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EMOTIONAL DYSREGULATION, COPING STRATEGIES AND POST-TRAUMATIC STRESS SYMPTOMS AMONG ADOLESCENTS LIVING AT LINE OF CONTROL (LOC)

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Summary

Background: *The current research investigates the relationship between Emotional Dysregulation, Coping Strategies and Post-Traumatic Stress Symptoms in adolescents living at Line of Control (LOC).*

Subjects and Methods: *Cross-sectional research design was used. The sample of 400 adolescent participants was drawn from different private and government schools by using convenient random sampling. The tools employed for collecting data included Difficulties in Emotion Regulation Scale (Gratz & Roemer 2004), Coping Strategies Scale for Adolescents (Sharif & Saleem 2014), and Post-traumatic Stress Symptoms Checklist (Foa et al. 1993).*

Results: *Results of the study revealed that Emotional Dysregulation and Emotion Focused Coping had a positive and highly significant relationship with Post-traumatic stress symptoms. It was also revealed that Emotional Dysregulation and Emotion Focused Coping positively predicted Post-Traumatic Stress Symptoms. Implications of the study and a few limitations have been discussed.*

Conclusion: *The findings of this study will help in regulating adolescents' psychological well-being by helping future researchers in not only understanding the coping strategies these children are employing at the moment but also developing and enhancing in them the healthy coping styles which they are currently not using. Furthermore, the unique nature of non-combatant civilian trauma remains to be understood from several other perspectives, to which this research was only a foundation stone.*

Keywords: *Line of Control, LOC, combat, military, Emotional Dysregulation, Post-Traumatic Stress Symptoms, Problem Focused Coping, Spirituality*

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INTRODUCTION

Research show that civilian mental health remains to be influenced the most as a consequence of war. Incidence and prevalence of psychological illnesses have markedly increased due to vary many forms of violence, as shown by many recent studies. Furthermore, children, elderly and the disabled persons are found to be amongst the most vulnerable strata as well. Degree of trauma and availability of emotional and physical support are significantly associated with prevalence rates. Data from developing countries frequently exhibit the use of religious and cultural coping strategies. Higher rates of psychological problems linked with trauma are most often found in children, especially those of Palestinian origin. In terms of the age-group, adolescence has emerged as the most at-risk population group. A number of studies advocate a direct relationship between the intensity of psychological issues and the degree of trauma. The greater the exposure to trauma – either of psychological nature or physical– the more debilitating are the complaints (Murthy & Lakshminarayana 2006).

Man perpetrated acts of violence such as war and terrorism have the tendency to psychologically and emotionally affect young people, especially children for the rest of their lives. A study conducted by Freh, Chung and Dallos (2013) concluded that a vulnerability to develop some form of psychopathological symptoms, PTSD, and lower psychosocial functioning is found to be present in one out of every three children residing in or around war zones; this is an inkling toward how violent and volatile their immediate environment is. Prolonged exposure of children to war-related stressors can manifest in posttraumatic stress related symptomatology which is often characteristic of anxiety and stress disorders including but not limited to PTSD, disruptive behaviors, depression and somatic symptoms (Allwood et al. 2002).

Individuals who had experienced severe and intense stressors during their developmental and growing years have neurobiological effects and many other psychological problems such as the risk of anxiety, emotional dysregulation, PTSD, aggressive decontrol problem, mood disorders, and low coping abilities (Schneiderman, Ironson & Siegel, 2008). Moreover, in support of emotional dysregulation in this population, research suggests that adolescents who face a constantly stressful environment have difficulty controlling their feelings appropriately (Silk, Steinberg, & Morris, 2003). It has been indicated that adolescents exposed to bombing are more vulnerable to developing emotional distress. These adolescents can develop PTSS in response to a diverse range of stressors. Due to these stressors, identity crises were developed during the adolescent time period (Duffy et al., 2015). Literature also suggests that if adolescents have prolonged exposure to traumatic circumstances, there are more chances to develop "disorder of extreme stress" (a complex form of PTSS) (Iribarren, Prolo, Neagos, & Chiappelli, 2005).

Barakovic et al. (2014) set out to determine the presence of symptoms of posttraumatic stress disorder (PTSD) in women with war missing family members in Bosnia and Herzegovina. The results showed that women with war missing family members showed significantly more severe PTSD symptoms. It was established that the forced disappearance of a family member is an ambiguous situation that can be characterized as a traumatic experience.

2015 marked an important milestone in history when in a precedence, the significance of mental health and well-being was acknowledged as a global issue by the UN, which led to elevated roles of psychologists at United Nations. Even the Sustainable Development Goals (SDGs) (2030 Agenda on Sustainable Development, n.d.) by the UN now include mental well-being as a significant marker. APA's team at the UN encourages youth to address the prevalent issues in international psychology. One of APA's intern and future psychologist Rathi (2016) addressed "Psychological Impact of Victims of War and Conflict" as one of the issues most relevant to international psychology. According to her, war adversely affects combatants and non-combatants alike, both physiologically and psychologically. Death, sexual violence, injury, malnutrition, disability and illness are some of the most threatening physiological consequences of war, while depression, post-traumatic stress disorder (PTSD), and anxiety are some of the psychological effects. The lives of the inhabitants in the war zone are disrupted and their relationships severed as a consequence of terrors of war. Rathi (2016) focused on how non-combatant civilians are psychologically influenced by violence in their region. She argues that the non-combatant civilians, particularly those caught in war areas or forcefully led to participate in war related activities, are frequently exposed to torture, war, and repression. Elbedour, Bensel, and Bastien (1993) used the term "collaterally damaged" population for the families caught in war and the helplessly victimized children. On the positive side, laudable humanitarian efforts are being made by both, local and international NGOs as well as UN agencies including conventions, resolutions, interventions and campaigns, the aim of which is to target perceived and actual stressors faced by non-combatants.

Developed nations share an assumption that the Western ideas of psychological dysfunction, cure and therapy are universal (Rathi, 2016). Yet, Summerfield (1999) argues whether Western models of mental health, technical and medical solutions aimed at providing psychological assistance to distressed populations of the developing countries trump the already prevalent religious and cultural coping strategies in those areas.

Along with other objectives, the present study extends on the aforementioned conclusions put forth by Summerfield (1999) and aims to confirm if the same (religious and cultural) coping strategies are used by non-combatant residents of the developing vicinities living alongside Line of Control.

In particular, the present study investigates the relationship between emotional dysregulation, coping strategies and post-traumatic stress symptoms among adolescents living at Line of Control. The Line of Control (LOC) is a 700-plus kilometer long military control line which divides the disputed governed part of Kashmir in two, between Pakistan and India (Dixit 2003, Singh 2016). 1947-1948 was the period of first war of Kashmir, since that time the LOC (referred to as the ceasefire line till the Shimla Agreement of 1972) has been subject to one too many conflicted narratives between Pakistan and India. There are many occasions when LOC and people residing there became the victim of Pak-India fought war. In the light of overall sensitive Kashmir issue, constant and immense stressors, tensions and challenges, and claims by the two countries, the LOC has been entangled in the judicious, regional, and security prototype (Singh, 2016).

The LOC has been badly affected due to incidents of violence. Increasing tensions at LOC trigger severe crises between both countries. Both Indian and Pakistani sources have no valid ceasefire database for violations along the LOC, because both countries report contradictory figures along with the number of violations of ceasefire each year. However, these sources reported that firing has been increased markedly since 2013 and due to both governments

not taking any serious action to stop the violence at LOC, the chances of it increasing are twofold (Dixit 2003).

People living at LOC face different problems due to frequent and unexpected violation of cease-fire, which further affect their day to day functioning. Firing and bomb blasts impact the lives of people of all ages but the most affected population are adolescents. The time period of adolescence is typically from 12-18 years of age. This period is also associated with increased emotional reactivity as well as risk-taking behaviors. Behavioral changes occurred due to external environmental and internal factors that elicit and reinforce behaviors; adolescence is the period of identity development, as well as social, emotional and cognitive changes (Jaworska & MacQueen 2015, Steinberg 2001). Adolescence is inherently the period of "storm and stress" before establishing a state of equilibrium in adulthood. The despondency curve starts at eleven, rises gradually and rapidly till fifteen, then falls steadily till twenty-three (Arnett 2006).

Studies suggest that exposure to violence, war and such stressors in childhood and adolescence result in severe psychological issues. Many children who had exposure to war, blast or similar instances of violence show significant psychological morbidity, such as post-traumatic stress and depressive symptoms. Individuals who had the experience of severe and intense stressors during developmental and growing years have the neurobiological effects and many other psychological problems such as risk of anxiety, emotional dysregulation, PTSD, aggressive decontrol problem, mood disorders, low coping abilities and early death (Schneiderman et al. 2008).

Children are not capable of regulating hyper-arousal of emotions on their own. Generally they look up to how their parents/caretaker regulate her/his own emotions. In situations like war, a child's ego is paralyzed with intense stimuli and floating anxiety, which hinders constructive solution for traumatic experiences (Kravic, 2020).

Three components related to emotional regulation are (a) Executive functions (b) Effortful control (c) Attention. These components of general cognitive processes affect an individual's ability to control emotions (Bornstein et al. 2010). Emotional dysregulation (ED) in adolescence may cause many psychological problems such as depression, anxiety, substance use, attention-deficit/hyperactivity self-harming behaviors, and conduct problems, but researches show that emotional dysregulation could cause mainly post-traumatic stress symptoms after exposure of any traumatic event (Betancourt & Khan 2008).

Individual's coping abilities play an important role in adjustment of life appropriately. Lazarus and Folkman's model stated that "coping abilities are the efforts to prevent or diminish threat, harm, and loss or to reduce associated distress. It is the behavioral and cognitive efforts once use to manage the internal and external demands of a stressful situation." Three important elements of coping abilities are (a) problem focused, (b) emotion-focused and (c) spirituality. The main focus of problem focused is to modify the stressful situation whether emotion focused change the internal reaction of stressful situations (Berman 2016, Kroger 2004).

With reference to religious focused coping, Hasanovic & Pajevic (2010) investigated the association between level of religious moral beliefs and severity of PTSD, depression and anxiety symptoms and severity of alcohol abuse. They found that higher index of religious moral beliefs in war veterans enable better distress control, providing better mental health stability. It also enables post traumatic conflicts typical for combatants' survivors to be more easily overcome. Additionally it was also found that such beliefs also led to healthier and more efficient mechanism of tobacco and alcohol misuse control.

Emotional dysregulation is considered a key component in the developing process of post-traumatic stress symptoms. For example, emotional dysregulation is positively associated with the PTSS and with all other factors of ED such as negative affect and impulsivity. During adolescence, exposure to violence is found to be highly associated with a range of unfavorable outcomes. Prior research suggests that one consequence of exposure to the violence is emotional dysregulation, which is associated with the manifestation of posttraumatic stress symptoms (PTSS) in adolescence (Buckholdt et al. 2015).

The development of emotional regulation skills and coping strategies enhance the coordination and interplay process of cognitive, social, and brain development under these periods of development. Studies suggested that coping strategies & emotional regulation skills play a vital role in the treatment of psychological problems and improvement of psychosocial well-being of the adolescents (Compas et al. 2014). The coping strategies could be both protective and risk factor for emotional dysregulation and post-traumatic stress symptoms. Adolescence who used problem focused and spirituality have less chances to develop emotional dysregulation and post-traumatic stress symptoms while those who used emotion focused coping are more vulnerable to develop emotional dysregulation and post-traumatic stress symptoms (Peh, Shahwan, Fauziana, & Mahesh, et al., 2017). Another study concluded that adolescents exposed to earthquake, who employed negative style of coping (specifically emotion-focused coping), showed PTSD symptoms for significantly longer durations (Vernberg, Silverman, Grece, & Prinstein, 1996). In the context of exposure to war related trauma, it was hypothesized in the current study that adolescents

having high Emotional Dysregulation will experience high PTSS and that these individuals will use more emotion focused coping and less problem focused and spiritual coping.

SUBJECTS AND METHODS

Participants.

In this research, 400 adolescents (50% boys and 50% girls) participated who were living within a 10 kilometer radius of Line Control (LOC), Sialkot Pakistan. The age range of participants was12-18 years (M=15 & SD=1.6). Convenient random sampling was used and the data was collected form government schools for boys and girls in the aforementioned vicinities.

Measures.

Demographic Performa developed by the researchers, Difficulties in Emotion Regulation Scale (a = 0.92) (Gratz & Roemer, 2004). Coping Strategies Scale for Adolescence (a = 0.69) (Sharif & Saleem 2014), and Post-traumatic Stress Symptoms Checklist (a = 0.91) (Foa et al. 1993) were used to collect data from the chosen sample.

Procedure and Ethical Considerations.

The proposal to conduct this research was approved on all ethical grounds by the Departmental Graduate Committee (DGC), Department of Clinical Psychology, University of Management and Technology, Pakistan. Approval letters were signed from both, public and private sector schools where the research was conducted. The mode of data collection was in-person/face to face. Data was individually collected during and outside classes, as per student availability. The questionnaire protocol used was in Urdu language for culture fair results. Consent to participate in the research was taken from the participants and they were briefed about research protocol alleviating any apprehensions. Furthermore, they were assured of the confidentiality of their identities. In case any participant felt uncomfortable or uneasy recalling the events, they were given the option for free, on the spot consultation with trainee clinical psychologist.

Statistical Analysis.

Pearson moment correlation and further regression analyses were used to test the relationship and possible predictors using the SPSS version 25.0.

RESULTS

The results showed that T-DERS (Total of Difficulties in Emotion Regulation Scale) has significantly highly positive correlation with post-traumatic stress symptoms and with the 1st factor of coping strategies, which was emotion focused coping, indicating that when emotional dysregulation increases, the post-traumatic stress symptoms and emotion focused coping also increases. At subscale level, almost all factors of difficulties in emotion regulation had a significant positive correlation with emotion focused coping. In addition, emotion focused coping and post-traumatic stress symptoms were also found to have significant positive correlation amongst each other.

In step I of regression analysis, all demographics were found to be non-significant. In step II, emotion focused coping was found to be significant positive predictor of post-traumatic stress symptoms while all other demographics were found to be non-significant. In step III, emotion focused coping and total of difficulties in emotion regulation scale were found to be significant positive predictor of post-traumatic stress symptoms whereas all other results were found to be non-significant.

In an unprecedented attempt, we set out to investigate emotional dysregulation, coping strategies and post-traumatic stress symptoms in adolescents residing at Line of Control (LOC), Sialkot Pakistan.

As hypothesized, the results indicated that post-traumatic stress symptoms had significantly positive relationship with emotional dysregulation and emotion focused coping. The existing empirical work, such as a study by Powers, Cross, Fani and Bradely (2015) revealing that traumatic events were a leading factor that contribute in the development of post-traumatic symptoms and emotional dysregulation and that PTSS and Emotional dysregulation were significantly positive correlates has thoroughly been supported.

DISCUSSION

Literature suggests that trauma exposure and emotional dysregulation have bidirectional relationship. The current study concluded that exposure to trauma is highly associated with a reduction in the ability to regulate emotions. A study by Dvir, Frod, Hill and Frazier (2015) confirmed the findings and concluded that individuals with trauma histories are at greater risk for emotional-regulation problems and post-traumatic stress symptoms.

The hypothesis that emotional dysregulation will have negative relationship with problem focused coping and spirituality was also supported. Ample evidence

Table 1 Summary of Inter-factor Correlation, Means and Standard Deviation of Study Variables (N=400)

	NER	DEGDB	ICD	LEA	LAERS	LEC	T-DERS	PSSC	EFC	PFC	SP
NER-F1	----	.393***	.288**	.327***	.454***	.159	.707***	.305***	.338***	.101	.003
DEGDB F2	----	----	.312**	.289**	.326**	.144	.640***	.210*	.331***	.159	.043
ICD-F3	----	----	----	.233*	.368***	.284**	.653***	.280**	.379***	.035	-.058
LEA-F4	----	----	----	----	.366*	.244**	.608***	.137	.130	.206*	.137
LAERS F5	----	----	----	----	----	.192*	.714***	.266*	.302**	.266*	.017
LEC-F6	----	----	----	----	----	----	.458***	.190	.193*	.047	-.027
T-DERS	----	----	----	----	----	----	----	.387***	.465***	.173	.019
PSSC	----	----	----	----	----	----	----	----	.441***	.028	.024
EFC-F1	----	----	----	----	----	----	----	----	----	-.054	-.037
PFC-F2	----	----	----	----	----	----	----	----	----	----	.332***
SP-F3	----	----	----	----	----	----	----	----	----	----	----
Mean	6.64	7.48	8.99	12.01	11.01	8.84	59.33	33.66	21.12	16.79	20.22
SD	3.36	3.53	3.75	3.46	3.94	2.69	14.76	10.19	8.96	3.59	3.65

Note. NER = Non-acceptance of emotional response; DEGB = Difficulty engaging in Goal-directed behavior; ICD = Impulse control difficulties; LEA = Lack of emotional awareness; LAERS = Limited access to emotional regulation strategies; LEC = Lack of emotional clarity; T-DERS = Total of Difficulties in emotion regulation scale; PSSC = Post-traumatic stress symptom checklist; EFC = Emotion focused coping; PFC = Problem Focused Coping; SP = Spirituality, ***p< .001; **p<0.01; *p<0.05

Table 2 Regression analyses for coping and difficulties in emotion regulation predicting post- traumatic stress symptoms

		SEB	*β*	*t*	*p*<
Step I. (R=.12[a], ΔR²=.01)	Gender	1.15	.08	1.43	.153
	Age_category	1.32	.07	1.02	.307
	Class_category	1.38	-.09	1.35	.177
	Sibling_numbers	.89	-.01	.25	.805
	Father's education	.54	-.01	.19	.849
	Mother's education	.56	-.05	.95	.345
	Family system	1.10	.05	.88	.379
	School	1.03	.06	1.14	.256
Step II. (R=.46[b], ΔR²=.19)	Gender	1.06	.02	.55	.580
	Age_category	1.19	.04	.82	.409
	Class_category	1.25	-.09	1.48	.140
	Sibling_numbers	.79	-.00	.04	.972
	Father's education	.49	-.01	.26	.797
	Mother's education	.51	-.05	1.05	.296
	Family system	.99	.03	.83	.409
	School	.94	.05	1.22	.223
	Emotion focused coping	.05	.44***	9.69	.001***
	Problem focused coping	.14	.06	1.19	.232
	Spirituality	.14	.01	.26	.796
Step III. (R=.50 [c], ΔR²=.23)	Gender	1.03	.03	.50	.617
	Age_category	1.16	.04	.70	.483
	Class_category	1.22	-.07	1.17	.242
	Sibling_numbers	.78	.00	.01	.991
	Father's education	.47	-.02	.39	.696
	Mother's education	.49	-.06	1.27	.204
	Family system	.97	.03	.67	.505
	School	.91	.07	1.56	.122
	Emotion focused coping	.06	.30***	5.71	.001***
	Problem focused coping	.14	.05	1.13	.260
	Spirituality	.14	.02	.32	.748
	Total of Difficulties in emotion regulation scale	.04	.25***	4.75	.001***

Note. All significant and non-significant results are presented in step I, II and III. *SEB* = Std. Error, *β* = Beta, *t* = t-value. Step I, F(8, 399) = .75, ***p<0.001. Step II, F(11, 399) = 9.27, ***p<0.001. Step III, F(12, 399) = 10.85, ***p<0.001.

including a study by Allen and Leary (2010) revealed similar results that stress had negative relationship with problem focused coping and spirituality, which align with the findings of the present study. Another study conducted in 2017 assessed the affects in response to stressors and coping strategies found that the stressors that contributed in emotional dysregulation had been reduced by using positive coping strategies such as problem focused coping and spirituality (Chaudhury et al. 2017). Thereby suggesting that coping strategies by and large determine the emotion experienced as a result.

As established by Peh et al. (2017), adolescence who used problem focused and spirituality have less chances to develop emotional dysregulation and post-traumatic stress symptoms while those who used emotion focused coping are more vulnerable to develop emotional dysregulation and post-traumatic stress symptoms, it is recommended that age specific therapeutic interventions are designed that can specifically target adolescents and help them develop healthier coping strategies early on to prevent adult pathology.

CONCLUSION

The present research is the first of its kind to document the empirical relationship between emotional dysregulation, coping strategies and post-traumatic stress symptoms that contribute to develop different problems among adolescents living at and around LoC. The findings of this study will help to regulate adolescents' psychosocial and physical well-being by helping future researchers in not only understanding the coping strategies these children are employing at the moment but also developing and enhancing in them the healthy styles which they are currently not using. Furthermore, the unique nature of non-combatant civilian trauma remains to be understood from several other perspectives, to which this research was only a foundation stone.

LIMITATIONS

A few noteworthy limitations of this study included the concerns of private school principals, who thought that the research questions could remind the children of the traumatic events and might affect their studies and performance at school. To cater the concern, the students were given complete opportunity to seek consultation regarding any issue following the protocol filling, for up to 3 working days.

Furthermore, the adolescents who lived farther than 10 km from Zero Line did not participate in the study, although they experienced hearing gunshots and bomb blasts too and it is fair to assume that their psychological functioning had received a similar impact, if not more.

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Author contributions: conducted the research as part of the mandatory MS clinical psychology degree program, N.T.; supervised the research, F.T.; added substantial contribution in the chapters of introduction, literature, conclusion, recommendations, references and formatting of the paper, M.H.

References

1. *Allen A & Leary M. Self-Compassion, Stress, and Coping. Soc Personal Psychol Compass. 2010;4: doi:10.1111/j.1751-9004.2009.00246.x*
2. *Allwood M, Bell-Dolan D, & Husain S. Children's Trauma and Adjustment Reactions to Violent and Nonviolent War Experiences. Journal of the American Academy of Child & Adolescent Psychiatry. 2002;41: doi:10.1097/00004583-200204000-00018*
3. *Arnett J. G. Stanley Hall's Adolescence: Brilliance and nonsense. Hist Psychol. 2006;9: doi:10.1037/1093-4510.9.3.186*
4. *Barakovic D, Avdibegovic G, & Sinanovic O. Posttraumatic stress disorder in women with war missing family members. Psych Dan. 2014;26:340-346.*
5. *Berman SL. Identity and Trauma. J Trauma Stress Disor Treat. 2016;5: doi:10.4172/2324-8947.1000e108*
6. *Betancourt T & Khan K. The mental health of children affected by armed conflict: Protective processes and pathways to resilience. Intl Rev of Psychiatr. 2008;20: doi:10.1080/09540260802090363*
7. *Bornstein M, Hahn C & Haynes O. Social competence, externalizing, and internalizing behavioral adjustment from early childhood through early adolescence: Developmental cascades. Dev Psychopathol. 2010;22: doi:10.1017/s0954579410000416*
8. *Buckholdt K, Weiss N, Young J & Gratz K. Exposure to Violence, Posttraumatic Stress Symptoms, and Borderline Personality Pathology Among Adolescents in Residential Psychiatric Treatment: The Influence of Emotion Dysregulation. Child Psychiatr & Human Dev. 2014;46: doi:10.1007/s10578-014-0528-5*

9. Chaudhury S, Galfalvy H, Biggs E, Choo T, Mann J & Stanley B. Affect in response to stressors and coping strategies: an ecological momentary assessment study of borderline personality disorder. Bord Personal Disord Emot Dysregul. 2017;4: https://doi.org/10.1186/s40479-017-0059-3
10. Compas B, Jaser S, Dunbar J, Watson K, Bettis A, Gruhn M et al. Coping and emotion regulation from childhood to early adulthood: Points of convergence and divergence. Aust J Psychol. 2014;66: doi:10.1111/ajpy.12043
11. Dixit NJ. India-Pakistan in war and peace. New York, Routledge Publishers, 2003.
12. Duffy M, McDermott M, Percy A, Ehlers A, Clark, DM, Fitzgerald M & Moriarty J. The effects of the Omagh bomb on adolescent mental health: A school-based study. BMC Psychiatry. 2015;15: https://doi.org/10.1186/s12888-015-0398-9
13. Dvir Y, Ford J, Hill M & Frazier J. Childhood Maltreatment, Emotional Dysregulation, and Psychiatric Comorbidities. Harv Rev Psychiatry. 2014;22: doi:10.1097/hrp.0000000000000014
14. Elbedour S, ten Bensel R & Bastien D. Ecological integrated model of children of war: Individual and social psychology. Child Abuse Negl. 1993;17: doi:10.1016/s0145-2134(08)80011-7
15. Foa E, Riggs D, Dancu C & Rothbaum B. Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. J Trauma Stress. 1993;6: doi:10.1002/jts.2490060405
16. Freh F, Chung M &Dallos R. In the shadow of terror: Posttraumatic stress and psychiatric co-morbidity following bombing in Iraq: The role of shattered world assumptions and altered self-capacities. J Psychiatr Res. 2013;47: doi:10.1016/j.jpsychires.2012.10.008
17. Gratz K & Roemer L. Multidimensional Assessment of Emotion Regulation and Dysregulation: Development, Factor Structure, and Initial Validation of the Difficulties in Emotion Regulation Scale. J Psychopathol Behav Assess. 2004;26: doi:10.1023/b:joba.0000007455.08539.94
18. Hasanovic M & Pajevic I. Religious moral beliefs as mental health protective factor of war veterans suffering from PTSD, depressiveness, anxiety, tobacco and alcohol abuse in comorbidity. Psych Dan. 2010;22:203-210.
19. Iribarren J, Prolo P, Neagos N & Chiappelli F. Post-traumatic stress disorder: Evidence-based research for the third. Evidence based complementary and alternative medicine. 2005;2. https://doi.org/10.1093/ecam/neh127
20. Jaworska N & MacQueen G. Adolescence as a unique developmental period. J Psychiatry Neurosci. 2015;40: doi:10.1503/jpn.150268
21. Kravic N. War atrocities and growing up: Risks we have to think about. Psych Dan 2020;32;Suppl 3:360-363
22. Kroger J. Identity in adolescence. London: Routledge; 2009.
23. Murthy RS & Lakshminarayana R. Mental health consequences of war: a brief review of research findings. World Psychiatry: official journal of the World Psychiatric Association (WPA): 2006:5:25-30. Retrieved from https://www.researchgate.net/publication/7025086_Mental_health_consequences_of_war_A_brief_review_of_research_findings
24. Powers A, Cross D, Fani N & Bradley B. PTSD, emotion dysregulation, and dissociative symptoms in a highly traumatized sample. J Psychiatr Res. 2015;61: doi:10.1016/j.jpsychires.2014.12.011
25. Peh C, Shahwan S, Fauziana R et al. Emotion dysregulation as a mechanism linking child maltreatment exposure and self-harm behaviors in adolescents. Child Abuse Negl. 2017;67: doi:10.1016/j.chiabu.2017.03.013
26. Rathi A. Issues Facing International Psychology: APA Interns Respond [Internet]. 2021 [cited 26 October 2020]. Available from: https://www.apa.org/international/united-nations/un-matters/interns- respond/
27. Schneiderman N, Ironson G & Siegel S. Stress and Health: Psychological, Behavioral, and Biological Determinants. Annu Rev Clin Psychol. 2005;1: doi:10.1146/annurev.clinpsy.1.102803.144141
28. Sharif S & Saleem S: Emotional and Behavioral Problem and Coping Strategies in Orphan and Non-Orphan Institutionalized Adolescents. Unpublished MS thesis. Department of Clinical Psychology, UMT. 2014.
29. Silk J, Steinberg L & Morris A. Adolescents' Emotion Regulation in Daily Life: Links to Depressive Symptoms and Problem Behavior. Child Dev. 2003;74: doi:10.1046/j.1467-8624.2003.00643.x
30. Singh P. Prospects of Travel and Trade across the India-Pakistan Line of Control (LOC). Sage Publications. 50(1&2). 71-91. 2016.
31. Steinberg L & Morris A. Adolescent Development. Annu Rev Psychol. 2001;52: doi:10.1146/annurev.psych.52.1.83
32. Summerfield D. A critique of seven assumptions behind psychological trauma programmes in war-affected areas. Soc Sci Med. 1999;48: doi:10.1016/s0277-9536(98)00450-x
33. Vernberg E, La Greca A, Silverman W, Prinstein M. Prediction of posttraumatic stress symptoms in children after Hurricane Andrew. J Abnorm Psychol. 1996;105: doi:10.1037/0021-843x.105.2.237
34. United Nations: Transforming our world: The 2030 Agenda for Sustainable Development. Retrieved from https://sustainabledevelopment.un.org/post2015/transformingourworld

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