses such as substance misuse, psychosis, depression, and personality disorders are all predisposing factors for aggression (Citrome & Volavka, 2003).

University students are a good sample for research purposes as they come from different social backgrounds. They are going through changes in their social life as they are more exposed to society (Education Indicators in Focus, 2003). These late adolescents and early adults are fully energetic, active, and enthusiastic (USC Center for Excellence in Teaching, 2003).

In university life, students face many problems due to new environmental settings; many challenges include their career adoptions, relationships, and future goals (Education Indicators in Focus, 2013). These situations in university students make them unique to study on them, as they face different challenges and circumstances due to which they exhibit their behaviours and emotions in this stage of life.

Literature Review

When a child experience maltreatment, it results in stress in his/her early childhood, which increases the risk of stress later in their life. This increases the likelihood of developing psychological problems such as stress, anxiety, and depression. Also, they have a pessimistic view of life which has negative consequences (Bremner, 2003).

Suppose a developing human is repeatedly threatened to stress. They are starting to produce high levels of stress hormones such as cortisol. The human body can learn that this is a typical stress response. Daily life stressors will damage the cardiovascular system and cause different health issues (Whitworth, Williamson, Mangos, & Kelly, 2005).

In another study, researchers found that individuals are not more likely to have secure attachments if he/she exposed to early trauma in their life. In adulthood, they have unresolved attachments with their family, friends, and peer groups (Murphy et al., 2014). Child maltreatment has a significant impact on psychological problems. These factors will influence their social, relationships, emotional, and behavioral problems (Kaplan et al., 1999). Studies show that male and female adolescents have different patterns of adjustment issues (Wolfee et al., 2001)

According to research, adverse childhood experiences are responsible for up to 54 percent of female suicides (Dube et al., 2001). Individuals with adverse childhood experiences were more prone to commit suicide at some point in their lives (Felitti et al., 1998).

Adverse childhood experiences can negatively influence an adult's life, such as education, career, and income status (Marilyn et al., 2017). Children who at some point witnessed any kind of violence were seen as more likely to engage in externalizing behaviours such as physical aggression and disobedience of rules (DeJonghe et al., 2011).

Adverse childhood experiences did not target only one race, class, or area; every child from all races, socioeconomic backgrounds, and geographic areas reported experiencing adversity. The prevalence rate of adverse childhood experiences is high in the lower class (Busby et al., 2011). These adverse childhood experiences make complex issues in an individual that underpins his/her relationship with the rest of the world (Paradis et al., 2010).

Most of the studies on adverse childhood experiences disclosed that the risk of juvenile delinquency increase when the relationship between a child and parents is abusive such as physical or verbal, or when a child faces neglect from his parents (Prather & Golden, 2009).

In 2018 research was conducted on adverse childhood experiences and their effects on chronic disease. Boullier & Blair stated that people with four or more adverse childhood experiences have a high chance of chronic diseases and mental health problems. Chronic heart disease includes cancer, heart disease, and diabetes (Boullier & Blair, 2018).

Natural disasters or accidents and human-caused traumas are the two categories into which psychological traumas fall. Human-made traumatic events can directly affect an individual's beliefs, view of society, and interpersonal relationships. As a result, psychological traumas resulting from human-made events, such as violence and terrorism, are thought to be more difficult and psychologically destructive than traumas resulting from natural events (Hermann, 2016).

Childhood traumas may directly relate to adult mental health problems (Simsek & Evresnel, 2018), such as depression, anxiety, and stress. Adverse childhood experiences are a concept that brings together numerous types of maltreatment that child experience under one umbrella. It allows understanding better complex childhood situations. The long-term consequence of adverse childhood experiences, such as low self-esteem, plays a role in aggressive behaviours (Walker & Bright 2009).

Amygdala is responsible for emotional regulation in the brain. A certain stimulus causes fear which is directly related to the connection between the stimulus and an

adverse event (Tabibnia & Radecki, 2018). For example, if a child is exposed to verbal abuse from his father, he later gets frightened when a man yells because he associates it with past experiences in the amygdala. It can be gradually disappeared when the stimulus occurs with a positive event or when a child lives their presence in a safe environment. Also, it can be changed when the child has a strong imagination and can perceive any potential threats based on past fear experiences (Tabibnia&Radecki, 2018). In 2018, Khodasbandeh and his colleagues researched childhood adversity and its risk factors in a forensic setting. He researched 350 men who were accused of physical aggression. They found that adversity in childhood causes risk outcomes related to violence, aggressive behavior, and low self-esteem in adulthood (Khodabandeh et al., 2018).

A study was conducted on rural postpartum women of Pakistan in 2021 on depression and adverse childhood experiences. A longitudinal study was performed from 2014 to 2016 by using random cluster sampling on 889 women. The result showed that more than 50 percent of women reported adverse childhood experiences. Most commonly, these women faced adverse childhood experiences. Mostly these experiences were physical abuse, emotional abuse, and physical neglect (LeMasters et al., 2021)

A study on aggression was conducted by Erturk, Kahya, and Gor in 2020 with childhood emotional maltreatment (CEM) to check the association between them. They found that early childhood schemas and emotional regulation difficulties link childhood emotional maltreatment and adulthood aggression. The study was conducted on a Turkish sample of 291 participants, 204 were females, and 87 were males using convenience sampling (Erturk et al., 2020). In 2021, at Foundation University in Istanbul, a study was conducted in young adulthood on the relationship between variables of childhood trauma and aggression. The study was conducted on 443 participants who were randomly assigned a sample. Females were 332 and males were 111, with the age range of 18-25. Study results showed a significant correlation between these two variables in young adults (Dinç & Küçük 2021).

A cross-sectional study on adverse childhood experiences with functional identity and impulsivity was conducted on adults in Pakistan. Using convenient sampling, two hundred sixty medical students aged 18 and above were taken from medical universities. The result showed that participants who scored high on adverse childhood experiences reported high impulsivity and disrupted functioning (Sheikh et al., 2018).

This research aimed to determine how adverse childhood experiences impact individual behavior, such as aggression in undergraduates (Pakistan). Adversity often leads to aggressive behaviours such as physical aggression, verbal aggression, anger, and hostility, which could greatly impact their interest in their studies, irritability, and self-confidence. Domestic violence and trauma not only occur in childhood and adolescence but future causes aggression in adulthood (Dinc & Kucuk, 2021). According to Intergenerational transmission theory (Besemer, 2011), children are not passive learners but active learners. They used coping and problem-solving methods when they observed any form of violent behavior in the family. They normalize that behavior and learn it. Therefore, the child adopts it as a method of coping. As a result, they can exhibit violent behavior during childhood and later in adulthood.

Present Study

This research explores the relationship between adverse childhood experiences and aggression. As an existing literature review, there are very few published research on adverse childhood experiences in Pakistan. Most research was conducted in western settings. In Pakistan, due to the sensitivity of this topic, the area is under-researched (Bokhari et al., 2016). This present study aimed to investigate the correlation of the above-mentioned variables in the Pakistani context. Further, aggression has dramatically increased over the past few decades, negatively affecting human interactions and relationships (Zinatmotlagh et al., 2013). Adverse childhood experiences could play a role in aggression among undergraduate students. The negative effects of aggressive behavior impact students' social, academic, and personal life (Smith et al., 1998). The study outcome can help the government implement a maltreatment prevention program as baseline information. Also, this study outcome will help parents, teachers, and therapists about adverse childhood experiences and their consequences on university students. The study intends to find out the relationship between adverse childhood experiences and aggression among university students.

Hypotheses

1. There is a positive correlation between adverse childhood experiences and aggression (anger, physical aggression, hostility, verbal aggression) among university students.
2. Females will report higher adverse childhood experiences than males

Method

Research Design

This study used a correlational research design to determine the relationship between adverse childhood experiences and aggression among university students.

Sample

The sample of the study includes 400 undergraduates. The sample was taken from 3 private and 4 public universities in Rawalpindi and Islamabad. The data was taken from those aged between 18-25 years. Out of 400 undergraduates, 126 students have not reported any adverse childhood experiences. The inclusion criteria for sample selection were age 18yrs or older, currently enrolled in a full-time undergraduate program and without physical disability. The participants were recruited through a convenient sampling technique.

Instrument

Adverse Childhood Experiences Questionnaire. In 1998, the Adverse Childhood Experience Questionnaire **(**ACE-Q) was developed by Felitti et al. It is a 10-item measure. It is used to measure childhood trauma. It measures two broad categories abuse and neglect. In abuse, this questionnaire measures physical abuse, psychological abuse, and sexual abuse. In neglect, it measures emotional neglect, physical neglect, and household dysfunction. A dichotomous scale (yes/no) will use to record responses. The scale shows a reliability of 0.6 to 0.8.

Buss-Perry Aggression Questionnaire. Buss-Perry Aggression Questionnaire (BPAQ) was developed by Arnold Herbert Buss and Mark Perry (Buss, A. H., & Perry, M, 1992). The aggression questionnaire consists of 29 items. The aggression scale includes four subscales (Physical aggression, verbal aggression, anger, and hostility). The test-retest reliability of this aggression questionnaire is 0.78.

Procedure

Permission from universities was taken before data collection. Information was provided about the nature of the research. On the consent form, an e-mail ID was provided to them in case of any queries related to the research. Inform consent was given to the participant in the research. Before starting the main study, a pilot study was carried out on at least 50 students. The data collection was done by directly approaching the students and handing them the informed consent and questionnaires, guiding them to fill out questionnaires and giving them 10-20 minutes to fill the questionnaires. After completion of the given questionnaires, collected data were further analyzed for results.

Ethical Considerations

This present study was conducted with the permission of the authority of the Capital University of Science and Technology. Respondents were briefed about the rationale of the study and to make them aware of how their information was further utilized. Scales were used with the permission of the authors. The consent form was taken for participation in the study. Confidentiality was ensured by anonymizing the information obtained from data collection.

Results and Discussion

Statistical Package for Social Sciences (SPSS version 2021) was used for quantitative analysis. Before analysis, data was entered in SPSS. After that data was cleaned. Then data were further analyzed using this software. Missing values on the SPSS sheet were coded as 9 for the demographics and the administered questionnaire.

For the Distribution of data, descriptive statistics were used. Frequency and percentages were calculated for mean, median, mode, standard deviation, skewness and kurtosis were computed for continuous variables. To check normal distribution of data, value of skewness, kurtosis, normality test and histogram was used for normality testing.

To examine the reliabilities of ACE and AQ by calculating Cronbach's Alpha (α) Inferential Statistics were computed. Pearson Correlation was calculated to see the relationship between the independent variable (adverse childhood experiences) and the outcome variable (aggression). An Independent-Sample t-test was used to examine the gender differences between adverse childhood experiences.

Reliability of Scales and Subscales

Cronbach's alpha for ACE was 0.70, which is considered moderate to good reliability (Zanotti, Danielle C et al., 2018). The Cronbach's alpha calculated by the original author was between 0.6 to 0.8. that is comparable to subscales of ACE in this research. Cronbach alpha for BPAQ was 0.85, for subscales anger = 0.57, verbal aggression =.48, hostility = 0.60, physical aggression = 0.70. Cronbach's alpha found by the original author was 0.72 to 0.80 (Buss & Perry, 1992).

Table 1

Relationship between adverse childhood experiences (ACE) questionnaire and aggression questionnaire (AQ) among university students (N = 274).

Variables	N	*M*	*SD*	1	2	3	4	5	6
1.ACE	274	2.71	1.85	-					
2.AQ	274	90.07	16.70	.26**	-				
3.A	274	20.90	4.92	.17**	.83**	-			
4.PA	274	25.37	6.70	.29**	.82**	.58**	-		
5. H	274	16.12	3.85	.23**	.77**	.53**	.46**	-	
6. VA	274	24.90	5.29	.09	.68**	.44**	.44**	.41**	-

Note: ACE = Adverse Childhood Experiences, AQ = Aggression Questionnaire, A = Anger, PA = Physical Aggression, H = Hostility and VA = Verbal Aggression. *p < .01

It was hypothesized in this study that there is a correlation between adverse childhood experiences and aggression (anger, physical aggression, hostility, and verbal aggression). Adverse childhood experiences have a relationship with aggression (r= .26, p < .01). Adverse childhood experiences have a relationship with anger (r = .17, p < .01). Adverse childhood experiences have a relationship with physical aggression (r = .29, p < .01). Adverse childhood experiences have a relationship with hostility (r = .23, p < .01). Adverse childhood experiences has a relationship with verbal aggression (r = .09, p < .01). Research determines the significant association between childhood trauma and adult aggression (Chen et al., 2011). Results of the current study show a positive relationship exists between adverse childhood experiences and aggression.

Table 2

Gender differences across undergraduates with adverse childhood experiences scores, aggression (1 or more ACE) and aggression (ACE 0)

	Male		Female		*t*	*P*	*Cohen's d*
	M	*SD*	*M*	*SD*			
ACE	2.87	1.96	2.53	1.70	1.52	1.77	.18
AQ (1 or more ACE)	89.90	16.72	90.25	16.73	-.17	.04	.02
AQ (ACE 0)	78.00	17.88	72.23	15.38	1.89	.28	.34

Note: *M* = Mean, *SD* = Standard deviation, ACE = Adverse Childhood Experiences, AQ = Aggression Questionnaire.

Mean difference was analyzed on adverse childhood experience and aggression based on gender. The result of the t-test showed a non-significant difference exists between adverse childhood, which does not support the hypothesis. In 2016, research was conducted on adverse childhood experiences was conducted in Lahore (Pakistan) to study the relation with impulsivity; their result shows men reported more adverse childhood experiences than females (Bokhari et al., 2016). According to the New York Council on Children and Families (2010), men are significantly more likely than women to have adverse childhood experiences. However, they discovered that women experienced sexual abuse and a household member who was depressed, mentally ill, or suicidal at significantly higher rates than men (New York Council on Children and Families, 2010). Moreover, the t-test shows that female students who experience one or more than one ACE

reported more aggression. Also, the present study finds out that students who reported no adverse childhood experiences have no significant gender difference in aggression. These findings would be the cause of social desirability among undergraduates.

Conclusion

This study highlights the gender-specific relationship between adverse childhood experiences and aggression among undergraduate students. It was concluded that a significant positive relationship exists between adverse childhood experiences and aggression among university students. To address ACEs in Pakistan, preventive strategies for gender basis need to be considered. Intervention should be needed for both genders to reduce adverse experiences that begin in childhood and adolescence.

Implications and Recommendations

The present research findings enhance the knowledge that aggression in university students can be due to their adverse childhood experiences. Gender differences in aggression due to adverse childhood experiences are also found. The university wellness center and therapist could use the present research findings to deal with such students' inability to manage their aggression. In Pakistan, preventive programs and campaigns need to be implemented, such as parenting education, early sexual education and mental well-being.

Future exploration may include a community-based approach, in which data may be taken from young adults. Future research should also examine the demographics of socioeconomic status, family system, and class system in relation to childhood experiences and aggression.

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Integration of Analytic Intervene and Autosuggestion in Eye Movement Desensitization and Reprocessing

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Eye Movement Desensitization and Reprocessing (EMDR) is an evidence-based trauma-focused psychotherapeutic intervention for trauma-related disorders. It has especially gained acceptance as the most efficacious treatment for Post-Traumatic Stress Disorder (PTSD). But, in the majority of cases, it is used as a singular module, and there has been no report on the integration of any other psychotherapeutic approach with EMDR in the treatment of PTSD. In this article, two case studies of individuals were described in which EMDR Treatment was conducted according to the standard protocol presented by Shapiro (1995) in combination with a few psychodynamic principles in one or two sessions to resolve trauma effects. It was a supportive therapeutic relationship along with a deeper understanding of the clients' and therapists' unconscious processes. It was called and discussed as "Analytic Intervene'' in EMDR.

Keywords. Eye movement desensitization and reprocessing (EMDR), Post-traumatic stress disorder, trauma, analytic intervention, depression.

Introduction

Traumatic experiences lead to a variety of psychological problems, and PTSD is the most common among them, which also has high comorbidity with other psychiatric conditions (American Psychological Association, APA, 1994; Kessler et al., 1995). EMDR is widely recognized as the first line of treatment for such trauma-related conditions (Hase & Brisch, 2022; Shapiro & Laliotis, 2011). It consists of eight phases such as history taking and preparation of the client, identifying the target traumatic memories, dual-attention stimulation in the form of repeated sets of eye movement, installation, resolving any residual somatic sensations, closure, and reevaluation that address past traumatic events and present triggers of the symptoms (Davidson, 2001; Marcus, 1997; Shapiro, 2001).

Clinical applications of this therapy are primarily explained by the Adaptive Information Processing model (AIP; Hase, 2021), which posits that the direct reprocessing of the stored memories of etiological events and other experiential contributors can have a positive effect on the treatment of most clinical complaints. This prediction has received support in several research studies, including clinical trials and case studies (Hase, 2021; Shapiro & Laliotis, 2011; Shapiro, 2002; Valiente-Gómez et al., 2017). Very limited studies have been conducted to see its effectiveness in Pakistani culture. One such study was carried out by Mustafa (2015) in which the application of EMDR treatment of PTSD along with depressive symptoms in the Pakistani scenario was established (Mustafa, 2015).

In recent years, additional applications have been developed by expanding the standard protocols by experts and consultants in several sub-specialty areas, such as **clients with acute trauma, a wide variety of PTSD, and even trauma-related personality issues (Brown & Shapiro, 2006).** Moreover, components of other psychotherapies have been incorporated into the standard EMDR (Capps, 2006). Similarly, in the present study, two clinical case studies were conducted where psychodynamic psychotherapy was integrated into EMDR as an analytic intervention. We have used it as a strategy to deal with the blocked processing.

Method

The research design of the present research study was a descriptive case series design in which two patients having psychological trauma were enrolled for the administration of EMDR by a therapist through convenient purposive sampling.

The therapist was a consultant psychiatrist and EMDR practitioner. These patients came to the therapist in a public sector hospital for the management of their psychological issues.

After the initial session, their suitability for the EMDR was established through protocol suggested by EMDR, which includes a patient history of psychological trauma, his/her willingness to get EMDR, and his/her positive response during safe place building. They were briefed

about it, and their consent was obtained before the start of treatment. The detail of these two cases is narrated below:

Case Study 1

The patient was a senior Government officer in his late forties and presented with seven monthly histories of low mood and flashbacks of traumatic memories. There were multiple traumatic memories, and the main scene was where he witnessed a massive firing by terrorists.

His sleep and short-term memory caused him some difficulty. Since then, he has had frequent flashbacks of the scenes of firing by terrorists. His sleep was further disturbed over time. He started to use alcohol to relax, but he was unable to concentrate on his sensitive job.

At the same time, he lost an important promotion, and he had a sense of losing his carrier due to the same experience, which was traumatic and now professionally embarrassing as well. He started to feel persistently low and has had frequent reminders of this traumatic event. After seven months of personal struggle, he decided to consult. The patient was fortunate that he had a large support system, including a family who cared for him and an active professional life. He has easy access to psychiatric help. On the first assessment, the Individual simultaneously fulfills DSM IV diagnostic criteria for Post-Traumatic Stress Disorder and Major Depression. After detailed history taking, EMDR was decided as the first line of treatment for him. Six EMDR sessions were done in a total period of about two months.

In the first EMDR session, the Subjective Unit of Disturbance (SUD) was checked with its range of 0 to 10, where 0 means no disturbance and 10 donates maximum disturbance; it was 8 for the major traumatic memories. The Validity of Positive Cognition (VOC) was determined, which has a range of 1 to 7, where 1 has weak positive cognition, and 7 is strong positive cognition, and it was found to be 1 for this patient. Negative cognition was that “I am a failure,” and preferred cognition was that “I am competent and successful.” This session was done as incomplete at the end; SUD was 6 in the next session again, SUD didn't drop below 6, and again it was declared as an incomplete session and ended in a safe place.

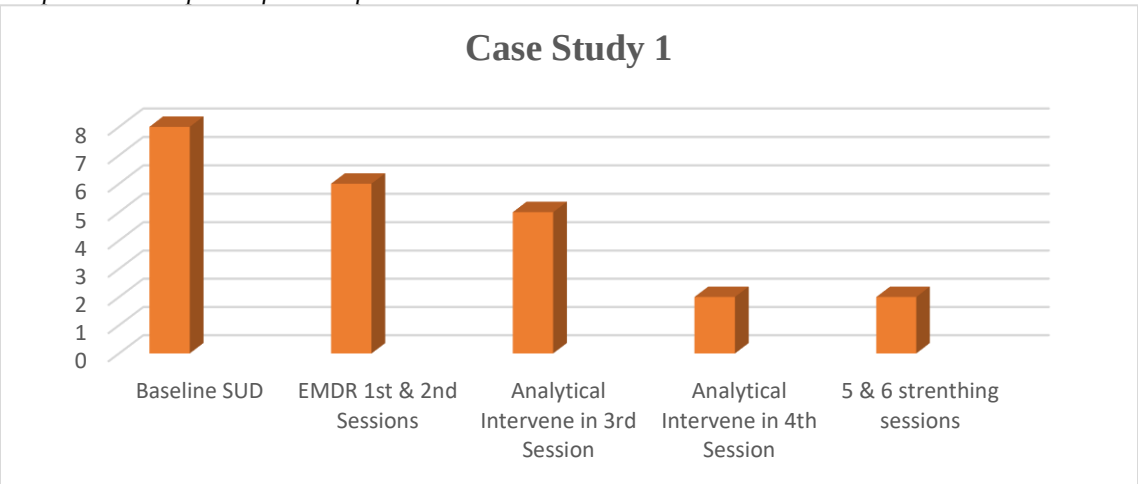
In the third session, Light Stream Technique was also done to soften the image in addition to cognitive

Discussion about the acceptance of himself in the present rank and blocking belief of losing his career after that traumatic experience was challenged in cognitive intervention, but at the end of the third session, SUD was still not less than 5. It was the time that therapist tried to understand the client at an analytic level. The patient talked, and the therapist made interpretations of the patient's words and behaviours. In this broad therapeutic orientation, it was realized that there is a conflict between the desire to get promoted and the social need to adjust to the present rank. Predominant defence mechanisms were intellectualization and denial. He has underlined perfectionist personality traits. After the trauma, this person regressed in the latency phase of his psychosexual development. In the fourth session, the individual was offered support, and his defence mechanism of intellectualization was utilized. During this session, while the patient was doing eye movements, he was suggested to feel comfortable/safe and to encourage himself to participate in this important operation in his country. After that SUD dropped to 2, and the session again ended in a safe place.

In the fifth session, the therapist observed that his mental state had changed. His mood was euthymic. There were no flashbacks or intrusive thoughts. He said, “At first, after the first and second sessions, I was very tired. But then, I was amazed as things lightened up. Now, when I think of the accident, it doesn’t affect me as it used to. It's an amazing phenomenon, and I’m working a few more hours. I feel much chirpier about it and look forward to working more. I want to do things at home. It's lifted a weight - pressure that was overbearing for a very long time. I'm conscious of it not being there. My wife has noticed a difference in me. I think that I might be able to write on "war and peace" based on my views, my own experiences, and knowledge.” The fifth session was a complete session, and major trauma was successfully processed; in the sixth session, minor scenes of traumatic memories were processed completely with standard EMDR protocol. A graphical description of the technique used with Case 1 is given in Figure 1.

Figure 1

Graphical Description of Techniques Used with Case 1



Case Study 2

In the present study, the second patient was 21 years old young adult, an only son of a senior Government officer. He lived in Rawalpindi and was a student for a master's degree. He came with four monthly histories of difficulty interacting with him and in his day-to-day social life. This interaction was unavoidable, and he used to feel sadness and guilt every time after the interaction. He started feeling difficulty concentrating on his studies. These academic difficulties ultimately brought the problem to the surface. Moreover, there were repeated reminders of the traumatic events related to the college. History revealed that the boy had a history of being bullied by seniors; for two days, he decided to quit the academy, and at night he flew away. Soon after that, he realized that he had missed an important opportunity in his life, and now he could never join back.

He spent most of his childhood away from both his parents with his grandparents and uncles. As a child, he had never been able to get attention and respect from his parents. Therefore, as a young adult, he has never been able to make a cohesive sense of self and has a strong unconscious desire to identify with his father to get that attention and respect. His rigid superego does not accept his identity as a civilian and gives him constant remorse and guilt. Moreover, the individual was also facing constant rejection by his father ever since he left the academy.

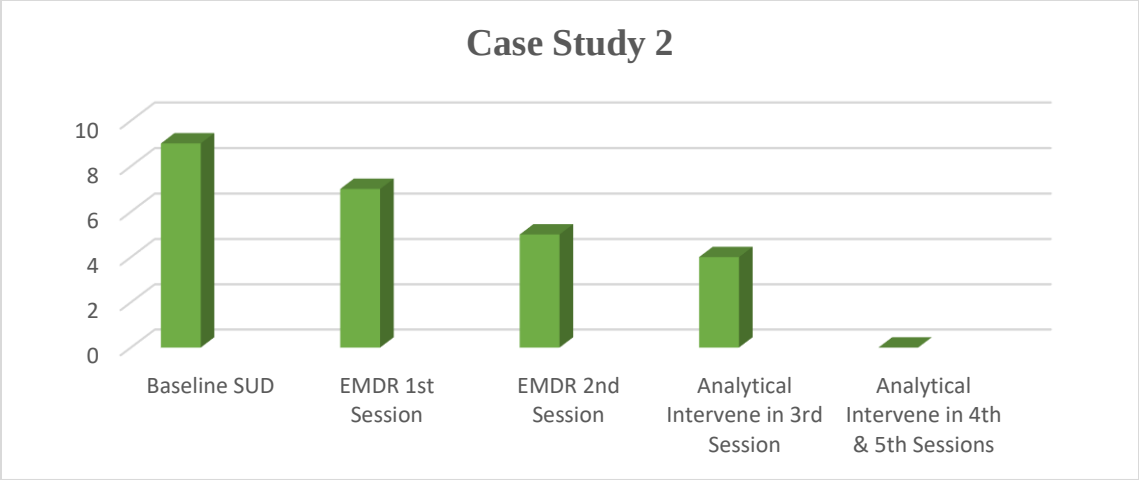
In the first EMDR session, the major traumatic memories were realized to be the scene of leaving the Air Force Academy at night. The subjective unit of distress (SUD) about this event was 9. His negative cognition was That "I am unacceptable," and his positive was, "I can learn to become accepted." The validity of cognition (VOC) was 2. The first two sessions were done as incomplete sessions. His SUDs after the first session were 7, and 5 after the second incomplete session. The individual was grounded with the safe place technique in both of these sessions.

In the third session, the light stream technique was tried. In the beginning, it was followed by an EMDR session, in which SUD dropped to 4. This session again ended as incomplete in a safe place. On the psychodynamic understanding of this student, it was identified that the conflict between the unconscious desire to identify with the military father and the social need to continue life as a university student. His behavior was explained in terms of past experiences and motivational forces. His actions were viewed as stemming from his unconscious desire.

In the fifth session, the client was offered support and acceptance by the therapist in a transference and defence mechanism of repression, and denial was registered for the Analytic Intervene. Transference was encouraged. The defence mechanisms of denial and regressions were supported. The therapist and the co-therapist accepted the individual as a young, educated civilian; the client was encouraged to develop himself in civilian life. He was encouraged to explore himself as a successful civilian. In the sixth session, the SUD dropped to zero. VOC was raised to 7. At this point, he was given insight into his behavior, and defence mechanisms were also brought into his consciousness. A graphical description of case 2 is given in Figure 2.

Figure 2

Graphical description of techniques used in Case 2



Discussion

The current case reports illustrate the importance of EMDR in the treatment of PTSD along with depression in two patients suffering from PTSD/depression in the Pakistani scenario. Patients' traumatic memories were reprocessed into adaptive ones using standard protocol EMDR and additional uniqueness (McNally, 1999). So, these case studies not only measure EMDR effectiveness in complicated trauma clients but also provide a proposal of an explanatory model. It looks at a relatively ignored or unidentified component of the EMDR treatment: the therapeutic relationship and analytic intervention. The unique aspect of these case reports is the integration of EMDR with psychodynamic psychotherapy. The author prefers to call it Analytic Intervene. We suggest that by incorporating key concepts of psychodynamic theory in the EMDR session as an analytic intervention, we can help the client. These basic concepts are early childhood experiences, psychosexual development, the existence of unconscious motivation or conflicts, the existence of ego, the superego, and the existence of defence mechanisms, transference, and countertransference. In analytic intervention like psychodynamic therapy, the patient talks, and the therapist interprets the patient's words and behaviours. Dream interpretation can also be a part of the analytic intervention. It is not recommended that an analytic intervene therapist has to do everything in every session or with every patient. Rather any one or two components from the above-mentioned concepts may qualify it to be called analytic intervention.

It is suggested that this analytic intervention can be used just like a cognitive intervention. Theoretically, it can also include a supportive therapeutic relationship that encourages transference and provides more opportunities to share feelings. The therapist identifies defense mechanisms and notices any arrests in psychosexual development. During the intervention, the therapist supports the healthy defense mechanism. It is proposed that after the analytic intervention, it becomes easier to deal with and reduce subjective distress (SUD) in a few cases. The researcher wanted to introduce it as a remedy for blocked processing and not as a component of standard EMDR therapy. It can also include analysis of transference, interpretation of dreams, and slips of the tongue. Practically at the time of blocked processing, the therapist may choose any of these psychodynamic mechanisms depending upon the individual case or his training and perform an analytic intervention to get the therapy going.

Although cognitive intervention is useful in many cases, it may not be acceptable by a few clients or therapists as it may affect the nonjudgmental stance of the therapist, especially with emotionally charged clients. Analytic intervention, on the contrary, is a supportive technique for a client who is in depression and dealing with traumatic memories. It places emphasis on the influence of experience on the development of current behavior. It emphasizes that previous relationships leave lasting traces which affect self-esteem and may result in maladaptive patterns of behavior, as we have noticed in our second client. An important innovation in our first patient was an auto suggestion. In our first case, during the last three sessions, the patient learned that if

during the session, he felt better with the suggestive statements by the therapist, for example ‘‘I am safe now” he can say this to himself whenever he gets a flashback or gets some disturbance due to the traumatic event. Simply by doing this, he noticed that the symptoms started to improve. This is different from the suggestion of hypnosis, where the patient is in an altered state of consciousness. In the suggestion part of analytic intervention of EMDR therapy, the patient is fully alert and can learn to do this on his own. We like to call it autosuggestion.

Shapiro (2001) views the dynamic of EMDR as one of accelerated information processing or dual attention stimulation; Dyck (1993) suggests a conditioning model, and Armstrong and Vaughan (1996) offer it as an orienting response model (Armstrong & Vaughan, 1996; Dyck, 1993; Shapiro, 2001). None of these models adequately address every aspect of the therapy. While in the present study, the psychodynamic basis of the therapeutic relationship and possible analytic intervention was suggested for future research. There is substantial reason to conclude that a carefully aimed analytic intervention, like cognitive intervention, may have a significant impact. The psychodynamic basis of EMDR is not a new subject. **Felicity de Zulueta (2006) wrote,** “For Freud, as for Shapiro, psychopathology (and dreams) is constructed out of networks of memories; the original troubling memories of childhood experience being subject to strategies of avoidance, yet ever ready to be triggered, with accompanying physiology, when an associative cue is encountered” (Felicity de Zulueta,2006).

There is no single psychodynamic perspective that has general acceptance. But one should also accept that this does not set principles of psychodynamics apart from other specialist fields of psychotherapy. In fact, over the past three decades, there has been a convergence of assumptions across different psychotherapeutic specializations, cognitive–behavioral, humanistic–experiential, and psychoanalytic–psychodynamic. Psychodynamic principles have been recognized as the most comprehensive body of knowledge for understanding the complexity of human subjectivity (Shapiro & Laliotis, 2011). There are a few limitations of this study as well, such as these case reports cannot provide information regarding a control group of individuals who did not receive any EMDR. The ostensible improvement resulting from EMDR in these reports may be due to numerous variables other than EMDR itself, such as placebo effects (Gastright, 1995). It should also be noted that these case studies do not challenge the existing explanatory model of EMDR. It looks at one component of the EMDR treatment. Interestingly, it has also been realized that psychoanalytic experiences in psychotherapies are more like feelings and not thoughts; therefore, become indescribable in thoughts for the therapist himself.

Conclusion

In treating stress-related disorders, EMDR may be seen as having the primary goal of helping clients reprocess information that is held dysfunctional to enhance adaptive functioning. In certain cases, EMDR therapy may get blocked, so it is proposed that therapists may use analytic intervention when working with clients to achieve these goals.

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Why Do People Bully Online? A Qualitative Inquiry of Household Dysfunction among Cyberbullies

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The current study was conducted to explore how household dysfunction affects cyberbullying behavior, building on the findings of past studies. It followed a qualitative exploratory design and a purposive sampling technique. Six participants (4 men and 2 women) with ages ranging from 18-24 years were approached using Facebook comments and screened using the Cyberbullying Scale (Husna, 2020) with a Semantic Differential Scaling Model. Data were collected using the semi-structured interview technique. The two main research questions mapped out the study, including what causes cyberbullying behavior among people and how household dysfunction leads to cyberbullying. Data were transcribed, and codes were assigned by following the guidelines of the instrument's coding manual (Saldana, 2015). Themes were reviewed using the reflexive thematic analysis (Braun & Clarke, 2019). The final themes included parental disengagement, dysfunctional family dynamics, and invalidation. The findings suggest that children's opinions are either silenced or disregarded in their homes, their accomplishments are downplayed, their competence is questioned, there is a lack of parental responsiveness to their needs, and children are singled out for unjustified blame.

Keywords. Household Dysfunction, Cyber-Bullying, Invalidation, Chaotic Family Dynamics, Parental Disengagement

Cyberbullying is a behavior that people use to intimidate someone online or use dehumanizing language against someone. Over the years, children have acquired a tendency toward the internet and mobile phones (Lenhart et al. 2011). These tools send defaming and calumniating content to a third party (Kowalski & Limber 2007).

Although cyberbullying is still a relatively new field of research, cyberbullying among adults is considered to be a serious public health issue. To deal with it, the major causes of it should be identified specifically the role of family dynamics on cyberbullies (Raskauskas, 2015 & Bradshaw, 2017). The social learning theory of aggression by Bandura (1978) is followed in this research. The social learning theory of aggression explains how aggressive patterns develop, what provokes people to behave aggressively, and what sustains such actions after they have been initiated.

Previous studies have emphasized family factors' impact on cyberbullying (Charalampous et al., 2018; Yang et al., 2018). A dysfunctional family is a cause of cyberbullying. In a dysfunctional family, conflict, misbehavior, and often child neglect or abuse by a parent occur continuously and regularly, leading other members to accommodate such actions. Also, higher family dysfunction and poor peer relations were associated with a higher risk of indirect cyberbullying victimization (Hong et al., 2021). Family variables play a key role in cyberbullying perpetration and victimization (Lopez et al., 2019). Studies have shown that childhood psychological abuse is an important predictor of cyberbullying perpetration among college students (Jin et al., 2017a). Adverse childhood Experiences (ACEs) have lasting effects on physical and mental health in youth and include experiences of abuse, neglect, and household dysfunction that led to cyberbullying (Deven et al., 2022). Young adults with higher levels of trait anger tend to experience anger, which may set the conditions for cognitive distortions conducive to justifying cyberbullying and enhancing their moral disengagement (Wang et al., 2017).

Internet frequency was also found to significantly predict cyber-victimization and cyberbullying, showing that as the time spent on the Internet increases, so do the chances to bully someone (Balakrishnan, 2015).

Some studies suggest that aggressive parental communication is related to severe cyberbullying victims, while open communication is a potential protective factor (Larranaga et al., 2016). Parental neglect, parental abuse, parental inconsistency in the supervision of adolescents' online behavior, and family dysfunction are related to the direct or indirect harm of cyberbullying (Hong et al., 2018, Katz et al., 2019). Results reveal that adolescents who their parents neglect are more likely to engage in cyberbullying perpetration (Wang et al., 2022). In addition to this, previous research has also focused on studying the connection between the family context and involvement in bullying or cyberbullying, and this idea has been linked to the parenting styles of the parents. The research seems to point out where the problem may be originating from, but it is still rather imprecise (Nocentini et al. 2018).

The present study aimed to extend prior contributions and provide a comprehensive review of cyberbullying, focusing on the household environment correlating cyberbullying.

Research Questions

What causes cyberbullying behavior among people?

How household dysfunction leads to cyberbullying?

Method

Study Design

The present research followed an interpretive qualitative research design as it tended to focus on meanings from participants 'perspectives (Bevir & Kedar, 2008). It was designed to rely heavily on qualitative data. This study hoped to extract themes from the indigenous data. Moreover, open-ended questions were posed to access and extract in-depth insight into the phenomena under research.

Sampling and Procedure

A protocol was developed on how to access the participants. The entire steps in accessing participants were followed correspondingly. Few posts on Facebook were scrutinized. Different comments on Facebook that reflected bullying behavior were highlighted; thus, participants were reached through Facebook. After this, they were screened using the Cyberbullying Scale. The Cyberbullying Scale was used with a Semantic Differential Scaling Model. Based on the results of the study (Husna et al., 2020), it can be recapitulated that the Cyberbullying Scale is valid and dependable. A cutoff score of 35 on the measure indicates cyberbullying behavior.

Participants scoring 35 or above on the Cyberbullying Scale were recruited for the present study. 10 participants were screened; consequently, 6 participants (4 men and 2 women) proceeded with screening and were selected for ages ranging from 18 to 24 years. They were selected voluntarily on their interests to unbosomer their thoughts about cyberbullying. Moreover, participants who didn't lie between the ages of 18 to 34 years were excluded because the study aimed to seek the phenomena among young adults.

Semi-structured interview technique was used as a data collection method. Questions were asked of the respondents within a predetermined thematic framework. Rubin and Rubin's (1995, 2005) interview guide was followed on how to avoid pitfalls while interviewing.

Information was conveyed to the respondents on how information gained from them will be used. Interviews began with easy questions followed by tough and tricky questions. Interviews were ended with a thank you for acknowledging the respondents

All the willing participants were informed about the selection process and the research purpose. Individuals who were familiar with the experience and were able to maturely communicate their feelings were recruited. Rapport was built between the participants to ensure the quality and authenticity of the research output. To ensure voluntary participation, consent forms were supplied a day before the semi-structured interview session. They were informed about the time and duration of the discussion. Semi-structured interviews were preceded by the following steps:

Succinct interview questions were designed by setting goals on what to achieve from such an interview.

Keeping given selection bias, participants were assembled.

Phone calls as a medium to conduct the interview were chosen.

While conducting the interview, the environmental conditions were kept constant; the tone of voice was moderated to avoid any bias. Data were collected till the point of saturation.

This research included six interview sessions ranging from 20 to 30 minutes to obtain productive and comprehensive data. Sessions were conducted from 12:30 PM to 1:30 PM over the phone. Recruited participants were briefed about the nature and scope of the discussion. All responses were audiotaped, and consent forms were provided to all the participants. Before formally starting data collection, they were briefed about the purpose of the research.

Ethical considerations

All the ethics mentioned in the research protocol were followed. Participants were informed about the purpose of conducting interviews, activities involved, risks, and benefits. The anonymity and confidentiality of participants were supported. Informed consent from respondents was taken to record their audios.

Transcription and Analysis

The obtained data were transcribed by consulting the transcription manual (Dresing & Pehl, 2015). The audio recordings were carefully transcribed in written form. Data were coded by consulting the coding manual for qualitative researchers (Saldana, 2013) and were analyzed by consulting reflexive thematic analysis (Braun & Clarke, 2012).

Data Analysis Strategy

Transcribed data were analyzed and coded by consulting the respective manuals for guidelines. Data was reread to become familiar with what the data entails; then the initial codes were formed. The coding process is rarely completed from one sweep through the data. Codes were refined by adding, subtracting, combining, or splitting content. Data were collapsed into labels to create categories for more efficient analysis. Inferences were made about what the codes meant. Codes were then combined into overarching themes that accurately depicted the data.

Themes were named, and after reviewing the themes and subsequently, the final report was produced.

The themes were merged from the thematic analysis applied to the verbatim transcription of participants.

Theme 1: Invalidation

Invalidation comes when kids' opinions are either suppressed or dismissed and when parents depreciate their children's achievements, making them feel worthless. Children's competence is doubted, and this doubt leads them to suffocate and pass their aggression in many other ways; these kids are often prey to self-doubt. Doubt is an unpleasant experience, and that unpleasant state could be removed by adding meaning to it. The sense of doubt leads to feelings of helplessness (Thompson et al., 2001).

“I worked hard to achieve the first position in my university final exams, but when I shared this exciting news with my parents, they said, it’s not hard to gain the first position in your university.”

“I am good at decision making but my family believes that I make worse decisions”. Repeatedly, respondents reported that they were facing invalidation that indicated self-doubt.

Theme 2: Chaotic Family Dynamics

Parents use a restrictive parenting style that demands compliance with verbal intimidation, and scapegoating was practiced for unmerited blame. Dysfunctional, conflictual family relationships increase social adjustment problems during adolescence, which contributes to the odds of engagement in cyberbullying perpetration (Buelga et al., 2017). In sum, the growing body of studies investigating the role of dynamic family variables has found evidence that family communication and family cohesion are deeply associated with adolescents’ cyberbullying behavior.

A recent narrative review of primary studies about parenting and bullying showed that family contextual factors (e.g., parental mental health and domestic violence) and family relational factors (e.g., child abuse, maladaptive parenting, and communication) were related to more bullying (Novenine et al., 2019).

“My father is a drug addict; we lack basic communication and are often criticized without any particular reason.”

“Yes, I suffered from verbal abuse and hate from my paternal side when I decided to live with my mother after my parent’s separation.”

Responses of respondents showed that they suffered from chaotic family dynamics.

Theme 3: Parental Disengagement

Parents show a lack of responsiveness to a child’s needs. Children receive neglect and little guidance from parents. Parenting is crucial in children’s social, emotional, and moral development. According to Bandura (1991), parents teach moral standards to their children by guiding their behavior and explaining the standards of conduct that are considered right. Hoffman (2000) proposed that a so-called inductive discipline, which consists of reasoning about morally desirable and undesirable behaviors, is often used to teach parental moral values.

Although some studies found that maladaptive parenting is related to moral disengagement in children (Hyde et al., 2010), there is a relationship between parental induction of moral disengagement, moral emotions, and moral disengagement in children, bullying, and cyberbullying.

“Because both of my parents were busy, they pay truly little attention to my daily activities."1 of the respondent was involved in cyberbullying, and responses show that he had affected childhood because of parental disengagement.

Discussion

While research on cyberbullying perpetration among college students has grown during the last decade (Jenaro et al., 2017), cyberbullying attitudes have remained a relatively unexplored field. Therefore, the limited number of studies on cyberbullying perpetration attitudes is generally exploratory (Wong et al., 2017). The findings of this study suggest that parents who don't let their children express their opinions lead to cyberbullying behavior among them. Children derive their self-worth from the support given by their parents. But if parents depreciate the achievements and efforts and belittle the experiences of children can have worse ramifications on them. Thus, they show their inhibited aggression by intimidating someone and posting derogatory comments online. This finding corresponds to one of the previous studies.

Childhood psychological abuse refers to the continuous and repeated adoption of a series of inappropriate

behaviors by adults, including the five types of behaviors, namely, terrorizing, ignoring, belittling, intermeddling, and corrupting, which causes tremendous damage to children's cognitive, emotional, and behavioral development (Pan et al., 2010). It was also found that when parents doubt the competence of their children, they, in turn, cover their hidden negative feelings by doubting themselves. Consequently, they use dehumanizing language against someone on social media. Scapegoating is also found as a form of verbal abuse. Parents distinguish children for not adequately earning blame.

Children threaten others online because of neglectful parenting, lack of affection, and lack of responsiveness toward their needs from parents. All these points are found to the powerful predictors of cyberbullying attitudes among children. The present research aimed to determine household dysfunction's effects on cyber bullies. As cyberbullies were approached through Facebook, they can give socially acceptable statements about not being judged as

"cyberbullies". This is the limitation of the study. Despite this limitation, the finding of this research is novel yet unique.

Conclusion

If parents do not respond well to children's needs, depreciate their achievements, supply little support and scapegoat, this leads to cyberbullying behavior among children. More research on cyberbullying is needed, especially in family dynamics. International cooperation and multi-pronged and systematic approaches are highly encouraged to deal with cyberbullying. Further research should involve large groups to explore the potential causes of cyberbullying.

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The Basic Methodological Concepts of Learned Helplessness Genesis

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The presented article describes the basic conceptual ideas of the theory of learned helplessness genesis. This new theory is based on the learned helplessness concept of American psychologist Seligman (2006), a theory about the cultural and historical development of the human psyche by Russian psychologist Vygotsky (2013) and ideas of transportive analysis developed by Russian psychologist Klochko (2005). The genesis of learned helplessness is being studied in ontogenesis by the analogy with human psyche development. In clarifying the factors determining the learned helplessness genesis, it is important to consider the role of society within which the formation and development of the child's personality take place. It is the behavior models of representatives of the closest adult environment, their style of attribution to their life events and events of the child's life. The common signs of learned helplessness and the four-compound structure of this destructive state are revealed. The vulnerability rating of individual spheres associated with learned helplessness components at different stages of ontogenetic development is described as well as the most influential pathological styles of child-parental relations. The Subjective Questionnaire Assessment of the Learned Helplessness Genesis (Volkova, 2016) was used as a psychological tool for investigating the learned helplessness formation - genesis, which allows building the further strategy of psychological assistance to the person having pronounced features of learned helplessness.

Keywords. Learned helplessness, genesis, subjectiveness, ontogenesis, self-attitude, vulnerability, parental style, and traumatic experience.

Introduction

Contemporary psychology is raising questions for researchers regarding the harmonization of psychological health, increasing the resilience of a modern personality to the effects of negative factors of the stressful external environment. The realities of life require significant resources from modern people to realize their internal potential, independence, ability to overcome difficulties, and skills to plan activities strategically, be active, and persevere in the pursuit of a concrete result. However, solving these life problems is complicated by the presence of a significant contradiction. On the one hand, a rapidly developing technogenic society declares guarantees for the success and prosperity of a person with freedom, self-identity, autonomy, independence, the ability to take responsibility for one own life, uniqueness, and creative adaptation, the ability to change, and develop the world through his unique ways, free and capable of pronounced search activity. On the other hand, the same society pursues the hidden goal of nurturing a person who is comfortable, non-free, flexible, manageable, capable of changing the world within strict limits, predictable, and helpless. Using the term society in this context, we emphasize its polysemantic meaning. We mean society as any association of people, whether it can be a family, educational institution, labor team, or community on interests (Seligman, 2018).

Socio-economic conditions, combined with a reduced level of public mental health, contribute to the formation of learned helplessness from the preschool age, including it in all aspects of life as one of the main mechanisms of human adaptation. The action of the helplessness mechanism itself is reinforced by the belief that the initiative is meaningless, activity is futile, creativity is reprehensible, and canons and regulatory norms of activity are spelled out from the outside (Miller & Seligman, 1976; Seligman, 2006; Volkova, 2018). Confidence in own strength and the positive outcome of any life situation is an integral part of the ability to initiate own activity and to be responsible for its result (both positive and negative). Such an approach forms a subjective attitude to life, activity, personal space, and the temporal continuum (Klochko & Galazhinskij, 2012; Leontiev, 2006; Volkova, 2018; Seligman, 2019). Accordingly, there is an applied and fundamental need to develop a specific technology for the study of the learned helplessness genesis, as well as a system of psychological assistance that can take into account the influence of external and internal factors, psychological and somatic, determining the genesis of the learned helplessness at different stages of human life and in different conditions of its implementation.

Numerous studies organized by Seligman (2006) and his followers since the beginning of the 70s of the 20th centuries made a significant contribution to clarifying the essence, structure, and conditions for the formation of the learned helplessness state (Maier & Seligman, 1975; Peterson, 1993). Interdisciplinary studies at the intersection of physiology, psychophysiology, and

psychology, presented by several research concepts and paradigms, set the main directions in the study of the learned helplessness issue. Even in the studies of the great Russian physiologist Ivan Pavlov, one can find the prerequisites for the emergence of ideas about learned helplessness. In Western science, attempts have been made to study learned helplessness as a state arising as a reaction to uncontrolled, mainly negative events, as well as to explain its connections with the optimistic or pessimistic attributive style of explaining and perceiving life events (Overmier & Seligman, 1967; Seligman, 1975; Fincham, 1986; Peterson, 1993).

In Russian psychological studies, attempts have been made to describe the phenomenon of learned helplessness as a stable trait at a personality level, which is a set of personal features combined with a pessimistic attributive style, neurotic symptoms, and certain behavioral features, the so-called symptom-complex of personal helplessness (Davydova, 2009; Tsiring, 2010; Vedeneeva, 2009; Yakovleva, 2008; Zabelina et al., 2016). At the present stage of psychological science development, in the context of the learned and personal helplessness phenomena study, research is underway on coping strategies, psychological defence mechanisms, socio-psychological features of learned helplessness, and its opposite state of independence. Factors contributing to the formation of the personal helplessness symptom-complex, the structure and psychological content of the autonomy or independence phenomenon are studied, and correlations of the learned helplessness with the state of somatic health at different stages of a person's life are detailed. Research is being carried out on positive personality constructs that increase resistance to the formation of helplessness (Fincham, 1986; Peterson, 1993; Seligman, 2010; Maier & Seligman, 2016; Volkova, 2020).

However, contemporary basic research does not reflect the problem of studying the learned helplessness genesis. Nevertheless, its clarification is seen to be important from the point of view of identifying those "weak" points in the process of ontogenetic development of a person who, being under the negative influence of pathological factors and conditions that determine the learned helplessness genesis, can become the target of psychological intervention aimed at psychological correction, psychotherapy, and psycho prevention of learned helplessness.

Method

In the presented theory, the concept of the learned helplessness genesis is proposed and substantiated at the intersection point of the basic principles of the learned helplessness theory (Seligman, 1975), the concept of the cultural and historical development of the human psyche (Vygotsky, 2013) and the method of transportive analysis (Klochko, 2005). The inhibition of motor activity characterizes learned helplessness, biological motivation is weakened, learning ability is lost, and somatic disorders appear. There is a tendency to generalize, which has arisen in one sphere of life and is transferred to others and rejection of attempts to solve problems based on internal resources.

The analysis of contemporary psychological studies showed that the following points are distinguished as specific features of learned helplessness: violations in motivational, emotional, volitional, and cognitive spheres. The low level of strong-willed qualities development of personality with signs of learned helplessness appears because cognitive features that characterize personal helplessness make it difficult to set goals due to the pessimistic attributive style, reduced creativity, and rigidity of thinking. External motivation and locus of control make a person dependent on other people or circumstances. A pessimistic forecast destroys the meaning of the actions taken, which weakens the strength of motives, complicates the decision-making process, and entails the rejection of the intention and execution of the action

A person's sense of uncontrollability of upcoming and current events entails the development of actual insufficiency of activity control, which subsequently has a direct impact on the reduction of motivation, the ability to learn new ways of mastering life reality, and the manifestation of such negative emotions as an increased level of anxiety, frustration, depression, feeling hopelessness, predestination of being and sadness. The uncontrollability of any activity's consequences naturally forms pessimism, passivity, a steady unwillingness to overcome difficulties, an objective (not subjective) attitude to the environment, and the desire to shift responsibility for the consequences of any activity to external determinants. Moreover, the decisive factor in the mechanism of the learned helplessness emergence is not severe emotional experiences associated with the failure of efforts but an insurmountable sense of uncontrollability, indifference, and despair.

The cultural and historical concept of Vygotsky (2016) includes three complementary parts. The first part contains postulates describing a person's relationship with a natural, authentic derivation (man and nature). Its main content can be formulated in the form of two theses. The first is the thesis that during the transition from animals to humans, there was a radical change in the relationship of the subject with the environment. Throughout the existence of the animal world, the environment acted on the animal, modifying it and forcing it to adapt to itself. With the advent of man, the

opposite process is observed: man acts on nature and changes it. The second thesis explains the existence of mechanisms for changing nature by man. This mechanism is the creation of tools and the development of material production.

The second part of Vygotsky's (2013) concept is devoted to the ratio of man and his inner world (man and his psyche). The first provision is that the mastery of nature did not pass without a trace for man, he learned to master his psyche and he had higher mental functions expressed in forms of arbitrary activity. Under the highest mental functions, Vygotsky (2016) understood the ability of a person to direct his efforts to remember some material, pay attention to an object, and organize his mental activity. The second provision is that a person mastered his behavior and nature with the help of tools, but special psychological tools referred to as psychological tools "signs". As the "signs" of Vygotsky (2013) called artificial means by which a primitive person was able to master his behavior, memory, and other mental processes. At the early stages of the psyche development, the signs were subjects (nodule for memory, a notch on a tree, etc.). The sign itself is not related to a specific activity; its purpose is to recall a certain action, which is important to reproduce. Faced with a similar symbol, a person connected it with the need to perform some specific operation. So, symbol signs were the trigger mechanisms of higher mental processes; they acted as psychological tools.

The third part of Vygotsky's theory (2013) is devoted to the study of genetic aspects, namely the problem of the sign's origin. The basis for the third part of the cultural and historical concept was the postulate, claiming that a person, as a species, was formed in the process of labor. In the process of jointly organized labor activity, communication between its participants took place using special signs defining the specific functions of each of the participants in the labor process. It is believed that in the initial stages, the functions of the person ordering and the person executing these orders were separated and the whole process; by definition, Vygotsky (2013) was neuropsychological, that is, interpersonal. Then this relationship turned into a relationship with self, that is, neuropsychological. The process of turning psychological relations into intra-psychological is called interiorization. During interiorization, external means signs (notches, knots, etc.) are transformed into internal ones (images, elements of internal speech, etc.). In ontogenesis, according to Vygotsky, similar mechanisms are observed. At first, the adult acts as a word on the child, prompting him to do something. Then the child adopts the way of communication and learns to influence the word on the adult. In the third stage, the child begins to influence himself with a word (Vygotsky, 2013).

Ontogenetically, at the initial stage, an adult evaluates a child's actions from outside: initiates the action and assesses it, often negatively, underestimating the degree of efforts and directional intentions invested by the child (often falsely justifying this with a special form of incentive, motivation). At the next stage, the child, being the initiator of the action himself and receiving at the first attempts to achieve what is desired, a result that does not meet expectations, becomes convinced of the objectivity of the external negative assessment, and stops trying to achieve a result close to the ideal model. At the third stage of the internal feeling of learned helplessness formation, the limiting child influences his actions, intentions, motives, will, emotions, thoughts, and, therefore, development - already without the influence of an adult (Vygotsky, 2016). Thus, the closest social environment is crucial to the learned helplessness genesis.

Studying not only the learned helplessness phenomenon content but its genesis, it is necessary to have in the arsenal those methodological tools that will detect the signs of genesis in the stages and periods of the already happened, past life of a person, as well as determine the degree of influence and potential impact of this phenomenon on the subsequent experience of human life. Accordingly, only a method that allows one to investigate the moment the consequences of the past and objectifies potentially possible variations in the future can create conditions for restoring a holistic picture of what is happening in a person (Klochko, 2008). This method of transflective analysis is supposed to investigate a personality at the present moment, taking into account the experience that this person owns due to the past life, as well as hopes and expectations concerning potential prospects (Klochko, 2005).

In this regard, a question arises regarding the objectivity obtained during the study of information, which (in a significant proportion) relates to the period of a person's life that is either no longer (past) or it has not yet happened (future). The answer to this dilemma can be found in Klochko (2007) reasoning about the state of contemporary psychology as a science of humankind: "Psychology is already frankly tired without a person. It has accumulated a large amount of information about the psyche and consciousness, some of which is simply redundant since it is no more than the scaffolding of the building of psychological science under construction…. Studying the psyche outside of man, science gradually ceases to be a science: it begins to wonder why this complex device is needed and what function it performs (in the positive language of science, it is called hypothesis nomination). It seems that it will take considerable time to overcome the textbook truths claiming that the psyche reflects, consciousness

regulates, need finds itself in the subject, attention elects, etc. All this is forced attribution of the role of an active principle to private systems in the absence of a true subject activity - a person" (Klochko, 2007, p.159).

This vision of the psychological problems increases the significance of the subjective attitude of a person to the surrounding reality (by and large, it cannot be objective a priori), to processes, what is happening within the framework of internal experiences, the attitude to these experiences, and to the experience itself, which would seem to be subject to dry objective measurement in units of events, injuries, discoveries, actions, acts, products, relationships, but which remained, remains and will remain that baggage, which from the inside is different than can be seen from the outside, substrate. One more thing is important in designing the basic methodological concepts for the learned helplessness genesis study – the structure of the learned helplessness state, which is presented in four major compounds, reflecting the violations in four personality spheres: emotional, motivational, will, and cognitive.

The following specific markers can identify the learned helplessness in the mentioned spheres.

Table 1

Markers of the Learned Helplessness According to its Generalized Structure

Personality Sphere	Markers of the Learned Helplessness
Emotional	Isolation, indifference, uncertainty, emotional instability, penchant for guilt, frailty, low control of emotions, offensiveness, anxiety, depressiveness, frustration, and asthenia.
Motivational	External locus of control, motivation to avoid failures, low self-esteem, low level of the claim, fear of rejection, extra-intensive motivation.
Will-power	Lack of initiative, indecision, timidity, low formation of self-management and perseverance, insufficient endurance and determination.
Cognitive	Low indicators of divergent thinking (low level of creativity, low divergent productivity), rigidity of thinking, and pessimistic attributive style.

In clarifying the factors determining the learned helplessness genesis, it is important to take into account the role of society within which the formation and development of the child's personality take place. It is the behavior models of the closest adult environment representatives, their style of attribution to their life events and events of the child's life that is a prerequisite for the formation of personal optimism/pessimism of the child, which, being, in fact, a type of attribution, allows or does not allow the learned helplessness phenomenon to arise and gain.

The study of the learned helplessness genesis is achievable in a situation of increasing the significance of a person's subjective perception of his own experience of living in the stages of his life, namely, the study of the past experience, the measurement of the available present, the nomination of hypotheses regarding the foreseeable and unobservable future (which is the key of the helplessness phenomenon is indicated by the level of realized potentials "I can/cannot"), specifically - using the principles of transflective analysis of Klochko (2005, 2007, 2008).

Founding these mentioned ideas as the methodological basis of the study allowed us to design and develop the authentic Questionnaire of Subjective Assessment of the Learned Helplessness Genesis (Volkova, 2018), which is aimed at studying the factors that influenced learned helplessness formation. The reflexive analysis allows revealing markers that can be necessary for further development of psychological assistance in the case of the learned helplessness state finding.

The logic and principles of the Questionnaire design can be summarized, including the importance of subjectiveness in self-perception and self-assignment, understanding of what learned helplessness and its 4-compound structure, formation of learned helplessness by analogy with the processes of interiorization of the sign system in the process of ontogenetic development – studying the relations with others and self-perception, and significance of a person's subjective perception of his own experience (past, present, and future).

The questionnaire is composed of three main blocks (past: pre-school age 5-7 years, junior school-age of 7-11year, adolescence 12-16 years, and youth 16-19 years;

present: actual state; future: "I will be in…"). Each of the blocks contains questions aimed at clarifying the subjective perception of the level of formation of personal spheres related to learned helplessness and the general social situation of the formation of the respondent's personality. The list of questions:

Estimation of the health state (somatic status: did you embrace yourself as healthy or not?)

Estimation of the emotional state (what were the predominant emotions and feelings during this period?)

Estimating the motivation level (was you motivated to engage in any activities?)

Estimation of the willpower level (was it easy or difficult for you to overcome difficulties?)

Estimating the cognitive sphere (did you embrace yourself as a smart kid or not?)

Locus of control estimation (who controlled all your activities: you or someone else?)

Describe the general atmosphere in child-parental relations.

Describe general characteristics of relations with the social environment (friends, relatives, teachers).

Six-year implementation of this authentic questionnaire allowed us to sum up some vivid results in a kind of matrix for identifying targets of psychological intervention aimed at reducing learned helplessness. We analyzed the system of the hierarchical significance of learned helplessness structural components at different stages of its formation during periods of ontogenetic development affected in this study (Volkova, 2020). As generalized results, the table demonstrates a kind of rating of learned helplessness components, among which every one of them plays an important role in the genesis of learned helplessness and, therefore, can be a marker of its formation, as well as become the goal of corrective and preventive measures that will be proposed.

Table 2

Vulnerability rating of individual spheres associated with learned helplessness components at different stages of ontogenetic development

Learned Helplessness Component	Pre-School Age	Junior School Age	Adolescence	Youth
Emotions	1. High level of anxiety	2.	2.	4.
Motivation	2.	1. Low level of learning motivation	3.	3.
Will	4.	3.	1. Low level of will development	2.
Cognitive sphere	3.	4.	4.	1. Low level of cognitive development

Discussion and Conclusion

The main goal of our study was to create an effective research tool to identify the targets of psychological assistance for people with varying degrees of learned helplessness. As theoretical and methodological foundations of the study, we adopted the combined concepts of American and Russian psychology, which, in our opinion, significantly complement and strengthen each other precisely in the context of studying the specifics of the learned helplessness genesis. Applying the described above basic methodological concepts for the learned helplessness genesis study allowed us to develop an authentic diagnostic tool that reveals the weakened spheres of personality during ontogenetic development and cases of traumatic experience that contributed to learned helplessness formation.

The data obtained by means of the Questionnaire of Subjective Assessment of the Learned Helplessness Genesis can be used for the development of the specific system of psychological assistance, which covers such forms of its organization as psychological correction, psychotherapy, and psychological prevention; and is built in the logic of transflective analysis as a method that allows covering three main time intervals of a person's life; that is, psychotherapy is focused on working out the negative experience of the past, which created the

prerequisites for the appearance of a state of learned helplessness, psycho correction is centered on solving problems that are actualized at the moment of the present, psycho prophylaxis is aimed at preventing potentially possible difficulties associated with the state of learned helplessness in the future. Thus, the new theoretical model developed by us and the author's Questionnaire of Subjective Assessment of the Learned Helplessness Genesis partially solves the problem of studying the specifics of the genesis of learned helplessness, opening up prospects for new narrower research projects in this scientific field.

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Psychological Distress and Wellbeing among Victims of Terrorist Attacks: Moderating Role of Resilience

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Terrorism inflicts a long-lasting psychological impact on its victims by affecting their overall well-being; however, limited research is available on protection factors. Hence, the present study aimed to explore the predictive role of resilience for psychological distress and well-being among terrorist attack victims. An Interview based quantitative study design was employed. The study sample comprised 200 Participants (men =100, women =100), with an age range between 18 - 60 years old (M = 30.9, SD = 10.4). Participants included survivors, witnesses, and close family members of the Hazara community living in the terror affected Balochistan province of Pakistan. PCL-5 Checklist, Flourishing Scale and Connor-Davidson Resilience Scale were used to measure the study variables. Findings showed that resilience was negatively correlated with psychological distress and psychological well-being. Moreover, the analyses showed significant gender differences between participants, showing that women scored higher on depression, whereas men scored higher on well-being. The gender difference was found to be insignificant in resilience. Based on the outcomes, it is suggested to include resilience-building initiatives while planning terror victim rehabilitation strategies.

Keywords. Psychological distress, terrorist victims, well-being, resilience

The psychological impact of terrorism on well-being & role of resilience as a moderator

The deleterious effect of Terrorism around the world outstretches beyond the political and economic damage, inflicting psychological distress among its victims. According to worldwide statistics on war and peace, a significant drop in the death toll has been reported (Human Security Report Project, 2013). Despite the significant decrease in wars between countries, acts of terrorism have challenged human security and are enabling dehumanization. Dehumanization explains the mechanism of the impoverishment of human qualities such as honesty, courage, self-awareness, integrity, etc., affecting humans on a personality and spiritual level (Webster, 2016). The rapid cases of terrorism and an intense mode of violence by terrorist groups, brutal and barbaric forms of violence, are spreading fear among citizens across different continents, creating a humanitarian crisis (Waheed, 2018).

Terrorism has a broad impact on culture and disturbs the usual activities of a functioning society by instilling fear among its residents, especially in regions where there is a greater risk of terrorist attacks, such as Pakistan. Between 2003 and December 2017 (South Asia Terrorism Portal, 2017), 22,191 citizens were killed in Pakistan and 6,887 of its rule enforcement administrators due to many terrorist activities. Australia's Institute for Economics and Peace (Global Terrorism Index, 2020) ranks Pakistan seventh in terms of the impact of terrorism. About 867 terrorist attacks have been recorded in Pakistan from 2007 to 2015 on educational institutions, resulting in 392 deaths and 724 injuries (Global Coalition to Protect Education from Attack, 2017). Pakistan is a multicultural and multi-religious country, with 96% of the population. Islam is the dominating religion in Pakistan which is further divided into Sunni-Shia sects. Increasing crime in Pakistan is a direct result of rebellious organizations developing close ties with criminal networks to sustain their activities. Sectarian violence and targeted killings are the new tools of terrorism (Abbasi, 2013).

The Shia Hazara communing, a minority group in Pakistan living in Quetta, Baluchistan Province of Pakistan, has been targeted because of their religious beliefs. Different local armed rebellions combined with sectarian hatred against religious minority groups, such as Shia Hazara Community in Baluchistan (Waheed, 2018), have been targeted by these local insurgents for the past 20 years (Tarar, 2018). Due to their unique facial features, Hazara people are easy to identify; their association with Shia religious sect made them vulnerable to target attacks. According to the National Commission of Human Rights, Hazara Community's entire population comprises around 0.4 to 0.5 million people. They have been targeted for terrorist attacks since 1999, reporting more than 2,000 deaths in the last 14 years (National Commission of Human Rights, 2018). Besides losing their loved ones, they have faced difficulties pursuing higher education. Furthermore, they have been restricted to a specific area due to fear of persecution. According to NCHR report, Hazaras suffer

from several problems, including intense, never-ending violence and limited mobility. This loneliness has led to frustration and despair because being a Hazara seems like a crime.

Psychological sufferings are more prevalent among the victims of terror attacks than physical pain. Most victims appear to have psychological problems, such as PTSD or other similar problems (Gabriel et al., 2007). Different studies have shown the effect of the terrorist attack on the psychological well-being of terrorist victims (Danielsson et al., 2018). However, recent researchers are exploring the role of protective factors in this respect. Resilience is one of the factors that negatively relate to the psychological impacts of terrorism.

The term Resilience refers to the ability to bounce back in the face of challenges. Empirical evidence provides support for the protective role of resilience against mental distress (Kashyap et al., 2014; Singh & Gujral, 2018).

Different aspects of terrorist attacks and the mental health of victims and survivors have been studied earlier; many studies have been carried out to know the effects of terrorism. Most of the research has been carried out in Western countries, and very few have been conducted in non-western societies (Khan et al., 2018; Ramírez et al., 2020; Shah et al., 2018). Most of the available research was focused on survivors of terrorist attacks; however, there is limited research on the family members of victims of terrorist attacks. Most of the families of the victims of terrorism belong to the lower or lower middle class, and many of them have lost their only bread earner of the family. How many incidents affect the families of martyrs also impacts the secondary victims psychologically.

Another point to be highlighted is that each individual responds differently to the traumatic event, depending upon factors such as social context, genetic makeup, past experiences, and expectations for the future (Ursano et al., 1992). Different studies showed different responses to trauma from different genders, such as females reported higher psychological distress than males (Ditlevsen & Elklit, 2010; Haskell, 2010; Irish et al., 2011; Taha & Sijbrandij, 2021). A study (Matud, 2019) shows that males have better well-being overall than females. Also, the presence of resilience within an individual affects the impact of distress on that individual. Thus, this study also highlights the gender differences with respect to the experiences of psychological distress and its effects on their well-being and the presence of resilient skills among its participants.

According to Cuijpers et al. (2009), psychological distress refers to non-specific symptoms of stress, anxiety and depression. Among these issues, post-traumatic stress disorder (PTSD) is a psychological disorder that can occur due to any traumatic experience, such as accidents, natural disasters, terrorist activities, etc., in which the victim may have witnessed death, injury, or any type of physical harm to self or others (Lin et al., 2007; McManus et al., 2007), in response to which victim may manifest symptoms of PTSD. It is a disabling condition that includes nightmares, flashbacks, avoidance and numbing, and hyper-vigilance. According to the APA (2013), out of other mental health-related issues, PTSD is the most frequently occurring disorder after any experience of a traumatic event. Terrorism has influenced the mental health of almost all of its victims, either in the form of PTSD or other related mental health problems (Gabriel et al. 2007). In a study conducted on 1200 veterans, Jordan et al. (1991) estimated that participants currently working in combat forces had PTSD symptoms for about 15%, whereas 30% of the participants developed PTSD throughout life. Also, another study conducted to examine the prevalence and characteristics of post-traumatic stress disorder showed that 28-35% of participants who were directly exposed to terrorist attacks develop PTSD symptoms (Lee et al., 2002).

This current study investigates two aspects of physiological suffering, that is, PTSD and Depressive symptoms. Depression and anxiety are categorized as psychological distress (Mirowsky & Ross, 2002). The research examined the frequency and features of post-traumatic depressive illness in the aftermath of the 9/11 attack and found that nearly 30 % of those subjected to a violent act acquired illness. (Lee et al., 2002), 29% and 31.9% prevalence rate of PTSD was found among females and males, respectively, in a study by Duhok et al. (2021). In a study of Pakistani rescue workers, 15% of participants had clinically relevant PTSD symptoms (Razik et al., 2013).

According to various epidemiological samples, 50% of persons with PTSD are likewise affected by depressive symptoms (Breslau et al., 1997). A study by Kessler et al. (1995) revealed that 48 percent of males and 49 percent of females who faced PTSD had depression too. According to a meta-analysis, around 52% of people with present PTSD also have MDD (Rytwinski et al., 2013). Depression can affect your health and well-being directly and indefinitely. According to research by Flory and Yehuda (2015), the latent structure of PTSD comorbidity shows that people with PTSD who report high negative affectivity and low positive affectivity are more likely to have a comorbid diagnosis of depression

Psychological well-being is a complex construct that concerns optimal psychological functioning and experience. Danier (1984) postulated three distinct

features of wellness in one's life: frequent positive affect, infrequent negative affect, and cognitive evaluations such as life satisfaction. Based on this conceptualization, subjective well-being is measured and assessed as a tripartite construct indexed by (high levels of) life satisfaction and positive affect as well as (low levels of) negative affect (Busseri & Sadava, 2011; Diener, 1984).

A study conducted by Shah et al. (2018) showed that adolescents' psychological well-being was negatively impacted by fear of terrorism. Another study (Khan et al., 2018) found that participants with low psychological well-being levels were likely to have depression. Socio-demographic trends were also significant in this study.

Resilience has been defined by Murphy (1987) as a generic concept concerned with how people cope with stress and how they recover from trauma. It consists of traits such as positive coping, harmony, and compliance. Resilience means adapting and coping with life's calamities and setbacks and not falling apart. Resilience plays a significant role in buffering psychological distress. Different research has studied the protective role of resilience against mental distress. A significant negative association was seen in a study between resilience and depression, stress, and anxiety. A moderated relationship was also observed between COVID-19 and anxiety symptoms with resilience (Traunmüller et al., 2020). In another study, resilience moderated the negative impact of perceived stress on depressive symptoms (da Silva-Sauer, et al., 2021). In a study conducted by Jong-Ku et al. (2016), the role of resilience as a protective factor against PTSD was identified. Their results showed that participants having high self-resilience had lower PTSD symptoms than those with low self-resilience.

Resilience is a personality attribute that vaccinates people from the impact of negative experiences (Connor & Davidson, 2003; Hu et al., 2015). A research study was conducted by Singh and Gujral (2018) to analyze the moderating effect of resilience on role stress and to increase the understanding of how variables like hardiness, internal locus of control, humour, positive outlook, self-efficacy and assertiveness help in developing resilience. The research findings validated the moderating effect of resilience on role stress through critical review and concluded that resilience could be developed over time, and it has a positive outcome in reducing stressors, including role stress. On the other hand, to our knowledge, there is a research gap in exploring the moderating role of resilience for psychological distress and well-being in terrorist victims in Pakistani culture. Hence, the present study focused on addressing this gap in the existing literature.

The rationale of the Study the government has focused and invested a considerable amount of energy and resources in reducing and eliminating terrorist attack incidents while at the same time paying no attention to the victims of such inhumane attacks. Unfortunately, the bereaved families of martyrs are barely remembered, and their sufferings are almost overlooked; they are forgotten entities in our country. This research aims to examine the effect of resilience on the psychological distress and well-being of terror attack victims belonging to the Hazara community. Hazara Community was selected as a sample as it has been constantly targeted by terrorists for the past 20 years (Tarar, 2018), with 2,000 taking allegedly being murdered in the last fourteen years alone (NCHR, 2018). By estimating the impact of psychological distress on the well-being of victims, a proper program for the elimination of psychological distress specifically caused due to PTSD symptoms could be introduced.

Objectives

The objectives of the present research were:

To explore the relationship between psychological distress (i.e., symptoms of PTSD & depression) and the well-being of terrorist attack victims of the Hazara community.

To study moderating effects of resilience between psychological distresses (PTSD & depression) and wellbeing among terrorist attack victims of the Hazara community.

To examine gender differences in the experience of psychological distress, well-being, and resilience among victims of a terrorist attack from the Hazara community.

Method

Sample

This research was conducted on terrorist victims of the Hazara community belonging to one of the affected areas of Pakistan, Baluchistan. The study sample consisted of 200 participants (males = 100 females = 100) having age range between of 18-60 years (M = 30.9, SD = 10.46; 104 participants from 18-30 years, 55 from 31-45 years and 41 participants were in age range of 45-60 years). Victims included survivors, witnesses, and close families of martyrs of the Hazara community were assessed. About 88% of the population had experienced direct threats or injuries during their traumatic experience.

Participants Selection Criteria

Victims of the terrorist attack, which included survivors, witnesses and close families of martyrs of the Hazara community, were assessed. Those who could

comprehend the Urdu language were included in the study.

Individuals lesser than age 18 were excluded from the study. Those individuals who have only heard of terrorism but have not experienced the trauma directly or do not fall into either of the prior options were excluded from the study. Those not suffering from any other psychiatric disorder and taking treatment for that per se were also not included.

Instruments

The following instruments were used to assess the participants on the given variables of the study.

Demographic Data Sheet. A demographic data sheet was created, including the respondent's age, gender, education, and questions related to trauma history, e.g., identifying the event, the number of years of exposure to a traumatic event, how the event was experienced and who was the victim.

PTSD Checklist 5 (PCL-5). Urdu-translated PTSD Checklist for DSM-5 (PCL-5; Samsoor et al., 2020) was used to assess psychological distress. It is a 20-item self-report measure that covers 20 signs of PTSD symptoms according to DSM-5. The total symptom severity score is from 0-80. The score ranges from 0-5, where 0 represents a symptom that does not present at all. A total of 10 items from the PCL-5 were evaluated for assessing symptoms of depression and ruling out the possibility of sadness (Questions 9-20). These were Questions 9-20, eliminating questions 10 and 17. Every question was given a rating of four, for a maximum of forty points. The trimmed number for sadness to be considered accepted was set at 50%, resulting in a trimmed value of 20. PCL-5 shows great interior steadiness (Cohen et al., 2015). The authors have reported satisfactory alpha coefficients of the measure.

Flourishing Scale. Urdu version of the Flourishing Scale (Choudhry et al., 2018) was used. This eight-item is a valid and reliable scale that assesses subjective wellbeing among individuals, originally developed by Diener et al. (2009). Scales anchors consist of 7 options, from strongly agree to strongly disagree with the statement. A score between 8 and 56 represents psychological well-being, whereas higher scores in the result show a high level of wellbeing in the respondent. The reliability tests of the flourishing scale confirmed that the values of Cronbach's alpha coefficient (α = .81) and test-retest (α .82) were acceptable. The Urdu version showed high consistency reliability of alpha coefficient (α = .91).

Connor-Davidson Resilience Scale (CD-RISC-10). The Urdu version of the

Connor-Davidson Resilience Scale (CD-RISC-10) (Connor & Davidson, 1993) was used to test the resilience of the participants. This 10-item scale had scores ranging from 0 - 40, each of which was scored from 0 - 4. The result's highest score shows a higher resilience level in participants. Urdu version scale shows high alpha reliability, i.e., α = .87 (Ghulam et al., 2016).

Procedure

Since the researcher belonged to the specific affected community, he was socially able to approach and negotiate with Hazara Community victims. Written informed consent was acquired from all participants before filling out the questionnaire; afterward, Participants were asked to answer the questions from the questionnaire. Questions were asked of the respondents in a structured interview style. Any participant who was not comfortable with the questions in the questionnaire and wanted to leave the interview even during the administration of the survey was permitted to leave at any point. Members were briefly informed about the objective of the research. The study was approved by the Ethics Committee of the University.

Participants were assured that participation would be retained confidential and the responses would only be used for research purposes. Consent forms were also given to the participants for their willingness for the research purpose. Members were briefly informed about the purpose of the research, the nature of the interview and questionnaire, and its implications. Every respondent that felt uncomfortable with the questionnaire's inquiries and wished to quit the session anywhere at any time was free to do so. The Ethics Committee also approved the study of the University

Results

Data collected in the research were analyzed through the Statistical Package for Social Sciences (SPSS)-25 version. Descriptive statistics of the study variables were calculated. To assess the correlation among study variables, correlational analysis was performed. Linear regressions were used to quantify the significant impacts of the independent factor on the dependent variable. Moderation analysis was also performed.

Table 1

Descriptive Statistics and Psychometric Properties of the Study Variables (N = 200)

Variables	*N*	*M*	*SD*	A	Min	Max	Variance	Skewness	Kurtosis
PTSD	20	2.97	.35	.74	1.30	3.50	.12	-2.12	5.98
Depression	10	2.88	.41	.62	2.6	3.0	.17	-2.28	9.85
Resilience	10	2.86	.66	.86	2.4	3.1	.44	.17	.16
Wellbeing	8	3.05	1.1	.93	2.8	3.2	1.37	1.28	.51

Table 1 represents the descriptive statistics of the study scales, which includes mean, standard deviation, values of skewness, and kurtosis of scales. The PTSD scale consisted of 20 items (α = .74), the Depression scale consisted of 10 items (α = .62), Resilience scale consisted of 10 items (α = .86) and the Wellbeing scale consisted of 8 items (α = .93).

Table 2 Correlational Among Study Variables (N = 200)

Variable	1	2	3	4
PTSD	-			
Depression	.92**	-		
Resilience	-.47**	-.41**	-	
Wellbeing	-.52**	-.50**	.76**	-

**p< .01.

Table 2 shows that depression and PTSD are highly positively correlated. Resilience is negatively related to PTSD and depression, while it is positively correlated with wellbeing. PTSD and depression are negatively related to wellbeing.

Table 3

Moderating Role of Resilience for the Relationship Between Psychological Distress and Psychological Well-being (N = 200)

	Unstandardized coefficient		Standardized Coefficient		
Model	*B*	*SE*	*β*	*t*	*p*
(Intercept)	-2.75	1.89		-1.45	.148
P-Distress	.41	.31	.27	1.33	.185
Resilience	2.43	.51	1.3	4.76	.000
Distress*Res.	-.21	.08	-.67	-2.51	.013

Table 3 shows the moderation effect of resilience between psychological distress and wellbeing. The result reveals that the interaction of resilience and Psychological distress has a positive effect with p-value < 0.05. ($R^2 = 0.636$, F (1,199) = 114.1, p < .05).

Gender Differences in Psychological Distress (PTSD & Depression), Wellbeing and Resilience

An independent sample t-test was conducted to explore gender differences between men and women.

Table 4 shows significant gender differences in psychological distress (PTSD & depression) and wellbeing. Women report more psychological distress as compared to men, while men score high on psychological well-being. There are no significant gender differences in resilience.

Table 4

Gender Differences on Psychological Distress, Psychological Wellbeing and Resilience (N = 200)

	Men		Women				95% CI		
	M	*SD*	*M*	*SD*	*t(198)*	*p*	LL	UL	Cohen's d
PTSD	2.90	.43	3.05	.23	-3.02	.003	-.24	-.05	0.43
Dep.	2.81	.50	2.96	.27	-2.65	.008	-.26	-.03	0.37
Res.	2.92	.68	2.80	.64	1.25	.651	-.67	.30	0.18
WB	3.22	1.2	2.88	1.02	2.09	.001	.01	.66	0.30

Note. CI = Confidence Interval; LL = lower limit; UL = upper limit; Dep. = Depression; Res. = Resilience; WB = Wellbeing.

Discussion

The study's main objective was to explore the relationship between psychological distress (i.e., PTSD & depression) and the well-being of terrorist attack victims of the Hazara community. Resilience, having the adaptive ability to cope with stress, trauma, and adversities (Luthar, 2006), has been studied as a moderating factor between psychological distress and well-being.

The prime objective of the study was to examine the relationship between psychological distress and wellbeing among terrorist attack victims. The present study showed a negative association between wellbeing and psychological distress. The main objective of the present research was tested by linear regression analyses, the result of which suggested that psychological distress explained 27% of the variance; and that psychological distress significantly predicts wellbeing among terrorist attack victims.

The findings of our study are consistent with previous studies. For example, a study investigated the impact of distress on the wellbeing of trauma survivors and found a negative correlation between PTSD and wellbeing (Wang et al., 2005). Another study showed that treating symptoms of PTSD and depression significantly improves the overall well-being of an individual (Berle et al., 2018). According to another study, psychological distress, social support, and coping strategies predicted psychological well-being for internally displaced persons (Oginyi et al., 2017).

Objective 1 validated the model of wellness by Danier (1984), that subjective well-being (Andrews & Withey, 1976; Bryant & Veroff, 1982; Diener, 1984). The negative association of psychological distress caused by terrorist attacks with the wellbeing of terrorist attack victims supports the fact that terrorism or terrorist attacks challenge an individual's existence and safety; this scarcity of safety needs affects the growth of other areas of life (Ryff & Singer, 2008), such as the esteem and self-actualization in individual's life which consequently impacts the sense of overall wellbeing. The findings of our study are also consistent with the results of the study, which was done to evaluate the effectiveness of treatment programs for PTSD and the comorbid symptoms, which shows significant improvement in the personal wellbeing of clients across the 9-months of the study, indicating that reduced symptoms of psychological distress were associated with improvements in overall personal wellbeing (Berle et al., 2018).

The second objective of the research was to explore the moderating role of resilience in the relationship between psychological distress and wellbeing among terrorist attack victims. The findings of the present research support the moderating role of resilience between psychological distress and wellbeing, suggesting that resilience exerts a strong influence on the impact of

psychological distress on the wellbeing of terrorist attack victims. Past literature also showed that resilient people had been found to demonstrate characteristics of effectiveness, high expectancies, positive outlook, self-esteem, internal locus of control, self-discipline, good problem-solving skills, critical thinking skills, and humour (Garmezy, 1991). This notion is supported by the factor model of resilience, which includes personal competence, trust in one's instincts, tolerance of negative affect, strengthening effects of stress, positive acceptance of change, secure relationships, and control (Connor & Davidson, 2003).

Our findings are consistent with past literature. A study conducted by Kashyap et al. (2014) showed that resilience significantly buffered the impact of stress on psychological health. Another study also confirmed the moderation effect of self-efficacy as a component of resilience, which showed that self-efficacy had a direct negative effect on the fear and distress of traumatic events (Mumtaz, 2021). Findings of another research elaborated that a higher level of resilience was associated with lower levels of anxiety and depression symptoms. Additionally, the more resilient individuals recovered from these symptoms after three months, while the less resilient individuals did not show any significant improvement (Leys et al., 2020).

Our last objective was to examine gender differences in psychological distress (PTSD and Depression), wellbeing and resilience in terrorist attack victims. Data were analyzed through a sample t-test. The results of the analyses supported the hypothesis and found significant gender differences in PTSD, Depression, and wellbeing of participants, whereas the gender differences were insignificant in resilience among participants.

Our study is consistent with the findings of the previous studies; Females are at higher risk than males for developing post-traumatic stress disorder symptoms (PTSD) following exposure to trauma (Ditlevsen & Elklit, 2010; Haskell, 2010; Irish et al., 2011; McManus et al., 2007). Taha and Sijbrandij (2021) conducted a cross-sectional survey on 358 female and 464 male adults living in Duhok, Iraq. Their results showed that females reported more somatic and depressive/anxious symptoms than males following a traumatic event. Similarly, results showed that females are more likely to suffer from depression after a traumatic event which is also consistent with previous studies (Harkness et al., 2010; Wang et al., 2019; Young et al., 1990). The present findings also showed significant differences, with the mean score for males being higher than for females. Hence, this confirms that men have better wellbeing overall than women in the current sample, which is consistent with the similar finding where statistically significant differences were found between women and men in some psychological well-being dimensions, with men scoring higher than women (Matud, 2019). The same results have also been found in individualistic countries, such as the United States (Ryff et al., 2006), and in collectivistic countries, such as Japan (Karasawa et al., 2011).

The t-test analysis of gender differences in the resilience of participants in the current study showed no significant differences in the scores for female and male participants. The findings are consistent with the studies where the magnitude of the difference in the means of the level of resilience was found to be very small hence showing no significant gender difference in the resilience of participants (Ebrahimi et al., 2012; Karairmak, 2010). A study conducted on earthquake survivors in Japan also found no difference in resilience levels (as measured by RISC-25) for men and women (Tsuno et al, 2014). Likewise, Liu et al. (2015) also reported insignificant gender differences in levels of resilience in large Chinese community samples. In another study done by Terrill et al. (2016), gender differences in levels of resilience were assessed in a sample with physical disabilities; however, nonsignificant gender differences were found in the sample.

Limitations and Recommendations

For the purpose of an in-depth understanding of the relationship of our variables, participants were chosen from a specific region of Quetta, Baluchistan as incidents of terrorism highly impact it. This prevents the inclusion of other subcultural perspectives or factors from other populations. The study only comprised participants having an age range from 18-60 years; however, individuals below 18, especially children and adolescents, were not included in the study due to the sensitivity of the research and the time constraints in taking parental assent. The research findings being limited cannot provide the difference in levels of the study variables due to development differences displayed by individuals below the age of 18 years. Based on these limitations, it is recommended to collect data from the vast population in terms of age, socio-cultural factors, and region. Furthermore, research needs to be conducted to investigate the specific mechanism by which resilience may help readjustment in individuals after traumatic events; thus, a qualitative account of these experiences may be taken into account in future to further ameliorate the research outcomes.

Study implications

The government has focused and invested a considerable amount of energy and resources in the reduction and elimination of terrorist attack incidents and has not paid sufficient attention to the victims of such attacks. Families of martyrs of terrorist attacks are forgotten entities in our country. As a result of this research paper, we have identified major psychological challenges faced by victims of terrorist attacks. These suggest possible solutions to alleviate psychological discomfort and shift the focus on the help and rehabilitation of terror attack victims. It is recommended that victims' mental health and well-being be considered when formulating policies to address terrorist attacks. Additionally, this research revealed the importance of resilience-building, a tool that supports the general population in dealing with life's challenges. Our findings proposed that psychological distress caused due to the traumatic experience of terrorist attacks affects the wellbeing of victims but constructing resilience among the victims of terrorist attacks population through training experiences may be crucial in ensuring preparedness for high contesting environments and adjustments after such traumatic experiences. Based on the outcomes of the study, it is also recommended to design a resilient building program to strengthen the inner self and be able to process and overcome hardships, specifically in the context of terrorism.

Conclusion

The result of the current study concludes that there is an association between psychological distress and well-being among terrorist attack victims of the Hazara community. A positive correlation was found between PTSD and Depression, while a negative correlation was seen between Psychological Distress (PTSD & Depression) and well-being. Moreover, resilience moderated the relationship between psychological distress and well-being. Resilience reduces the severity of psychological distress. Thus, having strong resilience among terrorist attack victims is considered an important factor in improving their well-being. Having strong attributes that encompass resilience, such as personal competence, trust in one's instincts, tolerance of negative affect, positive acceptance of change, and Control, seem to affect the relationship between psychological distress (PTSD & Depression) caused by terrorist attack incidents and the Wellbeing of victims.

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Conflict of interest. None to declare

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9th International Conference 2022

Call for Contributions and Peer Reviewers

Voices Against Torture - VAT journal is a semi-annual journal launched in 2020 as an organic extension of the education, advocacy, and community-building mandate of the Vancouver Association for the Survivors of Torture (VAST). VAT operates in alignment with the values and vision of the VAST community and hopes to lift the voices of torture survivors further to support resilience and dignity.

VAT aims to provide a platform for discussing torture prevention, improving awareness of and support for refugee and immigrant mental health, and highlighting global human rights concerns.

As an interdisciplinary and transdisciplinary journal, VAT invites submissions from a wide range of academic disciplines and actively seeks collaboration and conversation across disciplines. This approach intends to link theory and lived experience to social change, bringing together academics, activists, educators, therapists, healers, and those directly and indirectly affected by torture.

The Journal will consist of the following sections:

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- Follow APA 7th referencing and citation style consistently.

- Tables and figures should be inserted within the body of the text.

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Help Eliminate Torture: S.O.S. Appeal

Dear Patrons and Friends,

We, the Members of the Editorial Board of the Journal on VAT (Voices Against Torture- a newly incepted policy research communication organ of Vancouver Association of Torture Survivors (VAST), are gravely concerned over the worsening and deepening state of Torture in many parts of the world- Prohibition of Torture Index 2019-20 (Statista- https://www.statista.com/statistics/1131048/prohibition-of-torture-index-in-cis-by-country/).

As rightly maintained by World Organization against Torture, "Nothing can justify torture under any circumstances (OMCT- https://www.omct.org/), for it is tantamount to imprisoning both mind and souls. And not only that Torture leaves a lasting scar on the bodies and the minds of its victim(s), but as its psycho-social sequel, it also becomes a weeping wound for generations. In the recent past, an exodus of refugees (UNHCR - https://www.unhcr.org/figures-at-a-glance.html), from many countries; and violence perpetrated against women (BBC- https://www.bbc.com/news/av/world-53014211) and neglect and abuse of the elderly during the Contagion COVID pandemic (AGE Platform Europe- https://www.age-platform.eu/press-releases/elder-abuse-has-been-rise-during-COVID-19-pandemic-it-high-time-take-it-seriously) signifies the emergent need to help arrest torture becoming endemic, as stipulated in humanitarian and human rights law, which has unfortunately taken a contagious proportion. In this backdrop, the emergent need for evidence-based/ informed policymaking & advocacy around human rights; and rehabilitation & mainstreaming of torture victims needs hardly any emphasis. VAST, being mindful of this emergent need to cultivate respect for human rights as an underpinning factor for human security and containment of Torture worldwide, has chosen to reach out to the global stakeholders through VAT Journal.

Alongside VAT Journal, we plan to hold international & regional workshop(s) via both in-person and online platforms. With this initiative, we aim to help spread awareness in trauma recovery and further educate in civil society, academia, and the public sector to help develop Human Rights advocates and empower practitioners to help lead from the front lines of eradicating Torture from our world.

We at VAT Journal Editorial Board, through these lines, seek the support of the international community to join their heads and hands in this noble and emergent cause for the public good.

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