CHAPTER-1
INTRODUCTION AND LITERATURE REVIEW
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Background of the Study

Since 1989, the unending conflict has left its imprints on every Kashmiri. To dwell in such stressful conditions is not an easy task. It takes a heavy toll on person’s physical, social and psychological well-being. In Kashmir there are around 32,000 widows, 1500 half widows and 97,200 orphans, (Dabla, 2010). Among widows, 80 percent belong to the age group of 25 to 32 years (Mustafa, 2014). According to the Asian Human Rights Commission, there have been between 8,000 and 10,000 cases of disappearances. In such situations, the nearest aim of psychology is to help people not to feel bad. When the basic needs of security are at stake, it will be insufficient to talk of something beyond happiness as can be seen in Maslow’s hierarchy of needs (1943). Seligman (1999) argued that traditional psychology was shaped by the melancholic human history and as such the main aim of psychology remained constricted to survival and defence. But in a place like Kashmir, survival and defence still matters the most. Therefore, the role of traditional psychology is essential in a place like Kashmir. But this does not mean that there is no role of positive psychology. As Seligman (1999) said positive psychology doesn’t replace traditional psychology, it is another arrow in the quiver. Traditional psychology on one hand can help in alleviating pain and managing trauma in Kashmir and on another hand positive psychology could play a role in uplifting a person from the stage of not feeling bad to a stage of feeling good. In pursuing this goal, positive psychology utilizes the positively oriented human resource strengths and psychological capacities. Thus, in the present study, researcher has amalgamated the concepts from both traditional as well as positive psychology keeping in view the importance of both. Accordingly the topic of present research was chosen to be “Stress, Social Support and Psychological Capital as related to Subjective Well-being among Kashmiris”.

In the following sections, the variables of the present study and relationships among them are explained.

Concept and Definitions of Well-being

Well-being is an emerging concept in the field of social and behavioural sciences and is viewed as a harmonious satisfaction of one’s goals and desires (Chekola, 1975). It refers to the optimal psychological functioning (Ryan & Deci, 2001). It transcends the limitations of body, space & circumstances and reflects the fact that one is at peace with
one’s self and others (Johnson, 1986). Levi (1987) defined Well-being as a dynamic state of mind characterized by a reasonable amount of harmony between an individual’s needs, abilities & expectations and environmental demands & opportunities.

Earlier, well-being was assessed in terms of economic and social indicators as rate of unemployment, average annual income, number of people suffering from major illnesses, levels of infant mortality, etc. It was later observed that these indicators provide incomplete picture of well-being. Polard and Lee (2013) described well-being as a “complex, multi-faceted construct”. Thus social and economic indicators are unable to meet the criteria of this complexity and multidimensionality of well-being. According to Positive psychological perspective, statistical approach i.e. measuring well-being through social and economic indicators is misleading. Positive psychologists argue that assessment of well-being is not complete without subjective evaluation and positive functioning. Well-being is an intangible and amorphous concept with perception differing from person to person (Wilcock, et al, 1998). Diener (1998) argued that subjective evaluation of well-being or subjective well-being is an essential component of well-being. It reflects an individual’s own judgement about the quality of his or her life. Subjective well-being is defined as life satisfaction, the presence of positive affect and the relative absence of negative affect. Though subjective well-being seem to parallel with the hedonism, it takes a broad view of happiness, beyond the pursuit of short term or physical pleasures defining narrow hedonism.

**Hedonic Well-being**

Bentham’s (1907) conception of hedonism is simplest one. He believed that more is the pleasantness in one’s life, the better it is, and the more painfulness one faces, the worse it is. In the hedonic tradition the concept of well-being is purely subjective. What a person feels about his/her well-being is emphasized in hedonic perspective. In psychology hedonic well-being includes the pleasures of both mind and body (Kubovy,1999). Hedonic psychologists believe that well-being comprises of subjective happiness and all judgments about the pleasant/unpleasant elements of life. Happiness is thus not confined to physical hedonism, for it can be derived from attainment of goals in diverse realms (Diener et al., 1998). Kahneman et al (1999) defined hedonic psychology as the study of “what makes experiences and life pleasant and unpleasant”.

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Eudaimonic Well-being

In contrast, eudaimonic theories maintain that not all desires—when they are fulfilled—lead to well-being. They might produce pleasure but there is no guarantee that they will promote wellness as well. Thus, from the eudaimonic perspective, happiness is not the same as well-being. Waterman (1993) states that, happiness is hedonically defined, while as the eudaimonic view of well-being means to live in accordance with one’s true self. He suggested that eudaimonia occurs when a person is involved fully in life activities and these activities are in tune with deeply held values. Eudaimonia results from realization of our potentials. Carol Ryff’s (1989) concept of well-being falls into the category of eudaimonia.

Hedonic Versus Eudaimonic Well-being

Waterman (1993) argued that many activities provide hedonic enjoyment unlike eudaimonic enjoyment which is provided by comparatively lesser activities. He conducted a research on college students to examine the relationship between these two conceptions. It was concluded that substantial overlap exists between hedonic and eudaimonic happiness. However, the two conceptions differ in some cases. Waterman found that hedonic enjoyment was associated with activities that made people felt relaxed, excited etc whereas, eudaimonic enjoyment was linked to activities that created feelings of competence, challenge, etc. After examining the relationships between positive affect (hedonic approach) and meaningfulness (eudaimonic approach), King and her colleagues (2006) concluded that hedonic pleasure and more meaningful pursuits (eudaimonic pleasure) should not be rigidly bifurcated.

Subjective Well-being

Subjective well-being (SWB) has been defined as the person’s affective and cognitive evaluation of his/her own life (Deiner, 2000). Subjective well-being has three primary components- life satisfaction, positive affect and negative affect. Positive and negative affect constitute the emotional component of subjective well-being whereas life satisfaction is the cognitive component. Positive affect refers to the frequency and intensity of pleasant emotions and negative affect refers to the frequency and intensity of unpleasant emotions like worry, anxiety, depressive symptoms, etc.
Since its origin, numerous factors have been associated with subjective well-being. These factors ranged from personality to cognitive ones. Accordingly many theories were propounded to describe the nature of subjective well-being and to understand it's functioning amidst different life situations. Some earlier theories regarded subjective well-being as a result of comparisons that a person made between his current situation and criteria he has set for himself (Multiple Discrepancies Theory, Michalos, 1985). Some theorists considered personality factors as being important in predicting subjective well-being (Shimmack, et al. 2002, Steel & Ones, 2002). Whatever factors played a role in determining subjective well-being, a popular belief among researchers was that subjective well-being is maintained most of the time (Diener, 1996). It was found in many studies that subjective well-being is stable over long term irrespective of encountering stressful life events (Cummins, Weinberg, Perera, & Woerner, 2010).

To understand the mechanism through which subjective well-being remains stable, some theories were propounded which include Adaptation Level theory (Helson, 1964), Set Point Theory (Headey & Wearing, 1989) and Theory of SWB Homeostasis (Cummins, 1995, 1998, 2010).

**Adaptation level theory**

This theory was propounded by Helson in 1964. The theory proposes that an individual has a reference point for his/her subjective judgements about stimuli. These subjective judgements are determined by earlier encounter with the various stimuli. This reference point associated with the subjective judgements decides the adaptation level of a stimulus for an individual. When individual encounters any stressful situation, the adaptation level is challenged. In such situation an individual makes it sure that his/her subjective well-being does not deviate from the adaptation level. In other words this theory proposed that subjective well being is stable and even if it gets deviated after encountering stressful situation, it gets restored to earlier adaptation level. Therefore, nothing could be done to improve it. In 1978, Brickman found that emotional aspect of stressful events is over exaggerated by the researchers and the effect of adaptation is not been taken into account.
Set-Point Theory

After Brickman’s findings, researchers focused on adaptation processes instead of emotional aspects. This new approach gave rise to Set-Point Theory. This theory proposes that individuals return to a set point after encountering challenging situations and this occurs due to genetically inherited personality traits. The concept of set point was later developed further with the addition of set point range. According to Cummins (1995, 1998, 2010), the set-point lies between 55-95 points on a point scale of 0-100. It was also suggested that this range may vary a little due to individual differences (Cummins & Nistico, 2002; Diener & Diener, 2006). But this theory failed to explain the processes that were responsible for controlling set point within a narrow range. To answer this question, Theory of subjective well-being homeostasis was proposed.

Theory of SWB Homeostasis

According to this theory when a person encounters stressful Life Events, there is an activation of psychological processes in an automatic manner. This happens in order to maintain subjective Well-being within a normal range or at homeostasis. This homeostasis functions when an event that a person encounters is stressful enough to challenge the person’s normal range of well-being. At this time person is motivated to make use of the resources available to him. These resources include both internal as well as external ones (Cummins, 2010).

In case of external resources, supportive personal relationships act as a first line of defence (Cummins, 2000, 2010). As support systems act as a buffer against adverse effects of stressful life events. Internal resources include positive outlook, hopeful thinking, self-esteem etc. These resources act as cognitive buffers.

When these resources (internal & external) are available to a person, he can overcome the detrimental effects of negative life events. But, when a person is not able to avail these resources, there is homeostatic failure and result may be depression (Cummins, Tomyn, Gibson, Woerner, & Lai, 2007; Cummins & Nistico, 2002)

PERMA Model

In his book, ‘Flourish’ (2011), Seligman proposed a multidimensional model of subjective well-being, encompassing both hedonic and eudaimonic components. This model is known by the name of PERMA model. PERMA is an acronym where each
letter stands for a component of the model. In this model, P stands for Positive emotions, E stands for engagement, R stands for Relationships, and M stands for Meaning and A stands for Accomplishments.

Positive emotions comprises of hedonic feelings of happiness (e.g. feeling content, cheerful). What makes a person happy are referred to as positive emotions. Engagement refers to be in the flow while doing what a person loves to do. A person feels connected to such activities. Relationships comprise of social support systems, to be cared about and to be satisfied with the support. Meaning in life means to achieve something bigger. True happiness originates from creating and having meaning in life. Accomplishment includes sense of achievement and being progressive towards goals. These components have been found to have strong ties with well-being.

**Measures of Subjective Well-being**
Subjective well-being comprises of two components- cognitive and affective. Cognitive component includes life satisfaction and affective component consists of positive and negative emotions. Positive affect involves joy, elation, etc and negative affect involves anxiety, fear, depressive symptoms, etc. In the present study Life satisfaction and Depressive Symptoms are taken into account as the positive and negative measures of Subjective Well-being. In the following sections, the concepts of life satisfaction and depressive symptoms are described.

**Life Satisfaction**
Life satisfaction is the cognitive component of Subjective Well-being. As it is difficult to define life, so is the case with life satisfaction. This is due to the fact that life encompasses innumerable factors and each factor in itself or life as a whole is a subjective experience. What might be satisfying for one person may be dissatisfying for another. For some people, life satisfaction might be equivalent to the fulfilment of basic needs, but for others it may be related to achievement of higher goals. Therefore, there is ambiguity in defining the concept and what it entails depending on the level of perception of each individual. Therefore one can find many different definitions and approaches.
Approaches to Life Satisfaction

Theories that emphasize objective circumstances and contextual sources as most persuasive for life satisfaction judgments are commonly named bottom-up theories whereas theories that make emphasis on stable individual attributes are named top-down theories.

**Top Down Approach**

Top-down theories state that global personality traits predispose level of life satisfaction (Costa & McCrae, 1980). This approach asserts that humans possess a global tendency to experience things positively and this tendency determines the interaction of person with his/her environment in a given context. As cited in the doctoral dissertation of life satisfaction in late life, Berg, A.I (2008) stated that certain traits, in particular extraversion and neuroticism, determine to what degree people experience happiness. Evidence for the stability of life satisfaction (Diener et al., 1999) supports the top-down perspective. Adaptation theory is one illustrative of the top-down approach that gives a more complex elaboration of the finding that critical life occasions, for example, changes in wage, marital status, and health status just have here and now impacts on life satisfaction. Su, Diener & Fujita (1996) revealed that the effect of a life event on life satisfaction diminishes in quality and decrease following 3 months. This demonstrates an adjustment has happened and life satisfaction is not influenced again. However, Adaptation theory has not been left unchallenged. In sum, among top-down theories, Adaptation theory is still controversial and an object for empirical testing, whereas the relevance of global personality traits is generally accepted.

**Bottom up Approach**

The proponents of the bottom-up perspective build their approach on the assumption that happiness depends on the realization of certain basic and universal human needs. Consequently, contextual conditions are influential sources of life satisfaction. This approach regards life satisfaction as the sum total of pleasure moments a person has experienced so far. In other words, a person assesses his/her life satisfaction by mentally adding up the experiences of pleasure and pain. Schimmack et al., (2002) proposed that bottom-up theories conceive life satisfaction as a sum of the satisfaction with various life domains. Being happy with social relations, lodging, well-being, or family decides a
higher satisfaction with life. Some contend that life satisfaction relies upon life conditions and the individual judgment of these, while other bottom up speculations, for example, the social-cognition tradition (Strack, 1988) see life satisfaction reports basically as articulations of what strikes a chord at a given moment.

Experimental studies within the social-cognition tradition have shown that level of life satisfaction depends on temporarily accessible information via mood influence (Schwarz & Strack, 1999, 1991; Schwarz, Strack, & Mai, 1991; Strack, Martin, & Schwarz, 1988). An event that comes to mind can influence reports of life satisfaction via mood in two different ways according to how the information is used; directly, as an assimilation effect, by forming the mental representation of “life today” or as a contrast effect by which current life situation can be compared.

Life satisfaction has been among the key indicators of Well-being. It has been used to assess the welfare of societies for more than three decades (Zapf 1984). As per Diener and Suh (1997), well-being is comprised of three inter-related components—pleasant moods/emotions, unpleasant moods/emotions and cognitive sense of satisfaction. Pleasant and unpleasant moods are called affect and the cognitive sense of satisfaction with life is known as life satisfaction. Life satisfaction is regarded as an essential construct in positive psychology (Gilman and Huebner 2003). Measures of life satisfaction entail the entire spectrum of functioning, thereby providing indicators for both well-being and psychopathology. Veenhoven (1984) defines life satisfaction as “the degree to which an individual judges the favourableness of quality of his life as a whole”. Life satisfaction is a holistic view, encompassing the overall life span of an individual and is not a specific aspect (Bowling, 1997). Life satisfaction refers to the attitudes that the individuals possess about their past, present as well as future, with respect to their psychological Well-being (Chadha and Van Willigen, 1995). Life satisfaction is one among a wide range of concepts that is assumed to reflect the conditions of life. Life satisfaction is the extent to which a person positively evaluates the overall quality of his/her life. It refers to an overall evaluation of life rather than to current feelings. According to Tellman and Unsal (2004) “life satisfaction, in general, represents personal satisfaction about his/her own life”. Heller et al. (2002) proposed that life satisfaction is a summary of evaluation on the parts that the individual likes or dislikes in his /her own life. Diener (1984) defined life satisfaction as “a cognitive judgmental global evaluation of one’s life. It may be influenced by affect but is not itself a direct measure of emotion”.

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Life satisfaction and Demographic Variables

Life satisfaction differs considerably across gender. Significant difference has been found in life satisfaction scores between males and females (Al-Attiyah & Ramzi Nasser 2016). Shi, et, al, (2015), carried out a cross sectional study to investigate the related demographic factors of life satisfaction and it was found that life satisfaction differed significantly across gender. Jan & Tasia (2008) conducted a study to evaluate life satisfaction among women and to analyze the influence of socio-personal characteristics of women on life satisfaction. Sample comprised of 120 women from J&K. Life Satisfaction Scale was used to collect data. After analysis, it was found that with an increase in age, the overall life satisfaction decreases, whereas with an increase in personal income and family income, the overall life satisfaction increases. Daig et al., (2009) carried out a research study to determine age and gender difference effects in domain-specific life satisfaction in the German population. 5,036 participants (53.6% female) with mean age, 48.4 years were approached. Measurements included domain-specific life satisfaction (FLZM), anxiety (GAD-7), Depressive symptoms (PHQ-2), and socio demographic variables (e.g., marital status, income, employment, education, urbanity, part of Germany, religiousness, age and gender). Results indicated that women were more satisfied with their family Life, men showed greater satisfaction with their leisure activities. Age-group differences appeared in every life satisfaction domain.

Depressive Symptoms

Depressive symptoms are the expression of negative affect. Depression has been defined as a mood of sadness consisting of feelings of hopelessness and helplessness. Depression is more than usual sadness that fails to recover within a reasonable length of time. The term ‘depression’ can variably be defined as an affect, mood state, a disorder or syndrome, or a specific entity. Depression can be viewed as a temporary feeling of sadness or gloom, often occurring due to a perceived loss or sense of helplessness regarding a particular event. A depression ‘condition’ (be it a disorder, syndrome or specific disease entity) is generally distinguished by a longer duration, by more or greater number of clinical features and by distant social impairment. In its clinical state, major depression (APA, 2000) represents a debilitating syndrome which lasts for a minimum of two weeks; although in many instances the length of depression is much longer.
Different perspectives explain depression in different ways. Psychoanalytic theory interprets depression as anger turned inward against the self. Freud (1917) theorized that the potential for depression is created during oral stage of psychosocial development, if a child’s needs are insufficiently or overly gratified. He also argued that in some cases depression may occur due to loss or rejection by parent.

Behaviouristic approach focuses on the similarity between depression and the phenomenon of learned helplessness. According to this view, depression occurs when a person believes that his actions make no difference in bringing about pleasure. In this perspective behaviour is viewed in terms of people’s skills in getting social reinforcement and their typical ways of dealing with stressful situations. Behaviourists believe that the people cope with stress by delaying and seeking emotional support from others.

According to cognitive perspective depressed people perceive causes of events in an unfavourable way. Here negative thoughts and beliefs are considered as major causes of depression. Aeron Beck’s theory (1976) is the most important cognitive theory of depression. Beck proposed that depression is associated with the negative triad: negative views of the self, the world and the future. According to this model, negative schemata acquired in childhood due to loss of a parent, social rejection etc causes cognitive biases or tendencies to process information in certain negative ways.

The manifestations of depression have been pretty much set in the literature of psychiatry since the mid 1970s, when Research Diagnostic Criteria (Feighner et al.1972) were initially created. According to Radloff (1977), the major components of depressive symptomatology include depressed mood, feelings of guilt and worthlessness, loss of appetite, feelings of helplessness and hopelessness, sleep disturbance and psychomotor retardation.

The current list of symptoms(DSM V, 2013) for diagnosing depression include depressed mood, loss of interest/pleasure, changes in sleep(insomnia or hypersomnia), psychomotor agitation or retardation, changes in appetite or weight, feelings of worthlessness or excessive or inappropriate guilt, recurrent thoughts of death, fatigue/loss of energy, decreased focus or concentration.

**Depressive Symptoms and Demographic Variables**
Depressive symptoms vary considerably across gender and other demographic variables.
Age, gender and marital status have been found to have profound impact on depression. Women typically have a twofold increased risk of major depression as compared to men (Bebbington, 1996). Individuals who are separated or divorced have significantly higher rates of major depression than do the currently married and prevalence of major depression generally goes down with age (Velde, et al 2010; Andrade, et al 2003; Weisman, et al, 1996).

**Depression in Kashmir**

The prevalence of depression in Kashmir has been found out to be 55.72 %, being highest in 15-25 year age group, followed by 65.33 % in 26-35 age groups (Amin & Khan, 2009). Research has indicated that 70-80% of acute depression cases are women. Dr. Arshid Hussain, a psychiatrist points out that 25% of the people of Kashmir suffer from lifetime depressive symptoms. Reports indicate that more than 60% of the patients reported at Srinagar Psychiatric Hospital were women, and almost 50% suffered from major depression (Jeelani, 2002). According to a recent Kashmir Mental Health Survey Report (2015), 1.6 million adults (41%) are living with depressive symptoms and 415,000 (10%) meet the criteria for severe depression. Also, 37% of adult males and 57% females suffer from probable depression as indicated by the report.

**Life satisfaction and Depressive symptoms: Two poles of Subjective Well-being**

Life satisfaction and depressive symptoms could be regarded as the two poles of subjective well-being, with life satisfaction at positive end and depressive symptoms at negative end. Daig et al., (2009) carried out a research study to determine the interaction effects in domain-specific life satisfaction in the German population and examined to which degree depressive and anxiety symptoms are associated with life satisfaction in addition to socio demographic variables, and which domains are affected. 5,036 participants (53.6% female) with mean age, 48.4 years were approached. Measurements included domain-specific Life satisfaction (FLZM), anxiety (GAD-7), Depressive symptoms (PHQ-2), and socio demographic variables (e.g., marital status, income, employment, education, urbanity, part of Germany, religiousness, age and gender). Anxiety and Depressive symptoms contributed significantly to the explained variance of domain-specific Life satisfaction.
In a population based twin study (Ragnhild, Nikolai, Espen, Ragnhild, Kristian and Ted, 2012), the genetic and environmental influences on association between Major Depressive Disorder and Life satisfaction was examined. It was found that individuals who fulfilled the criteria for MDD (Major Depressive Disorder) reported significantly lower levels of Life satisfaction. Rapaport et al., (2005), while examining the quality of life impairment in depressive disorders found that 85% subjects with double chronic depression, 63% with MDD and 56% with dysthymia had severely impaired satisfaction scores. Koivumaa-Hoonknen, Kaprio, Honkanen and Koskenveo (2004) conducted a study in order to investigate the cross sectional and longitudinal relationship between Life satisfaction and depressive symptoms in healthy adults. It was a 15 year prospective study conducted on 9697 Finnish healthy adults who responded to Life satisfaction Scale and Beck Depression Inventory. An increased risk of depression was found in those who were dissatisfied as compared to satisfied individuals.

In 2016, Srivastava explored the relationship between life satisfaction and depression among 140 working and non working married women. After analysis it was found that life satisfaction correlated negatively and significantly with depression.

The well-being of a person is determined by numerous factors. These factors may influence well-being in two ways. The first way is to increase life satisfaction and reduce depressive symptoms, thereby contributing positively to well-being. The second way is to decrease life satisfaction and increase depressive symptoms, thereby reducing well-being of a person. In the present study, contribution of three of these factors- Stress, Social Support and Psychological Capital will be examined on two measures of Subjective Well-being i.e. Life satisfaction and Depressive symptoms. In the following sections, Stress, Social Support and Psychological Capital and their relationship with Subjective Well-being (Life satisfaction & Depressive symptoms) are discussed.

**Stress**

Stress is an unwanted but unavoidable phenomenon that is encountered at one time or another during the course of one’s life. Stress has a profound impact on the well-being of a person.

Walt Schafer (1991) defined stress as arousal of mind and body in response to demands made upon them. Stress is a universal feature of life as arousal is an unavoidable thing. Some degree of arousal is always associated with our thinking,
feeling and acting. A person can’t and he/she shouldn’t avoid stress rather he/she should learn to manage and direct it. Stress has multifaceted nature. Stress involves whole body of a person. In addition to physiology, thoughts and emotions are also present. Behaviours such as short temperedness, fast talking, etc are often outward manifestations of stress (Schafer, 2000, p.6.)

According to Selye (1973), “complete freedom from stress is death”. Some amount of stress is necessary to keep a person motivated (Zuckerman, 1994). As is stated in Holy Quran, “Be sure We will test you with something of fear and hunger, some loss in goods or lives, but give glad tidings to those who are steadfast, who say when afflicted with calamity: To God we belong and to Him is our return. They are those on who (descend) blessings from God and mercy and they are the ones that receive guidance.” (Qur’an 2:155). Stress is not always negative, it can be positive as well. Positive stress is called eustress (Hans Selye, 1936) and negative stress is known as distress. In daily life ‘stress’ is often used to refer to negative stress. Positive stress leads to motivation and better performance. Events such as getting married, having a child, getting a promotion at work, or winning a major competition can give rise to the pleasurable rush associated with eustress. In general, people perform at their best and live their lives to the fullest when they experience a moderate level of stress. Distress, or negative stress, is caused by events such as financial problems, the death of a loved one, academic difficulties, and the breakup of a relationship, etc.

**Approaches to Stress**

There are three approaches to address the concept of stress. They are

1. **Stimulus**: The concept of stress as a stimulus originated during 1960s. In this approach the environment of a person is emphasized. Under this approach, stress is referred to as external threats that are both physically and psychologically challenging. Stress refers to external pressures which tensions the internal pressures. Stress can be considered as any factor (life event or change) which acts at internal or external level and makes it difficult to adapt and that induces increased effort on the part of the person to maintain a state of equilibrium both internally and with the external environment (Humphrey, 1992).

2. **Response**: This approach emphasizes responses of a person to Stressful situation. As per this approach, stress is defined as a reaction to a stimulus that disturbs our physical or
mental equilibrium. Stress is an organism’s response to a challenge, be it right or wrong.” Stress as the body’s automatic response to any physical or mental demand placed upon it. Stress has generally been regarded as neurological and physiological responses that serve an adaptive function (Franken, 1994). Stress may be viewed as the body’s response to any real or imagined event perceived as requiring some adaptive response and/or producing strain (Eliot, 1988). The response to Stressor may be either physiological such as perspiration, dry mouth etc or psychological such as feeling nervous etc. This physiological or psychological response to stressor is called as strain.

3. **Process**: This approach emphasizes the relationship between person and environment. Stress results as a person continuously transacts with environment. Stress can be loosely defined as "the relationship between the person and the environment that is appraised by the person as taxing and endangering to his or her well-being" (McGowan et al. 2006, p. 92). Stress is a process of behavioural, emotional, mental and physical reactions, caused by prolonged, increasing or new pressures which are significantly greater than coping resources. This approach views person as an active agent possessing various strategies to combat stress.

**Forms of Stress**

There are three forms of stress: acute, episodic and chronic.

**Acute Stress**: It is typically intense, flares quickly, and disappears. This form of stress is widely experienced, as it is triggered by daily demands and pressures of recent past and near future. It brings joy, excitement and thrill in small doses but too much of it is exhausting. It occurs for short span of time and is followed by several emotional and problems like anger, anxiety, irritability etc and physical problems like headache, upset stomach, dizziness, bowel disorders etc.

**Episodic Stress**: when acute stress occurs frequently, it is termed as episodic stress. This type of stress is experienced by those who make unrealistic demands and thus feel stressed while attempting to accomplish these goals. People with Type A personality witness this type of stress frequently. Symptoms of episodic stress include longer periods of intermittent depression, anxiety, ceaseless worry, etc.

**Chronic Stress**: In contrast to acute stress, chronic stress is dangerous and unhealthy. This is the grinding stress that wears people away day after day, year after year. It gets accumulated with time when a person is exposed to traumatic events. Chronic stress
destroys bodies, minds and lives. It comes when a person never sees a way out of a miserable situation. It's the stress of unrelenting demands and pressures for seemingly interminable periods of time. With no hope, the individual gives up searching for solutions. Chronic stress may lead to serious health issues like cancer, coronary heart diseases, etc.

**Physiological consequences of Stress**

Stress takes a heavy toll on a person’s physiology. Whenever a person confronts any stressor, many physiological reactions follow such as rapid heartbeat, dry mouth, trembling of legs and arms etc. This physiological part of strain (response to stressor) is called reactivity. Reactivity is measured by comparing it with a resting level of arousal (Lovallo, 2005). Stress affects almost every part of the body. Some of the physiological effects of stress are briefly given below:

- High stress levels may cause excessive hair loss and some forms of baldness. The most common stress-induced hair loss is telogen effluvium. This condition pushes colonies of hair into a resting phase in which much more hair falls out than grows. A similar condition, alopecia areata, occurs when stress triggers white blood cells to attack and destroy hair follicles.
- Pain in the neck and shoulders, lower back pain, and many minor muscular twitches and nervous tics are more observable under stress.
- Cardiovascular disease and hypertension are linked to accumulated stress.
- High levels of mental or emotional stress adversely affect individuals with asthmatic conditions.
- Menstrual disorders and repetitive vaginal contaminations in women and impotence and untimely discharge in men.
- Stress can cause or aggravate diseases of the digestive tract including gastritis, stomach and duodenal ulcers, ulcerative colitis, and irritable colon.

Walter Canon (1929) provided a basic description of body’s physiological response to stressors. He was the first to describe the “fight or flight response” as a series of involuntary physiological and biochemical changes that prepare an individual to deal with threats or danger. In the flight or fight response, sympathetic nervous system stimulates many organs of the body. In addition, adrenal glands are also stimulated by sympathetic nervous system (SNS) to secrete adrenaline which arouses the body further.
Canon was of the view that this arousal could be either positive preparing the body for threat or negative as it can be harmful if it is prolonged.

**General Adaptation Syndrome**

Hans Selye (1936) discovered that fight or flight response is just one out of series of physiological reactions to stress. According to Selye, stress is the ‘non-specific’ physiological response of the body to any demands that are made upon it, which means that the body responds to stress in the same way, despite the nature of the external stressor. Selye introduced his concept of the body’s physiological defence against stress and called it: ‘General Adaptation Syndrome,’ which consists of three main stages.

**Alarm Stage:** When a stressor is encountered that exceeds a person’s resources to combat it, an alarm is initiated. In this stage, the body activates and begins to mobilize its resources against the stressor. Selye called this first stage the alarm phase—but it is similar to the pattern of reactions Cannon called the fight-or-flight response. The hypothalamus sets off two parallel emergency messages. One message signals the hormone system, especially the adrenal glands. The result is a flood of steroid hormones into the bloodstream—chemicals that support strength and endure. Endorphins are also released, which reduce the body’s awareness of pain signals. Second message is relayed through the sympathetic division of the autonomic nervous system to internal organs and glands, arousing the body for action. Blood flow to the heart, brain, and muscles increases, enabling us to think and react better and faster. Blood flow to the digestive system, conversely, decreases—presumably so our bodies are not expending precious energy on nonessential functions during an emergency. Pupils dilate, enhancing peripheral vision, and perspiration helps keep the body from overheating. Available blood sugar increases as well, to provide an additional energy boost. Hypothalamus-pituitary-adrenal axis (HPA) is activated in alarm phase. Hypothalamus stimulates pituitary gland to secrete ACTH (Adreno Cortico Tropic Hormone) which in turn causes adrenal gland to release cortisol into blood. In this way body’s mobilization is further enhanced.

**Resistance Stage:** If the stressor persists—but is not so strong that it overwhelms us during the first stage—we enter the resistance phase. During this stage, reactions of SNS become less pronounced and the HPA activities predominate. The immune system is in high gear as well, and white blood cell count increases to help fight off infection. In this stage, the body attempts to adapt to the stressor. But it may become less possible for a
person at this stage to fight another stressor. As per Selye, this makes a person vulnerable to health problems which he termed as diseases of adaptation.

**Exhaustion Stage:** If the organism is not able to return to a normal level of resistance a third stage, the stage of exhaustion, ensues. At this time, endocrine activity is heightened; high circulating levels of cortisol begin to have pronounced negative effects on the circulatory, digestive, immune, and other systems. Human resources become depleted, and permanent damage to the system through wear and tear or death or both is likely to occur.

**Psychological consequences of Stress**

Stress evokes a wide range of emotions in person experiencing it ranging from a sense of exhilaration, in the face of minor challenging stressors to the more familiar negative emotions of anger, nervousness, fear, jealousy and discouragement. Under stressful conditions, the sensitivity to environment diminishes. Disturbances in sleep occur. People get irritated and lose their temper easily when they are under stress. Memory is also impaired during stress. Under these stressful circumstances, the mind can draw a “blank,” and information that would normally be easily retrieved can be forgotten. There is difficulty in concentrating on a particular task. Under stressful situations, a person gets agitated and finds it difficult to get relaxed.

**Sources of Stress (Stressors)**

Stress is caused by a multitude of demands, such as an inadequate fit between what we need and what we are capable of, and what we are offered and what it demanded (Levi, 1996). The physical, environmental and social causes of stress state are termed as stressors. A stressor is any factor that causes disturbance in homeostasis. It may be purely physical, for instance an injury or trauma, noise, extreme temperatures, and so on. Stressors can be defined as external events that cause internal stress responses (both psychological and emotional) and biological or physiological reactions (Krantz, Grunberg & Baum, 1985). Stressors may also be psychological or psychosocial such as uncertainty, significant life events, time pressure, interpersonal difficulties, etc or stressors may be a combination of several factors. Stressors vary in intensity and can originate both from within the individual and from his or her environment.

Three major forms of stressors have been investigated in the literature: life
events, chronic strains, and daily hassles. Chronic strains are persistent or recurrent demands which require readjustments over prolonged periods of time (e.g., disabling injury, poverty, marital problems).

Hassles (and uplifts) are mini-events which require small behavioural readjustments during the course of a day (e.g., traffic jams, unexpected visitors).

**Stressful Life Events**

Any event that demands readjustment in one’s routine life induces stress. Life events are acute changes which require major behavioural readjustments within a relatively short period of time (e.g., birth of first child, divorce). Any event pleasant as well as unpleasant which forces an individual to shift from his /her habitual pattern would be stressful. Life events are the demands of a particular situation where individual has to exceed the resources available and thereby threaten his /her well-being and necessitate a change in managing the situation. Life events are typically defined as experiences that cause the individual to substantially readjust his or her behaviour patterns (Dohrenwend and Dohrenwend, 1974; Holmes and Rahe, 1967). Selye (1956) in his classical work postulated that any type of life change could act as a stressor causing physiological arousal and enhanced susceptibility to illness.

Research has indeed found relationships between life changes and Stress. The birth of a child, for example, is often associated with lower marital satisfaction (Cowan & Cowan, 1988). Life events are associated with both physiological and psychological disturbances. Numerous studies have found relationship of stress with many diseases and dysfunctions e.g. headaches (Kohler and, Haimeri, 1990), rheumatoid joint pain (Anderson et al, 1985), cancer (Haney, 1997), coronary heart disease (Singh and Misra, 1987; Esler, 1998) and high blood pressure (Fredrickson and Mathews, 1990).

**Stress in Kashmir**

Being a conflict zone, people in Kashmir encounter numerous stressful events in their lives. An average adult in Kashmir witnesses 7.7 traumatic events during his/her life time (Kashmir mental health survey report, 2015). There are around 32,000 widows, 1500 half widows and 97,200 orphans, (Dabla, 2010). Among widows 80 percent belong to the age group of 25 to 32 (Mustafa, 2014). According to the Asian Human Rights Commission there have been between 8,000 and 10,000 cases of disappearances.
More than 15 percent of Kashmiris are afflicted with Post-Traumatic Stress Disorder (PTSD), according to a recent study by M.A. Marghoob (a leading psychiatrist). In a study it was found that in a sample of 167 PTSD patients, 35% patients had witnessed violent killing of their close relatives and 20% reported to have been tortured, and 30% were injured in shootouts, explosions, and so forth (Marghoob & Husain, 2001). According to Dr. Arshad (Psychiatrist, Psychiatric Hospital Srinagar), women form the major portion of the population suffering from PTSD. The community prevalence of trauma exposure in general population is 58.69% (59.51% in males and 57.36% in females), in Kashmir, while as the lifetime prevalence of PTSD in community is 15.19% (Marghoob et al., 2006).

**Stress and Well-being**

Whether positive or negative, almost all major life events have a variety of outcomes on person’s physical states and psychological experiences. The life events have adverse effect on well-being when they are stressful. In other words only those events which have stress (positive or negative) associated with them can affect an individual’s well-being.

**Stress and Life Satisfaction**

The life events when negative may create negative feeling causing people to experience its negative impact on their health and happiness. Several studies have demonstrated a negative relationship between stressful life events and life satisfaction. Shi, Wang, Bian & Wang (2015) examined the relationship between stress and life satisfaction in a sample of 2925 students. Stress was found to be negatively correlated with life satisfaction. In a study Bratt, Stenstrom and Rennemark (2016), found that the stressful life events like loss of spouse, child or both have negative association with life satisfaction. In yet another study (Kumar, Shaheen, Rasool & Shafi, 2016), the relationship between psychological distress and life satisfaction was examined. DASS (Depression Anxiety Stress Scale and Satisfaction with Life Scale were administered on 398 university students. Results indicated a significant negative correlation between psychological distress and life satisfaction. In a study to examine the impact of spousal bereavement on the self assessed health status, Tseng, Petrie and Gonsalz (2014) have found that spousal bereavement increases depression by 1.46 CES-D points and decreases life satisfaction.
by 0.71 points. Kang, Chapin & Kim (2017) found that lower levels of stress were directly associated with higher levels of life satisfaction. Stress has been found to predict life satisfaction as well. In a study conducted by Farooq (2017) on widows, it was found that stress predicted life satisfaction negatively and significantly. The effect of stressful life events on life satisfaction is not only retrospective but prospective as well. Luhman, Lucas, Eid & Diener (2012), examined the prospective effects of life satisfaction on life events. Longitudinal data from three nationally representative panel data was analyzed. It was found that increase in Life satisfaction was associated with increase in Life Events like marriage and child birth and decrease in life events like marital separation, job loss, relocating etc. Life satisfaction was found to be an important predictor of Life outcomes.

**Stress and Depressive Symptoms**

Depression may be triggered by a multitude of factors. One such factor is encountering Stressful life events (Kendler, Karkowski & Prescott, 1999). Mild and moderate stressful life events have been found to be positively related to increase in Depressive symptoms (Sangeun & Kenneth, 2013). Exposure to stressful events may act as a risk factor for adverse psychiatric outcomes including depression (Lowe, Joshi, Galea & Aiello, 2017).

Armstrong and Boothroyd (2008) conducted a study on 125 adolescent girls and found that stressful life events were significant predictors of emotional problems and other psychological problems. Stressful life events are causal for the onset of depression (Hammen, 2005; Kendler et al. 1999). Stressful life events are often preceded by anxiety disorders (Faravelli & Pallanti 1989, Finlay-Jones & Brown 1981). Stressful life events trigger episodes of depression (Kendler, Karkowski and Prescott, 1999). It has been found that certain types of life events like loss and humiliation trigger depressive episodes (Kendler, Hettema, et al., 2003). People with depression report that they had been experiencing long term chronic stressors such as poverty before depression (Brown & Harris, 1989). Depressive episodes often develop following the occurrence of a major negative life event (Paykel 2001). In 2000, Kendler, Thornton and Gardner, found a strong association between life event occurrence and the onset of major depression. In another study carried out by Hetolang & Amone, P’ Olak in 2016, it was found that people higher on depression have experienced more negative events. Leano & Kennedy (2017) assessed depression and Stressful Life Events in 304 students at Botswana
University. After regression analysis it was found that Stressful Life Events significantly predicted Depression.

Social Support

As can be seen, well-being and its determinants are adversely affected by stressful life events. But many people manage to cope up during stressful times and move on. They possess some internal as well as external resources which don’t let them to fall an easy prey to stressors. These resources guarantee their well-being amidst stressors. The resources may be available in many forms and from many sources. External resources may include social support systems like family, friends, etc. In his book, ‘Bowling Alone’ Robert Putman concludes, “As a rough rule of thumb, if you belong to no group and decide to join one, you can cut your risk of dying over the next year in half” (Putman, 2000, pp. 331).

The roots of the concept of social support are found in nineteenth century when sociologists such as Durkheim (1951) established the link between diminishing societal ties and an increase in suicide. Social support evolved as a concept over time starting with the term ‘societal ties’, as used by Durkheim. Broadly speaking, social support is the “resources provided by others” (Cohen & Syme, 1985). Capalan (1974) defined social support as range of significant interpersonal relationships that have an impact on individual’s functioning. Social support is usually defined as the existence or availability of people on whom a person can rely, who let a person know that they care about, value and love him/her.

Albrecht and Adelman (1987) define social support as “verbal and non-verbal communication between recipients and providers that reduces uncertainty about the situation, the self, the other, or the relationship, a perception of and functions to enhance the personal control in one’s life experience”(p.19).

Kaplan, et al. (1977), viewed social support as enduring interpersonal ties within a group of people who can be relied upon to provide emotional sustenance, assistance and resources in times of need, provide feedback, and share standard values. The National Cancer Institute (www.cancer.gov/dictionary) defines social support as “a network of family, friends, neighbours and community members that is available in times of need to give psychological, physical and financial help”. Gottlieb (2000) defined social support more broadly as the “process of interaction in relationships which improves coping,
esteem, belonging and competence through actual or perceived exchanges of physical or psychosocial resources” (p.28). Lin, Dean, & Ensel (1986) in their book entitled ‘Social Support, Life Events and Depression’, have given a synthetic definition of social support which was arrived at by induction. They have defined social support as the perceived or actual instrumental and/or expressive provisions supplied by the community, social networks and confiding partners. Social support is provided by primary groups most important to the individual (Cassel, 1974). Social support is sometimes seen as attachments among individuals or between an individual and a group that serve to promote emotional mastery, offer guidance and provide feedback about one’s identity and performance. (Caplan, 1974). Social support begins in infancy. As life progresses, support is derived increasingly from other members of the family, then from peers at work and in the community, and perhaps, in case of special need, from a member of the helping professions. As life’s end approaches, social support is again derived mostly from members of the family (Cobb, 1976).

**Received v/s Perceived Social Support**

Two types of social support have received attention in research endeavour – perceived social support and received social support. Perceived support refers to the psychological sense of support derived from feeling loved, valued and part of a network of reliable and trusted social relationships (Gottlieb, 1985). Received support, on the other hand, represents concrete instances of helping derived from one’s social network, with this help or ‘provisions’ usually being categorized as emotional support, instrumental support, appraisal support and informational support (House and Kahn, 1985).

Perceived social support, also known as available or functional support was derived from the findings of epidemiological research. This type of support is considered as a generalized resistance factor (Casel, 1976; Cobb, 1976; Weiss, 1974). Perceived social support is useful to persons confronted with stressors as it enables them with more support to deal effectively and in a better way with problems evoked by stressors.
Social Support and Stress

The role of social support in dealing with stress has been well documented. There are two main models to describe the mechanisms through which social support functions to ameliorate the effects of stress on the physical and psychological well-being of a person—Stress Buffering Model and Direct Impact Model (Cohen and Wills, 1985).

**Stress Buffering Model:** This model proposes that social support is beneficial for the people who are under stress. Social support protects (or "buffers") people from the bad effects of stressful life events (e.g., death of a spouse, job loss). The buffering (interaction) effect model hypothesizes that social support mediates or 'buffers' the adverse effects of chronic or adverse life stressors (Cohen & Wills, 1985). In this model it is believed that social support prevents those responses to stressful situations that may be harmful for the well-being of a person. The perceived availability of social networks helps a person to appraise stressful situations as benign or less threatening. In this way social support (perceived) prevents the health compromising responses while encountering stressors. The functional aspects of social support such as perceived support operate through stress buffering mechanism. This effect influences problem-solving coping directed at changing or managing the stress situation (Thoits, 1986).

Stress buffering gets confirmed when the association between stressful situations and poor health is weaker for people with higher social support. The weak association between stress and health for people with high social support means that social support has shielded people from stress. As stated by Lazarus and Folkman (1984) regarding the relationship between the life-events and social support; “it can help to prevent stress due to events, i.e. by making harmful and threatening experiences been less consequential, or provide valuable resources when stressful event does occur”. Thus social support serves as a buffer in facing stressful events. Stress buffering is commonly seen in case of perceived support than for received support.

**Direct Impact Model:** This model proposes that social support has benefits for all people whether they are under stress or not. The structural aspects of social support such as social networks & social integration operate through this mechanism. Social integration provides normative guidance to a person about healthy behaviours. Social networks lead to positive psychological states like sense of purpose, security, etc. In the direct impacts (likewise called fundamental impacts) theory, individuals with high social support are in preferred well-being over individuals with low social support, hardly affected by stress.
In addition to showing buffering effects, perceived support also shows consistent direct effects for mental health outcomes. Both perceived support and social integration show profound impact on well-being. The direct (main) effect model of social support states that social support can prevent exposure to certain stressors, induce more benign appraisals of threat and/or boost morale and sense of well-being (Gottlieb, 1981). This effect impacts the well-being in ways that don't essentially include enhanced method for adapting to actual stressors or stressful events. In this model, social support is seen as a vital etiological variable, and is "conceptualized as a fundamental human need that must be fulfilled in order to enjoy a sense of well-being ".

Social support bears a direct relationship to measures of psychopathologies and is a method for essential counteractive action. Kessler (1989) has defined the term social support as the mechanisms by which interpersonal relationships protect people from deleterious effects of stress. Social support is an important tool for coping with stress.

**Social Support and Life Satisfaction**

Social support has a very important role to play in maintaining an optimum level of efficiency and is necessary for feelings of physical as well as psychological well being (Broadhead, et al, 1983).

In 2013, Mahanta and Aggarwal studied the effects of Perceived Social Support on the Life satisfaction of 100 University Students. Gender differences of perceived social support and life satisfaction, among the participants were also investigated. The Perceived Social Support Scales by Procidano & Heller and the Satisfaction with Life Scale (SWLS) by Diener, Emmons, Larsen, & Griffin (1985) were administered to the participants. Results indicated no gender differences in perceived social support from family but a significant difference was found out for the perceived social support from friends. Also, it was found that female university students have a higher satisfaction with life as compared to male university students. Finally, the findings revealed that higher the levels of Perceived Social Support from family and friends, the higher the Life satisfaction. Gencoz, Ozlale & Lennon, 2004 investigated the direct and indirect effects of social support on psychological well-being among 342 undergraduate students. Results revealed that aid related social support and psychological well-being association was partially mediated by experiencing fewer life stresses. On the other hand appreciation related Social Support had a direct impact on Psychological Well-being.
Lincoln (2000) critically reviewed the literature in order to investigate the relationship between social support and negative social interactions and their simultaneous effect on psychological well-being. A review of 28 studies revealed that there are conceptual, theoretical, and methodological limitations associated with this body of research. In order to unravel some of these limitations, studies are grouped according to three conceptual models: the additive effects model, the moderator model and the domain specific model. Further, article discussed some directions for social work practice which should be taken in order to tackle and appreciate the complexities of the relationship between Social Support and psychological well-being. Social support has been found to moderate the association between stress and life satisfaction (Milesova, Gvozden, Richter, Milosen & Niklewski, 2017). Malinauskas conducted a study in 2010 to examine the relationship among Severity of injury, and participant’s perception of Stress, Social Support and Life satisfaction. Multidimensional Scale of Perceived Social Support, Perceived Stress Scale and Satisfaction with Life Scale were administered on 123 College students. Results indicate that greater perceived Stress was associated with diminished Life satisfaction for athletes with a major injury more than for those with minor injury. The interaction between perceived stress and perceived social support was associated more with diminished life satisfaction for participants with major injury. In a study, Aranda et al in 2001 investigated stress, social support and coping as predictors of depressive symptoms. One hundred and seventy one individuals participated in the study. Beck Depression Inventory, Hispanic Stress Inventory, Coping Resources Inventory-Adult Form and Dimensions of Social Support Scale were administered to collect data. It was found that men and women differ in terms of stress and social support associated with depression. For women the household context i.e., family and marital domains were significant sources of both stress and social support. For men, stress from work and support from relatives outside the household appeared to be more salient.

**Social Support and Depressive Symptoms**

Warheit (1979) found that the persons with personal, familial and interpersonal resources had significantly less depressive symptoms than those without such resources. A deficit in parental support has been shown to predict subsequent increase in depressive symptoms and onset of major depression (Stice Ragan & Randall, 2004). In turn initial depressive symptoms and major depression predicted future decrease in peer support but
not parental support. Lack of social support systems or lack of perceived support endangers well-being. Milesova, Gvozden, Richter, Milosen & Niklewski (2017) examined the role of Perceived Social Support in the association between stress and depressive symptoms. The sample for their study comprised of 412 adolescents. Multidimensional Perceived Social Support Scale, Adolescent Life Event Questionnaire and Centre for Epidemiological Studies Depression Scale were used as tools to collect data. After analysing data it was found that perceived social support acts a significant moderator in the relationship of negative life events and depression. Cacioppo, Hughes, Waite, Hawkley & Thisted (2006), determined the extent to which loneliness is a unique risk factor for depressive symptoms in 2 population-based studies of middle-aged to older adults, and the possible causal influences between loneliness and depressive symptoms were examined longitudinally in the 2nd study. In Study 1, a nationally representative sample of persons aged 54 and older completed a telephone interview as part of a study of health and aging. Higher levels of loneliness were associated with more depressive symptoms and perceived Stress. In Study 2, detailed measures of loneliness, social support, perceived stress, hostility, and demographic characteristics were collected over a 3-year period from a population-based sample of adults aged 50–67 years. Loneliness was again associated with more Depressive symptoms, net of demographic covariates, marital status, Social Support, hostility, and perceived Stress. Latent variable growth models revealed reciprocal influences over time between loneliness and depressive symptomatology. These data suggest that loneliness and depressive symptomatology can act in a synergistic effect to diminish Well-being.

Psychological Capital (PsyCap)

In addition to social support, an individual possesses other resources as well. These resources are positive psychological strengths like hope, optimism, gratitude, forgiveness, resilience, self-esteem, self-efficacy, etc. The four among these viz, hope, optimism, resilience and self-efficacy, are together referred to as Psychological Capital. Psychological Capital is an important construct in Positive Psychology. Before the emergence of Positive Psychology, traditional psychology focused on preventing people from feeling bad. Besides, there was no provision of providing any tools to feel good. Seligman argued that traditional psychology was shaped by the melancholic human history and as such the main aim of psychology remained constricted to survival and
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defence. With the advent of positive psychology, the science of well-being as Seligman called it, the focus of psychology extended to go beyond ‘not feeling bad’ to ‘feeling good’. The construct of Psychological Capital (sometimes referred to through the abbreviation PsyCap) originated from the positive organizational behaviour school of thought in twentieth century (Luthans, 2002). Positive organizational behaviour has been defined as “the study and application of positively oriented human resource strengths and psychological capacities that can be measured, developed, and effectively managed for performance improvement” (Luthans, 2002b, p. 59). The main aim of positive organizational behaviour is maximizing individual strengths rather than weaknesses (Luthans, 2002). In order to differentiate positive organizational behaviour from other positive approaches, some criteria were specified for any construct to be included. For a construct to be considered as positive psychological strength or behaviour, it must fulfil certain criteria which include- being a psychological capacity, having a foundation in sound theory and research, having stable & reliable measures and being a state like construct that can be developed and managed for performance improvement (Luthans, 2002).

Luthans et. al. (2007) investigated a number of behavioral constructs and concluded that the Self-efficacy, Hope, Optimism and Resilience meet all these criteria. Broadly speaking, psychological capital can be seen as an enhanced psychological understanding of self and others. The concept of psychological capital fills the gap between two related concepts-human capital and social capital. Human capital refers to a set of capacities that are associated with a person and social capital refers to a set of capacities that are originated through the formation of inter-personal networks and alliances (Whitehead, 2013).

At an individual level, Psychological Capital involves better understanding and control over the thoughts and emotions that shape behaviours. At social level, Psychological Capital is related to: 1) a better understanding of the role of others in shaping our feelings and actions, and 2) a better sense of appreciating the psychological drives that make people to act (Whitehead, 2013). PsyCap is developed through a pattern of investment of psychic resources that results in obtaining experiential rewards from the present moment while also increasing the likelihood of future benefit (Csikszentmihalyi, 1990). It’s about the state of the components of one’s inner life.

PsyCap represents the individual motivational propensities that accrue through positive psychological constructs such as Self-efficacy, Optimism, Hope, and Resilience.
In the present study, three components namely resilience, hope and Self-efficacy have been taken into consideration. The three components are discussed in the following sections

**Resilience**

The study of resilience started only 40 or 50 years ago. Early studies were mainly focused on young people deemed to be living in very risky social or physical environment, but over the last couple of decades it has become recognized that the demands of growing up mean that virtually all young people face Stress and pressure. As a result the study of resilience has expanded significantly and now encompasses practical applications and theoretical studies.

People encounter many challenges and threats throughout their life span but somehow they maintain their health and well-being most of the times and continue to grow. This dynamic process encompassing positive adaptation within the context of significant adversity or risk is known as resilience. In psychology literature, resilience was introduced as relevant to children by investigators who wanted to locate factors that protected those at risk of developmental psychopathology as a result of exposure to stress (Masten, 1989; Werner & Smith, 1982). The concept of resilience was first used by Garmezy and Nuechterlin in 1972 to describe a small sample of highly competent individuals who were well adjusted despite adversities like poverty, prejudice, etc. Resilience is not impermeable to Stress, instead it reflects the ability to recover and maintain adaptive behaviour that may originate from initial withdrawal or insufficiency while encountering a Stressful event (Garmezy, 1991). As per Garmezy, to be resilient one needs to show “functional adequacy (the maintenance of competent functioning despite an interfering emotionality) as a benchmark of resilient behaviour under stress” (Garmezy, 1991). Garmezy held an ecological view of resilience. He argued that some protective factors – both individual factors including temperament, positive responsiveness & cognitive skills and familial factors (internal and external) including family cohesion, warmth, parental concern, supportive institution, organization, etc all play important role in influencing Resilience.

Resilience is also defined as a dynamic process which encompasses positive adaptation amidst significant adversity (Luthar, Cicchetti and Bechur, 2000). Kahn and Mac Arthur Foundation Network on Successful Aging defined resilience as the ability to
recover swiftly from any misfortune and challenge. Ryff and Singer (2003) define resilience as “maintenance, recovery or improvement in mental or physical health following challenge”. In 2005, Ungar defined resilience as, “more than an individual set of characteristics. It is the structures around the individual, the services the individual receives, the way health knowledge is generated, all of which combine with characteristics of individuals that allow them to overcome the adversity they face and chart pathways to resilience” (Ungar, 2005a).

Resilience encompasses a set of processes that involve patterns of positive adaptation in the context of significant adversity or risk. This notion involves two critical conditions: (1) exposure to significant threat or severe adversity (Masten, Cutuli, Herbers, and Reed, 2009 p. 118); and (2) the achievement of positive adaptation despite major assaults on the developmental process (Garmezy, 1990; Luthar & Zigler, 1991; Masten, Best, & Garmezy, 1990; Rutter, 1990; Werner & Smith, 1982, 1992). As indicated by Coutu (2002) resilient people have a stout acknowledgment of reality, a profound conviction, regularly bolstered by firmly held values, that life is important and an incredible ability to improvise (Coutu, 2002). The basis for resilient responses includes flexible self concept, autonomy, environmental mastery and competence. Rutter (1987, 1990) has characterized resilience as the positive end of the distribution of developmental outcomes among individuals at high risk. Stewart and Yuen (2011) conducted a systematic review of resilience and related concepts to determine factors associated with predicting or promoting resilience. Self-efficacy, self-esteem, internal locus of control, mastery, hardiness, hope, etc were found to be associated with resilience.

Resilient responses are common across life span and such responses are named by Masten as ‘Ordinary Magic’. There are two aspects of this concept. First, resilience is not a rare thing. Most people show resilient responses to challenges of life. Second, Resilience doesn’t need extraordinary things to happen. It arises from everyday challenges of life.

As Victor Frankl (1963) argues in his book, ‘Man’s search for Meaning’, ‘will to the meaning’ is a basic motivating factor in person’s life. In order to sustain through odds of life one needs a sense of purpose, meaning and direction. Goals and ambitions give meaning to life and direct the resources towards future. When any experiences (Stressors) disrupt goals of a person, the person perceives his life as meaningless. Such
situations motivate a person to restore the sense of meaning and purpose, thereby providing avenues for personal growth and re-establishing meaning in life.

Psychological and clinical researches support the role of resilience in enhancing various aspects of human functioning, especially those related to posttraumatic coping and adaptation. Tedeschi et al., (1998). Luthans et al (2007) emphasize that resilient people use adversities as a 'springboard' to reach higher ground. Ryff and Singer (2003) also assert that resilient people experience enhanced self efficacy, self-Resilience, self-awareness, self-disclosure, relationship, emotional expressiveness, and empathy. Various studies have shown that the primary factor in Resilience is having caring and supportive relationship within and outside family. Barbara Fredrickson (2004), a psychologist, and her colleagues found that positive emotions are the "fuel" for Resilience. Positive emotions help people to find meaning in their life events. Barbara and her colleagues also found that resilient people felt more positive emotions, and it is the positive emotions that accounted for "their better ability to rebound from adversity and Stress, ward off depression and continue to grow".

**Subjective well-being and resilience**

Research has shown strong ties of resilience to well-being and its determinants. Abolghasemi and Varaniyab (2010) determined the relationship between Resilience and perceived Stress with Life satisfaction. Sample consisted of 120 students. Resilience Scale and Perceived Stress Scale were used to collect data. Results showed that Resilience and positive Stress were positively related to Life satisfaction and negative Stress was negatively related to Life satisfaction. Loh, Schutte and Thorsteinson (2013), carried out a research study in order to examine longitudinally whether Resilience mediates the relationship between Positive Affect and Depressive symptoms. Online survey of 217 participants was done and it was found that with increase in Positive Affect and resilience, depressive symptoms decrease. Negative affect and resilience also predict depressive symptoms. Also, resilience mediates the effects of positive affect on change in depressive symptoms. Achour & Nor (2014), examined the role of resilience and social support on life satisfaction and reducing of depressive symptoms in students. 200 students were approached for collecting data. It was revealed through analysis that social support and resilience positively related to life satisfaction and resilience was positively and significantly related to social support.
In 2013, He, Cao and others investigated the impact of dispositional optimism and resilience on subjective Well-being of burn patients (burn wounds being treated as severe Stressful event). 410 patients with burn wounds were approached. Data was assessed through LOT-R, Cannon Davidson Resilience Scale and Subjective Well-being Scale. After analysis it was found that dispositional optimism and resilience were significantly correlated with subjective Well-being. Resilience acts as a buffer against depression. In a study conducted to examine the association between adverse childhood experiences, adult depression and resilience, it was found that resilience moderated the relationship between adverse childhood experiences and adult depression. The association between adverse childhood experiences and depression was stronger among individuals with low resilience relative to those with high resilience (Poole, Dobson & Pusch, 2017). Samani, Jowkar & Narges, (2006), investigated the effects of Resilience on mental health and Life satisfaction. It was a cross sectional study of 287 university students. Conner Davidson Resilience Scale, Depression Anxiety and Stress Scale, and Satisfaction with Life Scale were used to collect data. After analysis it was concluded that negative emotions such as anxiety, Stress and depression have significant mediating roles on resilience and life satisfaction.

**Hope**

The concept of hope is being studied in numerous fields of health, behavioural sciences and religious studies. As per Forbes, “hope is a degree of active belief”. Tillich (1965) asserted that hope is lazy for the foolish, but hard for the wise. Everybody can lose himself/herself into foolish hope, but genuine hope is something rare and great. Hope refers to ‘the perception that one’s goals could be attained’ (Cantril, 1964; Farber, 1968; Frank, 1975; Melges & Bowlby, 1969; Menninger, 1959; Schachtel, 1959). Frankl considers hope as process of choosing personal meaning in life. Frankl believed that by rising above the apparently hopeless situations, a person arrives at meaning in life. Jevne (1994) stated that “hope has a unique meaning for each of us. It can’t be prescribed. It can’t be injected. It is hard to define and it is easy to tell a story about”. She included hope in the family of concepts such as coping, courage, faith, resilience and empowerment.

Erik Erikson defined hope as “the enduring belief in the attainability of fervent wishes”. For Gottschalk (1984), hope involves positive expectancies about specific
favorable outcomes, and it impels a person to move through psychological problems. Staats (1989) defined hope as “the interaction between wishes and expectations”. Averill, Catlin, and Chon (1990) define hope in cognitive terms as appropriate when goals are reasonably attainable, under control, viewed as important and acceptable at social & moral levels.

In behavioural perspective, hope is defined as affective form of secondary reinforcement (Mowrer, 1960). In this perspective hope is viewed as an emotion through which the future behaviour is reinforced. Here hope is linked to the expectation of pleasurable stimuli.

In 1993, two perspectives on hope were offered by Jacoby namely dynamic perspective and cognitive behavioural perspective. In dynamic perspective, hope is considered as a subjective entity and the role of hope in psychotherapeutic techniques is emphasized as was done by Erikson (1964) and Menninger (1959). Whereas, in cognitive behavioural perspective (Stotland, 1969; Gottschalk, 1974 and Averill, 1991), hope is thought of being an objective entity in terms of expectations. Psychodynamic and developmental theories believe that hope originates in early developmental stages (Gottschalk, 1974; Erikson, 1964 and Van Kaam, 1976). According to these theories, hope is regarded as a basic human behaviour that is responsible for activating, shaping and maintaining or sustaining psychological development (Aardema, 1984).

As per Erikson among basic ego qualities or virtues, hope is the earliest, most stable and indispensable which is inherent in the state of being alive (Erikson, 1964, p. 115). He believed that hope is the positive outcome of the early stage of trust and mistrust. He further said that at different stages of development, hope acquires new characteristics. When hope becomes mature, it becomes faith.

Van Kaam (1976) suggested that hope gets pampered only in relationship of mutuality. He considered faith, hope and love as indispensable triad of potentialities bestowed by God. These potentialities are inherent in humans and they have the ability of enhancing and deepening one another.

Cognitive behavioural perspective is best summed up in the classic work of Stotland (1969). As per Stotland (1969), hope is an expectation that is greater than zero of achieving a goal. Degree of this expectation is the level of person’s perceived probability to achieve a particular goal. Snyder and his colleagues (1991) defined hope more specifically in two ways. In first way hope was defined as “a positive motivational state that is based on an interactively derived sense of successful agency (goal-directed
energy) and pathways (planning to meet goals)” (Snyder, Irving & Anderson, 1991, p. 287). A second definition of hope described it as “a cognitive set that is based on a reciprocally-derived sense of successful agency (goal-directed determination), and pathways (planning to meet goals)” (Snyder, Harris et al., 1991, p. 571).

Subjective well-being and Hope

Research has shown a strong link between hope and well-being. Bailey, et al. (2007), conducted a study to explore the hope and optimism constructs and their unique variances in predicting life satisfaction. Adult Hope Scale (Snyder, 1991), Life-Orientation Test –Revised (Scheier, Carver & Bridges, 1994), Quality of Life Scale (Frisch, 1994) and Satisfaction with Life Scale (Diener, 1985) were used. Agency, Pathway Life Orientation Test Optimism and Life Orientation Test Pessimism related significantly with Quality of Life Inventory and Life satisfaction Scale. Correlations between the Hope subscales and Life-Orientation Test –Revised Subscales were stronger with the Global measure of Life satisfaction. Agency Subscale of Hope Scale was the best predictor of life satisfaction. It has been found that hope can moderate the relationship between stressful life events and determinants of well-being. Visser, et. al, (2012), examined hope as a moderator of association between negative life events and depressive symptoms. Sample comprised of 386 college students. It was found that negative life events were significantly associated with greater levels of depressive symptoms and hope moderated the relationship between negative life events and depressive symptoms. Those with higher levels of hope reported lesser levels of depressive symptoms related to traumatic events.

Valle, Huebner & Suldo in 2005 carried a longitudinal study in order to analyze the cognitive-motivational construct of hope as a Psychological Strength in adolescents. Students’ Life satisfaction Scale (Huebner, 1991), The Youth Self-Report form of the Child Behavior Checklist (Achenbach & Edelbrock, 1991) ,Life Events Checklist (Johnson & McCutcheon, 1980) and Children’s Hope Scale (Snyder, Hoza et al., 1997) were administered on 860 adolescents. Results also revealed that adolescents reporting higher initial levels of hope were more likely to report higher levels of Global Life satisfaction a year later. Besides, hope plays a functional role as a moderator in the relationship between stressful life events and adolescent well-being.
Arnau, Rosen, Finch, et al. (2007), conducted a longitudinal study to test the prospective effects of Agency and Pathway components of hope on depression and anxiety. In this study 552 college students participated. Beck Depression Inventory–II (BDI-II; Beck, Steer, & Brown, 1996), the Centre for Epidemiological Studies Depression Scale (CES-D, Radloff, 1977), and the Depression subscale from the Depression Anxiety and Stress Scales (DASS; Lovibond & Lovibond, 1995 were used. Hope was measured by the Snyder’s Hope Scale (Snyder et al., 1991). Structural Equation Modelling was used to test the reciprocal effects of the two components of hope on depression and anxiety. Results indicated significant negative effects for Agency component of hope on later depression but no unique effect of Pathway component was found. Agency component also showed a significant negative effect on later Anxiety.

In 2009, Bronk, et al. conducted a cross sectional study to examine the relationship among purpose, hope and Life satisfaction among 153 adolescents, 237 emerging adults and 416 adults. The Revised Youth Purpose Survey (Bundick et al., 2006) Meaning in Life Questionnaire (Steger, Frazier, Oishi, & Kaler, 2006), the purpose in life test (Crumbaugh & Maholick,1967), and the purpose in life subscale of Ryff’s Scale of Psychological Well-being were used in this study. Results revealed that having identified a purpose in life was associated with increased Life satisfaction at these three stages of life. Searching for a Purpose was only associated with increased Life satisfaction during adolescence and emerging adulthood. Aspects of hope mediated the relationship between purpose and life satisfaction at all three stages of life.

While examining the relationship of hope and optimism with subjective well-being among 150 women, hope was found to emerge as a significant positive predictor of life satisfaction (Farooq, 2017).

**Self-efficacy**

Self-efficacy is the first and most researched construct in Positive Organizational Behaviour. It has a widely acclaimed theoretical foundation (Albert Bandura, 1986). A long line of historical thinking has lead to the development of the construct of Self-efficacy. The concepts like wilfulness, or volition, in human thinking introduced by famous thinkers such as John Locke, David Hume, William James and Gilbert Ryle (Vessey, 1967) and the ideas like achievement motivation, (McClelland, Atkinson, Clark, & Lowell, 1953), effectance motivation (White, 1959), and social learning (Rotter, 1966)
drew Bandura to introduce self efficacy as a key concept in his Social Cognitive Theory. The theory holds that humans are not passive rather active in shaping their behaviours (Bandura, 1986). Social cognitive theory attempts to explain and predict human behaviour. It predicts that a person, person’s environment, and the cognitive & emotional processes specific to that person all interact to determine behaviour; thus behaviour can shape cognition and the environment, just as cognition and the environment can shape behaviour.

According to this theory behaviour can be best explained as a continuous reciprocal interaction among cognitive, behavioural and environmental factors. These functions operate as interacting determinants that influence one another. Within this theory there is a self theory. This self theory incorporates self-regulation and self-reflection. Self-reflection is the ability of people to reflect back on their experience with a given task and then process to what extent they can accomplish the task successfully in future. This self-reflection acts as a theoretical foundation for self-efficacy (Bandura, 1999). According to social cognitive theory, self-efficacy beliefs contribute to the base for human motivation, well-being and personal achievement. Important elements of his theory are outcome expectancies, incentives and self-efficacy that together determine behaviour.

Bandura defines self efficacy as “peoples’ beliefs in their capabilities to produce desired effects by their own actions”. Self-efficacy can be defined as the judgment that people hold about their capabilities to learn or to perform courses of action at designated levels. Self-efficacy beliefs are thus the self perceptions that individuals hold about their capabilities. It reflects a person’s belief in his/her abilities to overcome difficulties. Stajkovic and Luthans (1998) defined self efficacy as “one’s conviction about his/her abilities to mobilize motivation, cognitive resources and courses of action needed to successfully execute a specific task within a given context”. Self-efficacy is not a genetic endowment rather it is a learned human tendency to think. It is a lifelong process. Self-efficacy serves as a measure of general adaptational results. When a person has faith in his/her abilities to produce a desired impact, he has more chances to live a dynamic life.

In these definitions self-efficacy can be seen as a specific entity. Specific self efficacy follows Bandura’s conceptualization and is widely recognized by almost all efficacy scholars and the field of psychology as a whole.

Bandura emphasized the role of self-efficacy in regulating behaviour. He believed that all other motivations depend upon this core belief of self efficacy. Unless a person
has belief that he can accomplish a particular task, he has little or no incentive to act. Before making choices and initiating action, the process of self-efficacy begins. Before performing a person takes a look on his/her resources, gains information about these resources and finally integrates this information before acting.

Self-efficacy directly affects our choice behaviours. Whether a person is going to choose any particular task depends upon how efficacious the person finds himself in doing that task. Self-efficacy impacts our motivational effort as well. A person works hard and makes more effort in those tasks where he has higher Self-efficacy. Our perseverance is also affected by our self-efficacy. Those who have high self-efficacy tend to be resilient. They don’t give up easily on a task. Self-efficacy affects our thought patterns also. Person with high self-efficacy engages in positive self talks. Those with low self-efficacy are vulnerable to stress because they expect failure while as those with high self-efficacy tend to face stressors with confidence. People with high self-efficacy emphasize on those opportunities which they see as worthy to pursue. They view hindrances as surmountable. Even in situations with more obstacles and few offers, these people find out ways through ingenuity and perseverance. Those with low self-efficacy focus on hurdles rather than opportunities. They believe that their effort will be in vain without trying even in situations with many opportunities as they focus on few obstacles over which they have little control. Thus, self-efficacy has a vital role to play in stress management.

**Subjective well-being and Self-efficacy**

Self-efficacy enhances well-being and reduces depressive symptoms as can be seen in many studies. While examining the relationship between self-efficacy and life satisfaction of young adults, Caker (2012) found that self efficacy significantly predicted life satisfaction. In a three year longitudinal study to examine the relation between Self-efficacy judgments, cultural identity, theories of intelligence and depressive symptoms in a sample of 198 young people, Scott and Dearing (2012) found that people with high self-efficacy have lower depressive symptoms and increase in self-efficacy predicted decrease in depressive symptoms. Maciejewski, Prigerson & Mazure (2000), carried out a study to estimate the effects of stressful life events on self-efficacy, and to examine self-efficacy as a mediator of the effect of stressful life events on symptoms of depression. Using a sample of 2858 respondents from the longitudinal Americans’
Changing Lives study, path analyses were used to evaluate interrelationships between self-efficacy, life events and symptoms of depression controlling for a variety of potentially confounding variables. Separate models were estimated for those with and without prior depression. Results showed that for those with prior depression, dependent life events had a significant, negative impact on self-efficacy. For those without prior depression, life events had no effect on self-efficacy.

**Subjective Well-being and Psychological Capital**

Apart from its individual components, PsyCap as a whole has been found to have a profound impact on well-being. An extensive review of literature advocates the role of Psychological Capital play in determining the well-being of an individual. Research suggests positive relationship between psychological capital and various positive measures of well-being and a negative relationship with negative affect, depressive symptoms and physical health problems. Positive psychology programmes are of great use in enhancing the well-being. In order to examine the impact of positive psychology program in depression and life satisfaction in elderly, a study was conducted by Cauda-Peralta, Veloso-Berio & Puddu-Gaallardo (2012). Three groups of elderly were taken and results indicated that the group who attended positive psychology based workshops show significant decline in depressive symptoms and significant increase in life satisfaction. After analyzing literature on psychological capital and well-being (studies published between 2007 and 2014), Sabaityte (2014) found positive relationship between psychological capital and Well-being. It was also revealed that psychological capital correlated negatively with depression. Riolli, et al, (2012) examined the influence of psychological capital on the well-being of university students. Psychological Capital was found to mediate between stress and indices of psychological and Physical well-being. Psychological Capital also buffered the impact of Stress so that the relationship between stress and negative outcomes was reduced. Azimi in 2014 conducted a research study to determine the role of psychological capital in predicting mental health and well-being of female employees. 280 female employees comprised the sample. Psychological Capital Questionnaire (Luthans), Mental Health Questionnaire (Goldberg) and Satisfaction with Life Scale (Diener) were used as tools to collect data. After analyzing data, a significant positive correlation was found between psychological capital and well-being and significant negative correlation was found between psychological capital and mental
health. Riaz, Riaz & Batool (2014), conducted a study with the aim of examining the effect of positive psychological capital (Spiritual Wellness, Meaning in Life and Hope) as predictors of internalizing psychological problems (Depression, Anxiety & Stress) among flood victims. Findings indicated that positive psychological capital (spiritual wellness, meaning in Life, and Hope) had significant negative effect on depression. Gender differences were also significant. Male victims significantly scored higher on positive psychological capital as compare to female victims. Female victims significantly score high on internalizing psychological problems as compared to male flood victims. Rahimnia, Mazidi and Mohammadzadeh in 2013 examined psychological capital, constructive and destructive emotions, stress, anxiety and depression as antecedents of well-being. Sample comprised of 296 nurses. It was found that high psychological capital increases constructive emotions, decreases destructive emotions and increases well-being. Tripathi and Pankaj (2011) conducted a study aimed to explore the role of psychological capital on employee well-being and satisfaction with life among 37 male employees which were taken from insurance sector. The scales used were Psychological Capital Scale (Luthans et al., 2007), Satisfaction with Life Scale (Diener et al.1985) and Employee Well-being Scale (Ryff’s., 1985). The result of the study revealed that the psychological capital is a better predictor of employee well-being and satisfaction with life. In 2010, Khan & Hussain examined the relation of positive psychological strengths (hope, optimism, self-efficacy and resiliency) with subjective well-being and the role of social support as a moderator of positive psychological strengths. 116 men and 64 women participated in this study. Significant positive relations were found for Positive psychological strengths with subjective well-being and with social support network. Also, social support significantly moderated the relations of positive psychological Strengths with subjective well-being.
Rationale

An average adult in Kashmir witnesses 7.7 traumatic events in his/her lifetime (Kashmir Mental Health Survey Report, 2015). The consequences of the exposure of this kind are devastating. A report was released by GMC Srinagar on World Mental Health Day (19th April 2017) based on a scientific study conducted on 4000 people. The report indicated that 11.3% of adult Kashmiri population suffer from mental illness. Higher prevalence of mental health disorders was more in females than in males. The Indian national average for mental illness is quite lower than that being only 7.3% (Ganguly, 2000). Also those who had witnessed conflict induced trauma reported higher prevalence of mental illness (24.3%) as compared to those who had not witnessed such trauma (9.4%). A detailed report of mental health scenario was provided by joint collaboration of University of Kashmir, Institute of Mental Health and Neuroscience and MSF (2015). It has been reported that exposure to traumatic events is directly associated with anxiety, depression and PTSD. It was further reported that nearly 41% of adults in Kashmir are having significant symptoms of depression and 10% meet the diagnostic criteria of profound depression (Kashmir mental health survey report, 2017). 37% of adult males and 57% females suffer from probable depression as indicated by the report. According to World Health Organization 10% people who experience traumatic events will have serious mental health issues and another 10% will develop behaviour that will hinder their ability to function (WHO, 2001). Thus one could imagine the hazardous impact of violence on mental health of people in Kashmir. This debilitating scenario of Kashmir has always been the reason behind the focus of research on negative aspects in Kashmir. As can be seen in literature, the research work in Kashmir is up to a great extent dedicated to psychiatric problems like PTSD, depression, anxiety, etc. Thus, the role of traditional psychology dominated the scenario of research in Kashmir. It is obvious as the stressful situation in Kashmir, demand the role of traditional psychology for ameliorating the sufferings of people on account of encountering stressful situations since years.

However, there is a positive side to this coin, which has been neglected till now. The people in Kashmir have found numerous ways to cope with the situation. As Kashmir is a close knit society. There is great emphasis on relationships and neighbourhood. The social support systems available to a person in times of turmoil are the greatest assets one could have. The present research attempts to examine the role of
social support in determining the well-being of people residing amidst stressful environment.

Besides, there is lack of research addressing positive aspects of people of Kashmir. Positive psychological strengths are essential assets of people, especially while encountering stressful situations. These assets determine the way situation is appraised and faced, thereby, reducing the negative impacts of stressors. In Kashmir, no research regarding psychological capital has been carried out till now for general population. Psychological Capital has been studied in work settings, but the role of psychological capital resources needs the attention of researchers in the field of psychological well-being in general population. Through the present research an effort is being made to investigate the role of Psychological capital in maintaining well-being among Kashmiri people affected by conflict.

Till now no research study in Kashmir has been conducted to study the role of social support and Psychological Capital together in determining well-being amidst stress.

The present research will be the first research endeavour to find out how social support resources and psychological capital resources play their roles in ameliorating the impact of stressful situations on well-being among Kashmiris.

**Objectives**

Keeping the inter relationships among study variables in consideration, the present study was carried out in order to examine the relationship of Stress, Social support and Psychological Capital with two measures of Subjective Well-being i.e. Life satisfaction and Depressive symptoms. Accordingly following objectives were to be fulfilled in the present study

1. To examine the differences in study variables across gender.
2. To examine the predictive relationship of Stress, Social Support and Psychological Capital with Life satisfaction.
3. To examine the predictive relationship of Stress, Social Support and Psychological Capital with Depressive symptoms
4. To investigate the potential moderating effect of Social Support on the relationship between Stress and Life satisfaction
5. To investigate the potential moderating effect of Psychological Capital on the relationship between Stress and Life satisfaction.

6. To investigate the potential moderating effect of Social Support on the relationship between Stress and Depressive symptoms.

7. To investigate the potential moderating effect of Psychological Capital on the relationship between Stress and Depressive symptoms.

8. To investigate the potential moderating effect of Gender on the relationship between Stress and Life satisfaction.

9. To investigate the potential moderating effect of Gender on the relationship between Stress and Depressive symptoms.

**Hypothesis**

On the basis of the objectives set for the present study, below mentioned hypotheses were set

1. There would be significant difference between males and females on Stress, Social Support, Psychological Capital, Life satisfaction and Depressive symptoms.

2. Life satisfaction would be negatively predicted by Stress.

3. Life satisfaction would be positively predicted by Social Support and its dimensions (Family Support, Significant Other Support & Friends Support).

4. Life satisfaction would be predicted positively by Psychological Capital and its components (Resilience, Hope & Self-efficacy).

5. Depressive symptoms would be positively predicted by Stress.

6. Depressive symptoms would be negatively predicted by Social Support and its dimensions (Family Support, Significant Other Support & Friends Support).

7. Depressive symptoms would be negatively predicted by Psychological Capital and its components (Resilience, Hope & Self-efficacy).

8. The predictors of Life satisfaction would be different for males and females.

9. The predictors of Depressive symptoms would be different for males and females.

10. The relationship of Stress and Life satisfaction would be moderated by Social Support.

11. The relationship of Stress and Depressive symptoms would be moderated by Social Support.
12. The relationship of Stress and Life satisfaction would be moderated by Psychological Capital.
13. The relationship of Stress and Depressive symptoms would be moderated by Psychological Capital.
15. The relationship of Stress and Depressive symptoms would be moderated by gender.

**Conceptual framework regarding the relationship among variables**

![Conceptual framework](image)

*Fig.1.1 Conceptual framework regarding the relationship among variables:*

Figure 1.1 depicts that when a person is triggered with stressful situations/events, there is an impact on his/her subjective well-being. There may be increase in Depressive symptoms and/or decrease in Life satisfaction thereby, affecting the overall subjective well-being of a person. But the relationship between stress and well-being is not so direct. How stress is going to have an impact on well-being depends upon many things. In present study two of such factors are considered. One is person’s social support that he/she can avail amidst stressful situations and second is a person’s positive psychological strengths which are collectively called as Psychological Capital. It was anticipated that person having high stress and low social support will have high depressive symptoms and low life satisfaction and the person with high stress but high social support will be having low depressive symptoms and high life satisfaction. Similarly, person with high PsyCap will be having high life satisfaction and low depressive symptoms under high stress conditions.