

Gender Differences in Depression Among the Affectees of War on Terrorism and the Role of Psychological Interventions in the Rehabilitation

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Abstract

The present study was carried out to investigate the psychological effects of war and terrorism and the role of psychological interventions in the rehabilitation of affectees. The sample included two hundred participants (N=200) from two districts of Khyber-Pakhtunkhwa i.e. Swat and Buner using convenient sampling technique. It was further divided into two subgroups, males (n=100) and females (n=100). Pre and post test design was used for the study because it was carried out in two phases. Demographic Information Sheet and Geriatric Depression Scale (GPS) (Yesavage 1983) were administered for the assessment. It was hypothesized that the Victims of war and terrorism will score high on Depression Scale, and the prevalence of depression will be high among females as compared to males. It was also assumed that males will show decrease in symptoms of depression faster, than females after receiving psychological interventions. The results supported the hypotheses. Results of the research explored ($p < 0.05$) that people who are the direct victim and those who are eyewitness of the traumatic event suffered from serious psychological problem i.e. depression. In the second phase of study, results indicated that psychological interventions play a pivotal role in the rehabilitation of affectees.

Keywords

Gender Difference, Depression, Terrorism, Psychological Intervention, Pakistan, Rehabilitation.

Since time immemorial, especially the twentieth century, the world has experienced terrorism in different forms and faces with different expressions. Therefore, we know that terrorism is not a modern trend. Undoubtedly, a terrorism disaster, (whether the attack as 9/11 in 2001 or a natural event such as Hurricane Katrina in 2005, earth quake of Pakistan in 2005) has caused tremendous damage to individuals (e.g., buildings, roads, factories) and humans (e.g., illness, death). Twentieth century, certainly the century of the most blood suffering in human history, manifests a persistent increase and changes in such activities which are malicious and destructive. Yet this was not the main challenge for the international community, until the hijack of airplanes and the attacks of 9/11 on the towers of World Trade Center and the Pentagon, the main symbols of American economic and military supremacy (Musarrat, 2009).

World Health Organization (WHO, 2005) defines traumatic event as, "any event that causes damage, ecological disruption, the loss of life, deteriorating health services and health on a scale sufficient to meet extraordinary war from outside the disaster area or community." A threatening event, or the probability of occurrence of a potentially damaging phenomenon within a given time period and area". Physical natural phenomena caused by sudden events, are called slow or natural hazards. Natural hazards may be earthquakes, landslides or geologic, tsunamis and volcanic activity (World Health Organization, 2005). Technological hazards are man-made (complex emergencies, conflict, war, terrorism, famine, displaced population, industrial accidents and transport accidents) events handled by humans and those occur in Environmental regulation of human degradation, pollution and accidents (World Health Organization, 2005).

Taking terrorism as a subject is very difficult to be discussed. Due to political and social prejudices assumption, the statement may become biased. Experts of the field and policy makers' often show disagreement in their theoretical perspectives. For study of terrorism, mainly at least three approaches are used i.e. psychological, macro and psychosocial context (De la Corte, 2006). Political violence e.g. riots and demonstrations, change movements, wars (civil) and conflicts both national/international (armed) are generally consider factors which are associated with terrorism. Authoritarian regimes, repressive, poverty, cultural and religious practices are some other possible root causes of terrorism. (Crenshaw, 1995; Laqueur, 2003; Reinares, 2003; Corte, 2006; Newman, 2006).

After exposure to trauma, people frequently experience a range of cognitive, emotional, behavioral and physical symptoms. Often these problems constellate discrete psychiatric disorders such as anxiety disorders, depression, PTSD and / or profound changes in personality. Similarly, traumatized individuals experience a range of issues that fall outside these categories delineated rather psychiatric. Emotions such as guilt, shame, rage, anger and disgust are often widespread and extreme. Behavioral problems such as anger outbursts sleep disturbances, social avoidance and control and obsessive cleaning are also common. Not everyone's reaction to trauma is very negative in this way, there are others for whom the traumatic events seem to be a little more minor disruptions in the way of life and these individuals remain remarkably unaffected by their experiences. Indeed, for some, there are often positive psychological reactions to trauma, such as increased capacity to appreciate the fragile nature of life and the problems that other people could be affected (Taylor et al., 2003). In a stress, it was also noted that people's reactions to stressors varies along these lines, with some responding positively and some negatively respond (Taylor et al., 2003).

Norris et al. (2002a) found that 68% of their observed subjects facing a disaster were found to be the victims of PTSD. The investigators found depression as the next important psychiatric problem observed in 36% of the research subjects. Another problem observed in 32% of samples was different forms of anxiety. It was further noted that 23% of the subjects were also complaining about general health problems, which could not be verified (North, 2002).

Terrorism, a subset of human caused disasters can have a devastating impact negatively on psychological functioning. Terrorism carries with itself a potentially high impact on the responses of distress than any other disaster with behavior change and psychiatric illness by virtue of the unique features of terrorism events. Terrorists intend to intrigue the collective fear and uncertainty. This fear is not only limited to those who have direct experience, but can also spread rapidly among others, as the rest of their family members, survivors and also those exposed through images large cast iron. Mental and psychological suffering is usually more common than physical injuries from a terrorist incident (Slovic, 1987).

As a number of suicide bombings has increased explosives in some of the major cities of Pakistan, also increased the country's security risks. Because of a negative fact that in recent years, many terrorist group has emerged with some new crop of activists who are more violent and destructive and less sensitive to political strategies. Many of the existing terrorist groups have rebuilt, that have strengthened their ties with the new groups. Instead, the main objective of these terrorist attacks is to spread terror and fear among society, which is the threat itself. Therefore, the impact of psychological terror depends largely on how the acts are announced, or interpreted, which means that there are ways we can defend ourselves and loved ones by putting the concerns of fear into consideration and protect our children so that can use obscene or psychological damage to their minds. Situation of war and terrorism in Pakistan is deteriorating every day and this situation prevailed became very serious problem because it affects people negatively, affect the psychological / mental health of people who are directly or indirectly exposed to war and terrorism, incurring depression among people (Maria et al, 2004).

Depression is a psychological reaction caused by an encounter with a traumatic event, especially in situations of war and terrorism. Depression is a type of mental disorder that affects a person's mood, thoughts, feelings, behavior and overall health. It's very natural to respond in sadness and grief over the losses in life. This prolonged sadness, which extends continuously to one or more times a week becomes a disorder that we commonly name as depression (D'Aquila, Brain, & Willner 1994).

There is no specification of the age or something for depression to occur. It can happen to anyone, it can be a teenager or an old. Depression, most of the time, is

assisted with treatment, and yet there are those who cannot be helped by treatment. Depression has two kinds: the first being sad kind, called major depression, dysthymia, known as mania and others. In a depressed state of mind, you start to act reckless, cry, feel extreme sadness or guilt, for no reason, and lose confidence. They lose hope and become restless (D'Aquila et al, 1994).

Gender differences may be partly explained by the differences that we often see when psychological distress is expressed. In general, women are more likely than men to recognize psychological symptoms and report them (Nolen-Hoeksema, 1990). After a disaster, males can suppress feelings of psychological distress because of the expectation that men should be strong and capable (Wolfe & Kimerling, 1997). As discussed in a previous section, the most commonly studied post-disaster responses are PTSD, depression, and other forms of anxiety. Substance abuse and other behaviors in the act, such as interpersonal violence, are rarely evaluated. Men are more likely to express psychological distress through these types of behaviors, rather than to report symptoms of neurotic-like depression and anxiety (Myers, Weissman, Tischler, et al., 1984).

Psychological interventions play important role in dealing with victims of terrorism (man-made disaster). Evaluation research is the core aspect of psychology with a long history in this aspect which makes it an unavoidable partner for managers who needed it for assessment of effectiveness of their planning and response (Mitchell & Everly, 2000).

Psychological efforts should be directed when helping people to develop active coping mechanisms against passive and fatalistic ones. Sometimes in some cases when disaster happened, however it is found that no active strategy is available to use. Fullerton, Ursano, Vance, and Wang (2000) found that in emergency situation, females as compared to males seek three times more debriefing. Our earlier discussion of gender differences in vulnerability suggests that women may be particularly need support services after a social disaster. Most psychologists, as far back as, assumes that individuals need to face the trauma of the disaster. It may allow people to avoid effectively are just as useful, especially when the trauma is severe and there is little that can be done to change the situation (Lindemann, 1944).

Rationale of the study

Psychological mental health is nowadays becoming a central issue for public health complex emergencies. Until recently, there has been a gap of conducting a kind of study that covers every corner of psychological reactions during war and terrorism situations. This research present a culturally valid mental health action plan based on scientific evidence that is capable of addressing the mental health effects of complex emergencies. It will help people know of their mental conditions of the affected region and motivate the government and non-governmental

organization (NGOs) to map out strategically plans or solutions like psychological interventions, for both short or long term psychological problems and rehabilitation of the victims in cultural context of Pakistan, especially when working in Pukhtoon areas like District Swat and District Buner. This comprehensive study will be one of its kind, covering the psychological reactions of “War and Terrorism”, rehabilitation and recovery of mental health of these affected victims and preparing people for pre-event situation will be role played by psychological intervention.

The purpose of the study is to examine the psychological consequences of war & terrorism among the subjects in affected areas (Swat and Bunir) of Pakistan and to analyze the role of psychological strategies in the rehabilitations of affectees.

Objectives

1. To examine the prevalence of depression in the victims of war and terrorism after event.
2. To explore the intensity of depression among male and female.
3. To analyze the role of psychological interventions in the rehabilitation of affectees.

Hypotheses

1. The intensity of depression will be high among female as compared to male.
2. Recovery rate of male will be high than female in the psychological rehabilitation.
3. Psychological interventions play a significant role in the rehabilitation of affectees.

Method

Participants

The targeted population of the study was the Khyber Pakhtunkhwa province. Khyber Pakhtunkhwa province is divided into 24 districts. The study included sample from District Buner and District Swat, of Khyber Pakhtunkhwa. Convenient sampling technique was used. The sample consisted of 200 individuals (N=200), with the representation of both male and female from all walks of life at the age of adulthood. Further, two hundred sample (N=200) was divided into two groups. One hundred (n=100) were males and one hundred (n=100) were females from Swat and Buner. Average age of respondents were adults 40 years old.

Inclusion/Exclusion Criteria

In the research process, people who were the victim and people who were the eye witness of the war affected areas were included.

The research focused and included elderly people both male and female because it was easy to access those participants who took part in the first phase of the study.

Research did not focus on children and adolescents because that group of the targeted area were under special consideration by security agencies due to their close exposure to suicide attack training.

Individuals who visited mental health clinics were included in study because approaching participants at community level was not possible due to security risks.

Instruments

For this research one information sheet and one instrument was used namely Geriatric Depression Scale (GDS)

1. Demographic Information Sheet (DIS)

Demographic Information sheet was used to get information from the participants. Demographic Information sheet included Name, Gender, Area, Address and Date.

Geriatric Depression Scale (GDS)

The Geriatric Depression Scale (GDS) is widely used in screening depression among the elderly population. The original version (GDS-30) consisted of 30 questions in the form of yes / no and was designed for self-administration (Yesavage et al, 1983). Scoring criteria of Geriatric Depression Scale is normal 0-9, mild 10-19 and sever 20-30. The Geriatric Depression Scale (GDS) was used for rating the level of depression (Jerry Yesavage 1983). In the assessment of depression in adulthood age, the Geriatric Depression Scale (GDS) (Brink et al., 1982; Yesavage et al., 1983) is currently one of the most used depression self-reports. The GDS was developed and validated in two studies (Brink et al., 1982; Yesavage et al., 1983). None of the final 30 items was somatic (although 12 of the 100 original items had been), thus avoiding one of the problems with self-reports assessing depression in the elderly, namely the confusion of somatic symptoms with physical disturbances that are common in adulthood age. Reliability of GDS was found $r = .82$ being statistically significant ($p < .0001$).

Procedure

The sample of two hundred (N=200) participants were conveniently selected from different areas of District Swat and District Buner. The sample was divided into two groups, hundred were males (n=100) and hundred were females (n=100).

Fifty male (n1=50) and fifty female (n2=50) participants from District Swat and fifty male (n3=50) and fifty females (n4=50) from District Buner were selected. Criteria for selection of sample was convenient sampling technique.

Participants were approached at different mental health team clinics run by different non-governmental organization. Rapport was developed with the subjects. Pre and post test design was used in the study because the study was carried out in two different phases i.e. Phase I and Phase II. In Phase I, data was collected to find out the psychological consequences (prevalence of depression in victims) of war and terrorism. After three months, in Phase II, there was recollection of data to analyze the role of psychological interventions in the rehabilitation of affectees from the same sample assessed in phase I. All the participants and Organizations (both National and International) were thanked for their cooperation in this study.

Intervention

After the advent of war on terrorism, almost every one of the province of Khyber Pakhtunkhwa in general and District Swat and Buner in particular were facing different kinds of psychological problems. Different international non-governmental and national non-governmental organization started providing mental health services. For the data collection purpose different organizations mental health services were keenly observed and those who hired professional psychologist for providing psychological interventions were selected. They handled clients in a very professional way and most of the time applied counseling strategies (cognitive behavioral technique) depended on the problems clients facing at that time.

Data was collected from clients who were taking individual counseling. Duration for each individual session was 45 minutes according to international standard. Those who were taking individual counseling and therapy were surprised in initial session because before that, attitude of general public is developed that psychological problems can only be eradicated by using medicines. But after taking sessions, they were very much satisfied that there psychological healing is increased day by day by attending counseling and psychotherapy sessions.

Control of Extraneous Variables

Controlling of extraneous variables is important to make it sure that depended variable is changed because of the effect of independent variable. Controlling of extraneous variables in field experiment is difficult from laboratory experiment. During the study, clients were asked not to take any other services during counseling and psychotherapy taking duration which they were receiving from those mental health clinics established by different international and national organizations.

After disaster it is a parameter that people are naturally healed upto 6 weeks. After 6 weeks if people still remain in the same stressful condition, then they were advised to take counseling and psychotherapy services.

Table 1: Alpha Reliability of GDS scale (N=200)

Scale	No. of Items	Alpha
Depression Scale (GDS)	30	.79

Table 1: shows the alpha reliability of GDS scale. Results shows that the scale is internally consistent and can be used for present sample.

Table 2: Means, standard deviations and t-value of the depression scores of the Male and Female Affectees phase I on depression scale (N=200)

Scale	Male (n=100)		Female (n=100)				95% CI		Cohen's d
	M	S.D	M	S.D	t	p	LL	UL	
Depression	14.39	3.57	15.72	4.112	.45	0.01	.26	2.40	0.345

$df=198$ $p<.01$

Table 2 shows a highly significant difference between the male and female affectees on depression scale ($t=2.451$, $p<.01$). The figures show that female respondents are more depressed ($M=15.72$, $SD=4.11$) as compared to male respondents ($M=14.39$, $SD=3.57$).

Table 3: Means, standard deviations and t-value of the depression scores in the pretest and post-test of affectees (phase II) on depression scale (N=200)

Scale	Depression Pretest (n=100)		Depression Post-test (n=100)				95% CI		Cohen's d
	M	S.D	M	S.D	t	p	LL	UL	
Depression	15.06	3.90	13.63	4.33	3.49	0.001	.62	2.23	0.347

$df=198$ $p<.001$

Table 3 shows highly significant difference between the pretest and post-test of affectees on Geriatric depression scale by depression scores ($t=3.49, p<.001$). The figures show that the pretest have more depression ($M=15.06, SD =3.90$) as compared to post-test ($M=13.63, SD =4.33$).

Table 4: Means, standard deviations and t-value of the depression scores of the pretest and post-test of male affectees (phase II) on depression ($N=100$)

Scale	Depression Pretest (n=50)		Depression Post-test (n=50)				95% CI		Cohen's d
	M	S.D	M	S.D	t	p	LL	UL	
Depression	15.72	3.57	13.60	4.23	3.55	0.001	.93	3.30	0.541

$df= 198$ $p<.001$

Table 4 reveals highly significant difference between the pretest and post-test of male affectees on depression scale by depression scores ($t=3.550, p<.001$). The figures show that the pretest result(males) have more depression ($M =15.72, SD =3.575$) as compared to post-test result(males) ($M=13.60, SD =4.236$).

Table 5 Means, standard deviations and t-value of the depression scores of the pretest and post-test of female affectees (phase II) on depression ($N=100$)

Scale	Depression Pretest (n=50)		Depression Post-test (n=50)				95% CI		Cohen's d
	M	S.D	M	S.D	t	p	LL	UL	
Depression	14.39	4.11	13.66	4.45	3.32	0.001	-.36	1.82	0.170

$df = 198$ $p <.001$

Table 5 reflects a highly significant difference between the pretest and post-test of female affectees on depression scale by depression scores ($t=3.320, p<.001$). The figures show that the pretest result(females) have depression ($M=14.39, SD = 4.11$) as compared to post-test result(females) ($M=13.66, SD =4.45$).

Discussion

The objective of this study was to examine the psychological consequences of war and terrorism among the victims in affected areas (Swat & Buner) of Pakistan and to investigate the role of psychological intervention strategies in the

rehabilitation of affectees. Our findings indicate significant difference between phase I and phase II scores which shows tremendous role performed by psychological intervention in rehabilitation of affectees. In phase 1, it was hypothesized that affectees of war and terrorism will have high score on depression and the intensity of depression will be low among males than females. These research findings are consistent with the earlier research findings (Delisi et al., 2003; Farooqi, & Tariq, 2010; Khan, Alam, Warris, & Mujtaba, 2007; Nasky, Hines, & Summer, 2009; Pat-Horenezyk et al., 2007; Pfefferbaum et al., 1999; Solomon, 2009; Solomon, Gelkopf, & Bleich, 2005; Summers & Winefield, 2009; Tolin & Foa, 2006 and Willenz, 2006) which suggest that the female victims are more prone to develop psychological stress, depression and PTSD as compared to the male victims of war and terrorism.

The psychological effects of terrorism on threatened civilians have not been extensively investigated in the literature. Descriptions of gender differences in response to terror attacks are even sparser. Gidron (2002) reported that the prevalence of PTSD after terrorist attacks worldwide is estimated to be approximately 28%. Consistent with these results, Galea and colleagues (2002), who interviewed 1008 adults in Manhattan after the September 11 terrorist attacks, showed a substantial burden of acute PTSD and depression in the population after the attacks. Experiences involving exposure to the attacks were predictors of current PTSD, and losses as a result of the events were predictors of current depression. Research findings regarding gender differences in response to traumatic events are equivocal. Several studies have not identified gender differences at all (Amirkhan, Risinger & Swickert, 1995; Aranda et al., 2001; Lomranz et al., 1994). Many researchers, however, report a female-to-male lifetime prevalence ratio of as high as 2:1 for PTSD symptoms, even when levels of exposure are lower in females as compared to males (Ai, Peterson, & Ubelhor, 2002; Ben Zur & Zeidner, 1991; Breslau, 2001; Fullerton et al., 2001; Karanci et al., 1999; Saxe & Wolfe, 1999; Seedat & Stein, 2000). These data appear to be consistent with a review of 180 articles and chapters on 130 distinct samples involving over 50,000 individuals in 80 different traumatic events (Norris, Friedman, Watson, Byrne, Diaz & Kaniasty, 2002). The reviewed data reveal that in the aftermath of disasters, women appear to be at greater risk than men for developing long-term psychological problems, especially PTSD. The effects of gender were found to be greatest in samples from traditional cultures and within the context of severe exposure.

Many research studies on disaster victims show that stress, PTSD and depression are the most prevalent psychological problems after the occurrence of a disaster (Brier & Elliott 2000, Wang et al., 2000, Chen et al 2001, Livanou and others, 2002A).

Studies show that women are more vulnerable to depression and other psychological disorders (including PTSD) than men. However, studies conducted on gender differences with respect to psychological disorders in Vietnam and the Gulf War show inconsistent results. These studies do not fail to recognize the traditional role of women in Iraq and Afghanistan where many casualties occurred in combat operations (Rona and colleagues, 2007).

More evidence from the US substantiates the results of Rona and colleagues (2007). Referring the minimal differences between the sexes in psychological disorders, all U.S. military troops were given some mental health assessment for posttraumatic stress symptoms, depressive signs, and concern for their family when they returned from deployment. Out of the first 222/620 army and marine personnel, (10.6% of whom were women) reported psychological problems after returning from Iraq and 24% of women, developing some type of mental health problems compared with 19% of men.

Since long time, for victims and affectees of all kind of traumatic events (disaster and critical incidents) psychological intervention has been proved an effective, important, unavoidable and front-line intervention especially in result of severe psychological distress and trauma (Everly, Flannery, & Mitchell, 2000; Everly & Mitchell, 1999). According to the definition of psychological intervention given by Everly & Mitchell (1999), "it is the provision of emergency psychological services and care to victims as to help those victim's in returning to normal and an adaptive level of functioning and to prevent or mitigate the potential negative impact of psychological trauma."

Coping strategies reflect individual cognitive, emotional and behavioral efforts to manage internal and external demands of a stressful situation (Lazarus & Folkman, 1984). Two major categories of coping strategies have been consistently identified in the literature: problem-focused coping, designed to manage or solve the problem by "removing" the stressor; and emotion-focused coping, designed to reduce or eliminate the emotional stress associated with the situation. Theory and research suggest that problem-focused coping tends to predominate when people feel that something can be done to manage or control the situation, whereas emotion-focused coping predominates when people feel that nothing can be done about the situation (Carver & Scheier, 1989; Lazarus & Folkman, 1984; Zeidner, 1993).

Studies on gender differences in ways of coping with stress are inconclusive and complex. Some studies found that men employed more problem-focused coping strategies than women (Angst et al, 2002; Karanci et al, 1999). In a study on gender differences in the use of social support, problem solving and avoidance, and their effect on stress and depression, Felsten (1998) showed that women used social

support slightly more than men, but that there were no differences in the use of problem-solving and avoidance coping styles. Felsten also reported a slight positive correlation between stress and depression and stress and the predominance of problem-solving strategies.

In disaster whether man made or natural, different organizations raises fund and foster team work in their activities (Bolitho et al., 2006). Organizations shall remain harmonized, it is also important that they shall not duplicate each other when involve in relief and rehabilitation work which will save all the resources go in unnecessary drain (MacLachlan & Carr, 2005).

Limitations

Researchers faces several unique challenges while conducting rigorous studies/researches and interventions based on evidence in the conflicted areas. Researchers always face the problem of security and their lives are always at risks and other people working in mental health team are also at high risk because of the installation of land mines and unexploded ordinances. There is also security measure taken by peace keeping military troops and restricted from general travel which creates hindrances while providing services in different sectors by organizations.

There is the lack of comparisons with no-intervention control group and the lack of comparisons between classified as victims versus eye witnesses because of the nature of study. It was aimed to explore gender differences in developing depression of war and terrorism affected areas and to examine the effectiveness of psychological intervention in the rehabilitation of affectees.

There is another challenge faced and inherent in emergency situations/settings with displace/mobile populations it the concerns that the difficulty for mental health workers and researchers expose to when do effort to obtain measures of potential mediating variables such as coping style, pre-morbid mental and physical health status and social support,.

In any emergency situation, conducting a research requires to evaluate and identify the needy people to receive emergency mental health services, and to sort out what type of services are needed. Promoting resilience, preventing from psychological disorders which are related to traumatic event are needed to be studied in future. Same situation was faced while conducting this research study because of the least bothering interest of organizations both governmental and non-governmental in providing help and support.

This study was limited to only two districts of Khyber-Pakhtunkhwa i.e. Swat and Buner just because of security risks. General local conditions of these districts aftermath of conflict were better as compared to other areas of Khyber-Pakhtunkhwa i.e. Waziristan Agency and Orakzai Agency etc.

Replication of such study is possible in other districts of Khyber-Pakhtunkhwa when complete control of the areas is ensured and minimizes the risks of security.

Recommendations

It is the strength of the psychology that it always contributed clearly and meaningfully to people and societies in the context of one of the nation's specialized and learned profession. The basic crux of all the terrorism activities is fundamentally creating a psychological chaos and is by nature a psychological conflict.

Psychological evaluation and assessment of the people of the targeted areas, risks and needs after the advent of a conflict or disaster must be formulated and conducted with a focus on the types and strength/levels of symptoms experienced and formal diagnosis shall be avoided until two phases of emergency situations are elapsed. After the initial phases of the emergency situations that formal assessment and diagnosis will be made legitimately by the experts, then it will be helpful in providing treatment to illnesses, people will face. Population and individual's resilience assessment is the integral to assess risks.

Initial psychological interventions shall emphasize and provide supports to all those public and mental health activities which are helpful in eradicating and reducing mortality and morbidity. In any emergency situation psychological first aid will help in identifying and triaging those who are seriously psychologically ill and need specialized psychiatric and psychological treatment, care and using, mobilizing community-based resiliency and adaptation to the new circumstances.

To help and prevent people from the onset of psychological disorder/trauma related illness especially in vulnerable groups of women and children requires great investment in research to identify those risks.

If, want to know about the needs of the people when they are exposed to emergency situations like terrorism especially in country like Pakistan, new styles, ways and abrupt research planning should be formulated otherwise will not be able to know people's need . Along this we will never be able to discover ways and techniques to identify who is at high risk, and what kind of intervention will be needed to eradicate and prevent people from developing psychological disorders on long term basis.

Disaster planning and research findings should be incorporated more rapidly. Training in clinical and other schools and even in psychology departments, disaster preparedness programs and disaster/emergency response are not included in their syllabus which is an attention seeking situations. It is advised that such training program should be included in schools, colleges and universities syllabus for prior preparation for any sort of emergency situation.

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