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Impact of Posttraumatic Stress Disorder and Social Support on Life Orientation among Traumatized Adolescents

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Introduction

Trauma, either natural or man-made causes injury or wound. It is in fact, a Greek word meaning "wound" which was initially used just to explain an external injury; subsequently it was used to describe the internal wounds: which were sustained by the psyche and hence remained invisible. Wound of any kind can be fatal, however if it is external and observable; it can be recognized without much efforts and can be dealt with openly. On the other hand Internal wounding is hardly ever seen clearly and therefore cannot be easily treated. The internal wounding caused and signified by trauma is certainly characterized as being unexpressed or inexpressible [1]. Hence trauma can be termed as an emotional wound, caused by some gruesome incident or repeated frightening/ unpleasant events in life that may leave long-term effects on an individual, upsetting the course of sturdy, physical, emotional, spiritual and intellectual growth. Similarly, if we probe into the psychiatric literature, a trauma is defined as a sudden, life threatening incident, in which a person gets shocked, horrified, or helpless and holds such incidents as personal experience or witnessing brutal attacks [2].

Adolescence is actually considered a vulnerable stage since it is a transition period between childhood and adulthood. Being in a transitional period makes adolescents a very delicate group in the face of trauma. This transition and development is biological yet has a very large psychosocial component. One of these great changes is the tendency of adolescents to become independent and self-determining by establishing and developing their own definition of self and who they want to be. Trauma followed by PTSD can delay these developmental processes by causing the opposite of what adolescents long for. They may become dependent on parents and others, which may trigger them to find relief in substance abuse, and anti-social behavior. Hence, considering the sensitivity of this developmental stage of life lot of attention has been paid to adolescents' trauma experience in the last two decades [3].

History reveals and experiences have shown that some victims of the said incidents tolerate the adversities without any detrimental emotional consequences; however various sufferers get traumatized by such events in quite an insidious manner contributing to the development of lasting physiological and mental health ailments. Symptoms of such problems may include recurring and distressing dreams, night mares or thoughts of the occurrence, constant escaping of stimuli connected with the trauma, amplified startle reaction, and a sense of foreshortened outlook and future prospect, which can be classified as Posttraumatic Stress Disorder [4]. After facing or witnessing some serious trauma, many adolescents report symptoms of posttraumatic stress [5]. Posttraumatic stress disorder (PTSD) is amongst the leading mental health problems after witnessing or confronting a serious traumatic event.

Comprehensively, social support is a system of close family members, peers, co-workers, neighbors and each one who can be approached or is helpful in a case of emergency. At a glance, members of the family are said to be foremost selection to give each form of social support and has such a role in someone's perception of social support that will never be replaced by anyone else, other than that person. Social support means purpose and value of social relations and might influence the manner of coping with stressful situations. In view of many previous studies, social support plays a role of buffer thus lessening or preventing the appearance of stress. A lot of previous researches have confirmed that social support has a link with initiation of posttraumatic stress disorder. Powerful social support gives protection to persons against mental disorders and also assists psychological improvements after trauma and destruction. Thus, social support might have long lasting impact on lessening the influences of any disaster or trauma.

Several advantages of social support has been proved in many past researches from many kinds of cultures like a sample consisting of males and females of Norwegian population [6] as well as a sample consisting of American adolescents. Social support is particularly significant in improvement from mental sufferings whenever a person face traumatic events and harsh stress. For instance, presence of social support will provide comfort in experience of traumatic hurricane in adolescent sample [7]. In recent years, psychologists have become interested in people's orientations to life. This refers to the reasons behind what we do. One psychologist who has pioneered research into this topic is Veronika Huta at the University of Ottawa. Huta says that there are two main orientations to life. Optimism is described as a set of positive beliefs about the forthcoming life. Whereas, pessimism is described as anticipations about bad outcomes [8]. Some previous studies in relation to trauma and its assumed outcomes are explained below.

The aim of a previous study was to explore perceived posttraumatic growth (PTG) and its associations with potentially traumatic events (PTEs), dispositional optimism, perceived social support, posttraumatic stress disorder (PTSD) symptoms, and satisfaction with life (SWL) among adolescent refugees and asylum seekers. The results of that study concluded that PTG was positively associated with dispositional optimism and social support. It was discovered that dispositional optimism and social support positively predicted PTG. Whereas PTG was also positively related with SWL [9]. In a previous study, differences were explored in personality and daily life experiences of traumatized (*n*= 26) versus non traumatized (*n*= 30) college students. Study participants completed a variety of personality measures as well as a 28–day experience sampling study assessing daily activities, emotions, and physical health. Earlier age of trauma was associated with more pathological outcomes: lower self–esteem and psychological well–being, more anxiety, more pessimism, and emotional constriction of positive mood [10].

Operational Definitions of study variables

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a debilitating psychological condition triggered by a major traumatic event, such as rape, war, a terrorist act, death of a loved one, a natural disaster, or a catastrophic accident. High score on UCLA PTSD Reaction Index [11] will indicate PTSD positive and low score on the scale will indicate PTSD negative individuals among adolescents.

Social Support

Social support is the perception and actuality that one is cared for, has assistance available from other people, and that one is part of a supportive social network [12]. High scores on Multidimensional Scale of Perceived Social Support [12] will indicate high social support and low score on the scale will indicate low social support among adolescents.

Life Orientation

a. Optimism is described as a set of positive beliefs about the forthcoming life [13].

b. Pessimism is described as anticipations about bad outcomes [14].

Method

Hypotheses of present study: Following hypothesis are formulated for the study

i. There will be a negative relationship between posttraumatic stress disorder and social support among adolescents.

ii. There will be a negative relationship between posttraumatic stress disorder and optimism whereas positive relationship between posttraumatic stress disorder and pessimism among adolescents.

iii. There will be a positive relationship between perceived social support and optimism whereas negative relationship between perceived social support and pessimism among adolescents.

iv. Traumatized and non traumatized adolescents are different on posttraumatic stress disorder, social support and life orientation on the basis of gender.

Sample

Convenient sampling was used to collect data for this research. The sample of the study consisted of three hundred (N=300) adolescents including one hundred and fifty boys (n=150) and one hundred and fifty girls (N=150) with age ranges of 12-18 years. The non-traumatized sample was selected from Islamabad and traumatized sample was selected from Peshawar.

Research Instruments

Following instruments were used to conduct the study:

Demographic Sheet (Appendix A): The demographic sheet was formed to investigate various demographic variables including gender, age, educational level, birth order, family system, and number of siblings and parent's level of education.

UCLA PTSD Reaction Index for DSM-V: The scale UCLA PTSD Reaction Index for DSM-V will be applied in the present research. The scale was developed by Pynoos, M.P.H, and Steinberg (2013). The scale is consisted of 31 items and it is Likert type scale. In this scale there are 27 items to assess PTSD symptoms and 4 additional items to assess Dissociative Subtype. The scale has established psychometric properties.

Multidimensional Scale of Perceived Social Support

The Multidimensional Scale of Perceived Social Support developed by Zimet, Dahlem, Zimet and Farley (1988) will be used in the current research. The scale consisted of 12 items and three subscales including family support (item no: 3, 4, 8 and 11), friend support (item no: 1, 2, 5 and 10), and significant others support (item no: 6, 7, 9 and 12). The scale has established psychometric properties.

Youth Life Orientation Test

The Youth Life Orientation Test (YLOT) developed by Eye et al. (2005) was used to assess optimism-pessimism dimensions of adolescent's personality. Participants were asked to rate how accurate the responses are for them on a four point scale. The measure is composed of 6 items assessing optimism, 6 items assessing pessimism and 2 filler items. Specifically, participants were asked to respond by coloring in the circle describes them to be the best. The YLOT was intended to produce three scores: an optimism score, a pessimism score, and a total score. Larger score on any sub-scale indicated greater level of that construct. The scale has established psychometric properties.

Ethics, Data Collection and Data Analysis

Written informed consent was obtained from participants of the study to be a part of this research and the confidentiality of their personal data was assured. Data was collected by UCLA PTSD RI (DSM 5), Multidimensional Scale of Perceived Social Support (MSPSS) and Youth Life Orientation Test (Y-LOT) questionnaires. After data collection all the instruments were scored, coded and entered in the statistical package for social sciences (SPSS) version 23.0 for analysis.

Results

Table 1 characterizes the division of total sample on the basis of gender, age, socioeconomic status and trauma category. The age range of sample is 12-18 years. As the table shows, males make up about 50% and females make up about 50% of the total sample. Among 300 of the study sample, about 22% of the individuals lie in early adolescence age range, about 46% of the individuals lie in middle adolescence age range and about 32% of

the individuals lie in late adolescence age range. Approximately 7% of the sample belonged to lower class, 80% of the sample belonged to middle class and about 13% of the participants belonged to upper class. The trauma category distribution of sample is equal i.e., traumatized adolescence (50%) and non-traumatized (50%) adolescents. However on the basis of scores on UCLA PTSD RI DSM-V traumatized adolescence are divided into two categories of PTSD positive (19%) and PTSD negative (31%).

Table 1: Socio-demographic characteristics of the study population (N=300).

Variables	N	%
Gender		
Male	150	
Female	150	5050
Age		
Early adolescence (12-14 years old)	66	22
Middle adolescence (15 and 16 years old)	137	46
Late adolescence (17 and 18 years old)	97	32
Socioeconomic status		
Lower class	20	7
Middle class	227	80
Upper class	38	13
Trauma category		
Traumatized adolescence (PTSD positive)	57	19
Traumatized adolescence (PTSD negative)	93	31
Non-traumatized adolescence	150	50

The results of the **Table 2** show that all instruments i.e., UCLA PTSD Reaction Index for DSM-V, Multidimensional Scale of Perceived Social Support and Youth Life Orientation Scale have high alpha coefficient reliabilities. The reliability for UCLA PTSD Reaction Index for DSM-V is .78; Multidimensional Scale of Perceived Social Support is .98 and Youth Life Orientation Scale is .59. These values indicate moderate to good reliabilities.

Table 3 illustrates the results of correlation between UCLA PTSD Reaction Index for DSM-V, Multidimensional Scale of Perceived Social Support and Youth Life Orientation Scale among adolescents. The results show significant negative correlation between PTSD and social support, significant negative correlation between PTSD and optimism whereas significant positive correlation between PTSD and pessimism among adolescents. The results also show significant positive correlation between perceived social support and optimism whereas significant negative correlation between perceived social support and pessimism among adolescents. Significant negative correlation exists between optimism and pessimism among adolescents.

Table 4 shows regression analysis to study the predictive value of posttraumatic stress disorder and social support on life orientation. The table depicts that posttraumatic stress disorder (β = .21, t= 2.1, p< .01) and social support (β = .40, t= 0.6, p< .01) are significant predictors of life orientation in adolescents. The value of R^2 shows that 38% of variance is accounted for in life orientation by both posttraumatic stress disorder and social

Table 2: Alpha Reliability, Mean, Standard deviation, Skewness and Kurtosis of UCLA PTSD Reaction Index for DSM-V, Multidimensional Scale of Perceived Social Support and Youth Life Orientation Scale (N=300) Note. PRI: UCLA PTSD Reaction Index for DSM-V, MSPSS: Multidimensional Scale of Perceived Social Support, YLOT: Youth Life Orientation Test

Scales	a	M	SD	Min	Max	Skew	Kurt
PRI	0.78	44	25	9	81	-0.02	-1.8
MSPSS	0.98	47	21	6	65	-1	-0.8
YLOT	0.59	39	6.7	25	71	0.7	1.4

Table 3: Correlation matrix of UCLA PTSD Reaction Index for DSM-V, Multidimensional Scale of Perceived Social Support and Youth Life Orientation Scale (N=300)

Note: PRI: UCLA PTSD Reaction Index for DSM-V, MSPSS: Multidimensional Scale of Perceived Social Support, YLOT: Youth Life Orientation Test **p<0.01

S.No.	Scales	1	2	A	B
I	PRI	-	-0.57**	-0.10**	0.15**
II	MSPSS		-	0.10**	-0.30**
III	YLOT				
A	Optimism			-	-0.21**
B	Pessimism				-

Table 4: Multiple Regression to study the impact of Posttraumatic stress disorder and social support on life orientation (N=300) Note. CI = confidence interval.

		Life Orientation
		Model 1
Variables	B	95 % CI
Constant	43.12	[40,46]
Posttraumatic stress disorder		[-.09 , -.02]
Social support		[-.05 , .02]
R^2	0.38	
F	5.89	

support. The above stated prediction is significant at F (5.89) and p< .01. **Table 5** shows difference between male and female adolescents in terms of UCLA PTSD Reaction Index for DSM-V, Multidimensional Scale of Perceived Social Support and Youth Life Orientation Scale among adolescents. The results indicate that males have slightly high rates of PTSD than females. Whereas males have significantly high rates of social support as compared to females. The results further explain that males and females have approximately equal rates of optimism and pessimism as no significant differences are observed.

Table 6 shows difference between traumatized and non-traumatized adolescents in terms of UCLA PTSD Reaction Index for DSM-V, Multidimensional Scale of Perceived Social Support and Youth Life Orientation Scale among adolescents. The results indicate that traumatized adolescents have significantly high rates of PTSD than non-traumatized adolescents. Traumatized adolescents have significantly high rates of social support as

compared to non-traumatized adolescents. The results further explain that traumatized and non-traumatized adolescents have approximately equal rates of optimism and pessimism as no significant differences are observed.

Table 5: Difference between Male (n=150) and Female (n=150) adolescents in terms of UCLA PTSD Reaction Index for DSM-V, Multidimensional Scale of Perceived Social Support and Youth Life Orientation Scale (N=300)

Note. PRI: UCLA PTSD Reaction Index for DSM-V, MSPSS: Multidimensional Scale of Perceived Social Support, YLOT: Youth Life Orientation Test

Gender										
	Males n= 150		Females n=150					95% CI		
Scales	M	SD	M	SD	t	Df	P	LL	UL	Levene's t
PRI	44.8	24.6	44.3	25.5	.17	298	.08	-5.2	6.1	3.0
MSPSS	52.3	18.6	42.5	23.7	3.9	298	.00	4.9	14.6	57.2
YLOT										
Optimism	8.7	3.1	8.5	2.6	.82	298	.18	-.38	.92	1.7
Pessimism	15.9	3.9	15.8	3.6	.13	298	.31	-.80	.92	1.0

Table 6: Difference between Traumatized (n=150) and Non-traumatized (n=150) adolescents in terms of UCLA PTSD Reaction Index for DSM-V, Multidimensional Scale of Perceived Social Support and Youth Life Orientation Scale (N=300)

Note. PRI: UCLA PTSD Reaction Index for DSM-V, MSPSS: Multidimensional Scale of Perceived Social Support, YLOT: Youth Life Orientation Test

Trauma Category									
	Traumatized n= 150		Non-traumatized n=150				95% CI		
Scales	M	SD	M	SD	t	P	LL	UL	Levene's t
PRI	19.9	4.3	69.2	4.2	10.5	.00	-50	-48	.71
MSPSS	60.1	3.0	34.7	25	12.3	.00	21	29	51
YLOT									
Optimism	8.7	2.8	8.5	2.8	0.42	.27	-.51	.79	1.1
Pessimism	15.9	3.7	15.8	3.8	0.13	.63	-.80	.92	.22

Discussion

Present study was conducted to find the relationship of posttraumatic stress disorder and social support on life orientation of traumatized adolescents. Moreover hypotheses were based on differences in rates of these variables among traumatized and non-traumatized adolescents as well as among male and female adolescents. Convenient sampling was used to collect data for this research. The sample of the study consisted of three hundred (N=300) adolescents including one hundred and fifty boys (n=150) and one hundred and fifty girls (N=150) with age ranges of 12-18 years. The non-traumatized sample was selected from Islamabad and traumatized sample was selected from Peshawar. The data was collected by using UCLA PTSD RI (DSM 5), Multidimensional Scale of Perceived Social Support (MSPSS) and Youth Life Orientation Test (Y-LOT).

Data characterizing the division of total sample on the basis of gender, age, socioeconomic status and trauma category explains that the age range of sample is 12-18 years. As the table shows, males make up about 50% and females make up about 50% of the total sample. Among 300 of the study sample, about 22% of the individuals lie in early adolescence age range, about 46% of the individuals lie in middle adolescence age range and about 32% of the individuals lie in late adolescence age range. Approximately 7% of the sample belonged to lower class, 80% of the sample belonged to middle class and about 13% of the participants belonged to upper class. The trauma category distribution of sample is equal i.e., traumatized adolescence (50%) and non-traumatized (50%) adolescents. However on the basis of scores on UCLA PTSD RI DSM-V traumatized adolescence are divided into two categories of PTSD positive (19%) and PTSD negative (31%).

Internal consistency was also determined through alpha coefficients for all the scales. The results show that all instruments i.e., UCLA PTSD Reaction Index for DSM-V, Multidimensional Scale of Perceived Social Support and Youth Life Orientation Scale have high alpha coefficient reliabilities. The reliability for UCLA PTSD Reaction Index for DSM-V is .78; Multidimensional Scale of Perceived Social Support is .98 and Youth Life Orientation Scale is .59. These values indicate moderate to good reliabilities. The results show significant negative correlation between PTSD and social support. This proves the hypothesis that there will be a negative relationship between posttraumatic stress disorder and social support among adolescents.

Past research has also shown that, "even when stress is toxic, supportive parenting, positive peer relationships, and the availability and use of community resources can foster positive adaptation" [15]. That is, adolescents can learn to demonstrate resilience and to thrive when supported by trusted, nurturing, competent, and caring adults who offer positive guidance; provide opportunities for productive decision-making and constructive engagement in various social contexts; and promote the development of self-regulation, self-reflection, self-confidence, self-compassion, and character [16]. The results also explain significant negative correlation between PTSD and optimism whereas significant positive correlation between PTSD and pessimism among adolescents. Optimism represents positive aspect of life orientation whereas pessimism represents negative aspect of life orientation. This proves the hypothesis that there will be a negative relationship between posttraumatic stress disorder and optimism whereas positive relationship between posttraumatic stress disorder and pessimism among adolescents.

The aim of a previous study was to explore perceived posttraumatic growth (PTG) and its associations with potentially traumatic events (PTEs), dispositional optimism, perceived social support, posttraumatic stress disorder (PTSD) symptoms, and satisfaction with life (SWL) among adolescent refugees and asylum seekers. The results of that study concluded that PTG was positively associated with dispositional optimism and social support. It was discovered that dispositional optimism and social support positively predicted PTG. Whereas PTG was also positively related with SWL [17]. In a previous study, differences were explored in personality and daily life experiences of traumatized (*n*= 26) versus nontraumatized (*n*= 30) college students. Study participants completed a variety of personality measures as well as a 28–day experience sampling study assessing daily activities, emotions, and physical health. Earlier age of trauma was associated with more pathological outcomes: lower self–esteem and psychological well–being, more anxiety, more pessimism, and emotional constriction of positive mood [10].

The results also show significant positive correlation between perceived social support and optimism whereas significant

negative correlation between perceived social support and pessimism among adolescents. This proves the hypothesis that there will be a positive relationship between perceived social support and optimism whereas negative relationship between perceived social support and pessimism among adolescents. Social support is particularly significant in improvement from mental sufferings whenever a person face traumatic events and harsh stress [7]. For instance, presence of social support will provide comfort in experience of traumatic hurricane in adolescent sample [18]. A lot of previous researches have confirmed that social support has a link with initiation of posttraumatic stress disorder. Powerful social support gives protection to persons against mental disorders and also assists psychological improvements after trauma and destruction. Thus, social support might have long lasting impact on lessening the influences of any disaster or trauma.

The results of this study explained that significant negative correlation exists between optimism and pessimism among adolescents. Some Previous studies are also consistent with the findings.Chang [19] describes optimism and pessimism as psychological dimensions in which optimism represents a positive bias in perceptions and expectations in favour of positive features in life, while pessimism represents a negative bias. Optimists and pessimists seem to differ in their health habits their physiological response to stimuli, and in their overall psychological behavior (e.g., coping strategy, use of social support networks, attribution style, and mental health). Optimists have a set of epistemological beliefs such as that the world is good and that all human beings who inhabit it must work hard to achieve more in life. They believe that the future holds positive opportunities with successful outcomes for them [20]. This enables them to approach the world in a proactive and positive manner. On the other hand, pessimists tend to look at the world and future experiences in a reactive and negative fashion. They view the world as a place of bad experiences and events [21].

Regression analysis of the present study shows the predictive value of posttraumatic stress disorder and social support on life orientation. The table depicts that posttraumatic stress disorder (β = .21, t= 2.1, p< .01) and social support (β = .40, t= 0.6, p< .01) are significant predictors of life orientation in adolescents. The value of R^2 shows that 38% of variance is accounted for in life orientation by both posttraumatic stress disorder and social support. The above stated prediction is significant at F (5.89) and p< .01. The results of the present study also indicate that traumatized adolescents have significantly high rates of PTSD than non-traumatized adolescents. Traumatized adolescents have significantly high rates of social support as compared to non-traumatized adolescents. The results further explain that traumatized and non-traumatized adolescents have approximately equal rates of optimism and pessimism as no significant differences are observed. This proves the hypothesis that traumatized and non-traumatized adolescents are different on posttraumatic stress disorder, social support and life orientation. Some studies consistent with the findings are described below.

Studies conducted in war zones indicate that exposure to the traumatic event leads to the development of PTSD in childhood and adulthood [22]. Various other studies have been performed to determine the incidence of PTSD consequential of exposure to traumatic events. Studies after different conflicts have produced results ranging from a high incidence to low incidence of children with PTSD who had been exposed to war and conflicts. A study on Kuwaiti children who had lived through the Gulf war found that 70% of children showed symptoms of PTSD ranging from moderate to severe [23]. A study from September 11, 2001, conducted by Schuster and others [24], examined 768 adults affected by the attacks and interviewed majority of them. The researchers assessed the participants' stress reactions and symptoms, and subsequently their behavioral responses. Majority of the participants had indicated to turn to social support and volunteering and participation in social and community activities. Furthermore, majority of the participants in response cared and looked after the safety of their close others, made donations, and helped other afflicted individuals [24].

Several advantages of social support has been proved in many past researches from many kinds of cultures like a sample consisting of males and females of Norwegian population [6] as well as a sample consisting of American adolescents. In second research, social support from several resources was said to be an important cause of lessening the signs of depression and increasing the rates of self-esteem [25]. Furthermore, findings suggest that males have slightly high rates of PTSD than females while males have significantly high rates of social support as compared to females. The results further explain that males and females have approximately equal rates of optimism and pessimism as no significant differences are observed.

Conflict of Interest

Author have declared that they have no conflicts of interest.

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References

1. Maria PP Root (1990) "Reconstructing the Impact of Trauma on Personality." In Personality and Psychopathology - Feminist Reappraisals, edited by Laura S. Brown and Mary Ballou, New York, USA, pp. 229-267.
2. American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV). American Psychiatric Association, Washington, DC, USA.
3. Osofsky JD (2003) Prevalence of children's exposure to domestic violence and child maltreatment: Implications for prevention and intervention. Clinical Child and Family Psychology Review 6(3): 161-170.
4. American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Author, Washington, DC, USA.
5. Attanayake V, McKay R, Joffres M, Singh S, Burkle F, et al. (2009) Prevalence of mental disorders among children exposed to war.
6. A systematic review of 7,920 children. Medicine, Conflict and Survival 25: 4-19.
7. Murberg TA, Bru E (2004) Social support, negative life events and emotional problems among Norwegian adolescents. School Psychology International 25: 387-403.
8. Joseph S, Williams R, Yule W (1997) Understanding post-traumatic stress: A psychosocial perspective on PTSD and treatment. London, UK.

9. Sleijpen M, Haagen J, Mooren T, Kleber RJ (2016) Growing from experience: an exploratory study of posttraumatic growth in adolescent refugees. European Journal of Psychotraumatology p. 7.
10. Scott C Bunce, Randy J Larson, Christopher Peterson (1995) Life after Trauma: Personality and Daily Life Experiences of Traumatized People.
11. Pynoos MPH, Steinberg (2013) Post-traumatic stress reactions in children after the 1988 Armenian earthquake. Br J Psychiatry 163: 239-247.
12. Wills TA (1991) Social support and interpersonal relationships. In: Clark MS (Eds.), Review of personality and social psychology p. 12.
13. Zimet Gregory, Dahlem W, Nancy G, Zimet Sara, Farley Gordon (1988) The Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment.
14. Eye S, Hadley W, Allen DN, Palmer S, Klosky J, et al. (2005) A new measure of children's optimism and pessimism: The youth life orientation test. Journal of Child Psychology and Psychiatry 46: 548-558.
15. Easterbrooks MA, Ginsberg K, Lerner RM (2013) Resilience among military youth. The Future of Children 23(2): 99-120.
16. Browne Notkin, Schneider Muñoz, Zimmerman (2015) youth thrive: a framework to help adolescents overcome trauma and thrive. Journal of Child and Youth Care Work by National Organization of Child Care Worker Associations.
17. Sleijpen M, Haagen J, Mooren T, Kleber RJ (2016) Growing from experience: an exploratory study of posttraumatic growth in adolescent refugees. Eur J Psychotraumatol 12(7): 28698.
18. Vernberg EM, Silverman WK, La Greca AM, Prinstein MJ (1996) Prediction of posttraumatic stress symptoms in children after hurricane Andrew. J Abnorm Psychol 105(2): 237-248.
19. Chang E (2000) Optimism and pessimism: Implications for theory, research, and practice 2: 172-205.
20. Diener Suh, Lucas, Smith (1999) Subjective wellbeing: Three decades of progress. Psychological bulletin 125(2): 276-302.
21. Burke Joyner, Czech, Wilson (2000) An investigation of concurrent validity between two optimism and pessimism questionnaires: The Life Orientation Test - Revised and the optimism pessimism Scale. Current psychology 19: 127-1 47.
22. Thabet AA, Vostanis P (2000) Post traumatic stress disorder reactions in children of war: A longitudinal study. Child Abuse & Neglect 24: 291-298.
23. Nader KO, Pynoos RS, Fairbanks LA, Al-Ajeel M, Al-Asfour A (1993) A preliminary study of PTSD and grief among the children of Kuwait following the Gulf crisis. British Journal of Clinical Psychology, 32: 407-416.
24. Retrieved from http://dx.doi.org/10.1111/j.2044-8260.1993.tb01075.x
25. Schuster, Stein, and Jaycox (2001) A national survey of stress reactions after the September 11, 2001, terrorist attacks. New England Journal of Medicine 345: 1507-1512.
26. Colarossi, L., & Eccles, J. (2003). Differential effects of support providers on adolescents' mental health. Social Work Research, 27(1): 19-30.

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