CHAPTER II

REVIEW OF LITERATURE

A literature review is an account of what has been published on a topic by accredited scholars and researchers. It is a piece of discursive prose and a simple summary of the sources (Taylor and Procter, 2006). Comprehensive knowledge of the literature in the field is essential to research papers. The depth and breadth of the literature review emphasizes the credibility of the writer in his or her field (Anson and Schwegler, 2000).

The nursing students need to face exams, get grades, long hours of studying, work, family and other personal commitments, students also are faced with the challenges of clinical practice. Clinical practice has been identified as one of the most anxiety producing components in nursing programmes. Lack of experience, fear of making mistakes, difficult patients, discomfort at being evaluated by faculty members, worrying about giving patients the wrong information or medication and concern about possibly harming a patient are the major stressors for the nursing students.

TYPES OF STRESS

ACUTE STRESS

Acute stress is usually for short time and may be due to work pressure, meeting deadlines pressure or minor accident, over exertion, increased physical activity, searching something misplaced, or similar things. Symptoms are headaches, back pain, stomach problems, rapid heartbeat, muscle aches or body pain. Acute stress is common in people who take too many responsibilities and are overloaded or overworked, disorganized, always in a hurry and never in time. These people are generally in positions of importance at their workplace and stressful lifestyle is inherent in them.

CHRONIC STRESS

This type of stress is the most serious of all the stress types. Chronic stress is a prolonged stress that exists for weeks, months or even years. This stress is due to poverty, broken or stressed families and marriages, chronic illness and successive failures in life. People suffering from this type of stress get used to it and may even not
realize that they are under chronic stress. It is very harmful to their health. Symptoms are prolonged tension headaches, hypertension, migraines, chest pain and heart disease.

**SIGNS AND SYMPTOMS OF STRESS**

It is important to learn how to recognize stress when stress levels are out of control. The most dangerous thing about stress is how easily it can creep up on a person in such a way that he gets used to it and starts feeling familiar and even normal. He will not notice how much it is affecting him, even as it takes a heavy toll.

When one experiences stress he can develop a wide variety of physical, emotional/cognitive, psychological and behavioural symptoms. These symptoms are not a sign of disease because stress is not a disease; they are brought about by the body’s Fight-Flight Response, which is designed to give extra energy to the individual and speed to cope with the threat.

**PHYSICAL**

When under stress one may experience a pounding, speeding heart. This is not a sign of heart disease, but is in fact, caused by stress hormones stimulating the heart to pump harder and beat faster to get extra oxygen to vital muscles and organs so he can fight or run away. Individuals at this time experience different symptoms based on the severity of stress such as aches and pains, diarrhoea or constipation, nausea, dizziness, chest pain, rapid heartbeat, loss of sex drive and frequent colds.

**EMOTIONAL/COGNITIVE**

Stress affects the way the individual thinks and feels the individual tends to have memory problems, inability to concentrate, poor judgement, seeing only the negative, anxious or racing thoughts and constant worrying. Emotional disturbances such as, moodiness, irritability or short temper, agitation, inability to relax, feeling overwhelmed, sense of loneliness and isolation and depression or general unhappiness.

**PSYCHOLOGICAL**

Prolonged stress can give rise to different types of psychological symptoms which can affect the individuals day to life, such as abrasive, blaming others, catastrophising, cynical, depression, depressed/anxious thinking, excess guilt, excess worries over health, feeling a failure, feelings of fear, feeling unable to cope, frustration,
hopelessness/ helplessness, hostile, hypercritical of self/others, impatience, increased worrying, indecision, irritability, jealousy, lack of concentration, loss of confidence, lower self-esteem, mind in a whirl, mood swings, negative thinking, pessimistic thinking, rumination, sensitivity to criticism, snappy, stressful thinking, tense and worrying a lot.

BEHAVIOURAL

Due to Stress the individual experiences certain behavioural symptoms; the way the individual behaves is affected. The individual may start eating more or less, sleeping too much or too little, isolating oneself from others, aggression, agitation, crying, nail biting, poor eye contact, restlessness, withdrawal from relationships and other activities, procrastinating or neglecting responsibilities, poor time management, poor personal hygiene, using alcohol, cigarettes, or drugs to relax.

CAUSES OF STRESS

Whenever body feels something not favourable, then it tries to defend itself. If this situation continues for a long time, then the body is working overtime. There are several causes of stress. For example, individual is under stress when he is worried about something, children, the illness of his father, job security, or loans or similar things. He may be under stress due to several causes.

CAUSES OF STRESS AT HOME

Death of spouse, family, close relative or friend, injury or illness of any family member, marriage of self or son or daughter or brother or sister, separation or divorce from partner, pregnancy or birth of a new baby, children's behaviour or disobedience, children's educational performance, hyperactive children, sexual molestation, argument or heated conversations with spouse, family members or friends or neighbours, not sufficient money to meet out daily expenses or unexpected expenditure, not sufficient money to raise the standard of living, loss of money in burglary, pick-pocket or share market, moving house, change of place or change of city or change of country.

CAUSES OF STRESS AT WORK

To meet out the demands of the job, the relationship with colleagues, to control staff, to train the staff and take work from them, support one receives from his boss,
colleagues and juniors, excessive work pressure to meet out deadlines, to give new results, to produce new publications if in research area, working overtime and on holidays, new work hours, promotion or have not been promoted or a junior has superseded argument or heated conversations with co-workers or boss, change of job, work against will, harassment, sexual molestation.

COMMON INTERNAL AND EXTERNAL CAUSES

Physical threats, social threats, financial threat and lack of sleep, major life changes, work, relationship difficulties, being too busy, children and family, inability to accept uncertainty, pessimism, negative self-talk, unrealistic expectations, perfectionism, lack of assertiveness, fear, intermittent or continuous.

EFFECTS OF STRESS

Modern life is full of hassles, deadlines, frustrations and demands. For many people, stress is so common that it has become a way of life. Stress is not always bad. In small doses, it can help perform under pressure and motivate to do the best. But when one is constantly running in emergency mode, his mind and body pay the price.

STRESS RESPONSE

When one perceive a threat, his nervous system responds by releasing a flood of stress hormones, including adrenaline and cortisol. These hormones arouse the body for emergency action. Heart pounds faster, muscles tighten, blood pressure rises, breath quickens and senses become sharper. These physical changes increase strength and stamina, speeds up the reaction time and enhance the focus in preparing one to either fight or flee from the danger at hand. Stress is a normal physical response to events that make feel threatened or upsets the balance in some way. When the danger is sensed, whether it is real or imagined the body’s defenses kick into high gear in a rapid, automatic process known as the ‘fight-or-flight’ (Cannon, 1932).

There is evidence that points to abnormal stress responses causing various diseases or conditions include anxiety disorders, depression, high blood pressure and cardiovascular diseases, certain gastrointestinal disease, some of the cancers and process of aging. Stress also seems to increase the frequency and severity of migraine headaches, episodes of asthma and fluctuations of blood sugar in diabetics. There are scientific evidences showing, people
experiencing psychological stress are more prone to developing colds and other infections than their less-stressed peers. Overwhelming psychological stress (such as the events of 9-11) can cause both temporary (transient) and long-lasting (chronic) symptoms of serious psychiatric illness called Posttraumatic Stress Disorder (PTSD). Long-term exposure to stress can lead to serious health problems. Chronic stress disrupts nearly every system in the body. It can raise blood pressure, suppress the immune system, increase the risk of heart attack and stroke, contribute to infertility and speed up the aging process. Long-term stress can even rewire the brain, leaving more vulnerable to anxiety and depression.

THEORIES OF STRESS

There are several theoretical positions devised for examining and understanding stress and stress-related disorders. Brantley and Thomason (1995) categorized them into three groups: response theories, stimulus theories and interaction (or transaction) theories.

RESPONSE THEORIES

Chronic stress responses involve actual physiological changes to body systems and organs, a good bit of attention has been paid to acute physiological stress responses and how they might possibly lead to subsequent chronic stress responses (McEwen and Stellar, 1993). Historically, both Cannon (1929) and Selye (1956) provided the foundation for the current interest in this physiological process.

WALTER CANNON

The term ‘homeostasis’ was used by Cannon, Physiologist, Harvard University, according to Cannon (1929), the body possesses an internal mechanism to maintain stable bodily functioning or equilibrium. As the environment presents the organism with various challenges, the body must respond to each new situation by adjusting various physiological systems to compensate for the resources being taxed. A classic example of this type of compensation involves fluid regulation.

When an organism ingests a large amount of water, the kidney releases more waste fluid into the bladder for eventual disposal in an effort to maintain bodily equilibrium. Many of the feedback mechanisms, that regulate blood pressure, share similar characteristics with bodily systems that maintain homeostasis. According to
Cannon (1935), failure of the body to respond to environmental challenges by maintaining bodily homeostasis results in damage to target organs and eventually death.

Translating his work with physical challenges associated with eating, drinking and physical activity into those of a psychological nature, Cannon hypothesized that common homeostatic mechanisms were involved. Accordingly, if an organism’s response to threat involves significant sympathetic nervous system arousal so that respiration and heart rate increase significantly, the body’s compensatory response should involve either reducing sympathetic nervous system activity or increasing parasympathetic nervous system counter-activity.

If the compensatory response is inadequate, tissue damage can result, placing the organism at a greater risk for subsequent medical problems associated with the damaged tissue.

HANS SELYE

Selye (1956) was the first investigator to use the term ‘stress’ to describe the problems associated with homeostasis identified by Cannon decades earlier. Although he borrowed the term from physics, he used it to describe the effects on the organism rather than the environmental stressors he examined in his empirical work.

According to Selye (1956), the ‘stress’ response of the organism represented a common set of generalized physiological responses that were experienced by all organisms exposed to a variety of environmental challenges like temperature change or exposure to noise. From his perspective, the stress response was nonspecific; that is, the type of stressor experienced did not affect the pattern of response. In other words, a wide variety of stressors elicited an identical or general stress response. He termed this nonspecific response the General Adaptation Syndrome, which consisted of three stages: Alarm Reaction, Resistance and Exhaustion.

Selye (1985) reasoned that the first stage, Alarm Reaction, involved the classic ‘fight-flight’ response. As a result, the body’s physiological system dropped below optimal functioning. As the body attempted to compensate for the physiological reactions observed in the Alarm Reaction Stage, the organism entered the Resistance Stage. Physiological compensatory systems began working at peak capacity to resist the
challenges the entire system was confronting and actually raised the body’s resistance to stress above homeostatic levels.

However, because this response consumed so much energy, the body could not sustain it forever. Once energy had been depleted, the organism entered the stage of Exhaustion. In this stage, resistance to environmental stressors broke down and the body became susceptible to tissue damage and perhaps even death. In Selye’s terminology, the Alarm Reaction Stage was comparable to the acute stress response and the Exhaustion Stage was comparable to a chronic stress response.

The historic works of Cannon and Selye that have attempted to explain how acute physiological stress responses evolved into chronic stress responses have been revisited McEwen and Stellar, 1993; McEwen, 1998 at Rockefeller University. In contrast to the state of physiological equilibrium of homeostasis essential for survival according to Cannon (1935), McEwen (1998) used the term ‘allostasis,’ referring to the body’s ability to adapt to a changing environment in situations that did not challenge survival.

From his perspective, an organism that maintained a perfectly stable physiological equilibrium during a stressful encounter (a nonresponse) might be just as problematic as an organism that exhibited an exaggerated physiological response. Allostasis referred to the body’s ability to adjust to a ‘new steady state’ in response to the environmental challenge (McEwen and Stellar, 1993).

Mandler's (1982) Interruption Theory of stress provides a transition between the internal component of stress and the interaction component. Mandler defines stress as an emergency signaling interruption. The basic premise is that autonomic activity results whenever some organized action or thought process is interrupted. The term interruption is used in the sense that any event, whether external or internal to the individual, prevents completion of some action, thought sequences, or plan and is considered to be interrupted. Interruption can occur in the perceptual, cognitive, behavioural, or problem-solving domains. The consequences of the interruption will always be autonomic activity and will be interpreted emotionally in any number of ways, ranging from the most joyful to the most noxious.
The third component of the biopsychosocial model of stress is the interaction between the external and internal components, involving the individual's cognitive processes.

Lazarus and Launier (1978), Lazarus and Folkman (1984), have proposed a cognitive theory of stress which addresses this interaction. They refer to this interaction as a transaction, taking into account the ongoing relationship between the individual and the environment. It emphasis on the meaning, an event has for the individual and not on the physiological responses. They believed that one's view of a situation determines whether an event is experienced as stressful or not, making stress the consequence of appraisal and not the antecedent of stress. The way an individual appraises an event plays a fundamental role in determining, not only the magnitude of the stress response, but also the kind of coping strategies that the individual may employ in efforts to deal with the stress.

According to the Transaction Theory of stress, the cognitive appraisal of stress is a two-part process which involves a primary appraisal and a secondary appraisal. Primary appraisal involves the determination of an event as stressful. During primary appraisal, the event or situation can be categorized as irrelevant, beneficial, or stressful. If the event is appraised as stressful, the event is then evaluated as a harm/loss, a threat, or a challenge. A harm/loss refers to an injury or damage that has already taken place. A threat refers to something that could produce harm or loss. A challenge event refers to the potential for growth, mastery, or some form of gain.

Dienstbier (1989) offers a reformulation of the Transaction theory, which focuses on the emotional consequences of appraising an event as a stressor or as a challenge. He asserts that when an event is appraised as a challenge, it lead to different physiological consequences than when it is appraised as a harm/loss or threat. Dienstbier uses the term stress to refer to transactions that lead only to negative emotions and he uses the term challenge to describe a transaction that could lead both to positive and negative emotions.

**MANAGEMENT OF STRESS**

One may feel that the stress in a person’s life is out of control, but he can always control the way he responds. Managing stress is all about taking charge is like, taking
charge of thoughts, emotions, schedule, environment and the way one deals with the problems. Stress management involves changing the stressful situation when one can and to change his reaction when he cannot take care of himself and also providing some time for rest and relaxation.

STRENGTHENING RELATIONSHIPS

A strong support network is a greatest protection against stress. When one has trusted friends and family members he can count on, his pressures will not be overwhelming as it helps in spending time with the people he loves and not letting responsibilities away from social life. If one does not have any close relationships or his relationships are the source of his stress, making a priority to build stronger and more satisfying connections will help in managing the stress.

RELAXATION

A relaxation technique (also known as relaxation training) is any method, process, procedure, or activity that helps a person to relax; to attain a state of increased calmness; or otherwise reduce levels of anxiety, stress or anger. Relaxation techniques are often employed as one element of a wider stress management programme and can decrease muscle tension, lower the blood pressure and slow heart and breath rates, among other health benefits (Goleman, 1986).

One cannot completely eliminate stress from his life, but can control how much it affects oneself. Relaxation techniques such as yoga, meditation and deep breathing activate the body’s relaxation response along with a state of restfulness which is opposite of the stress response. When practiced regularly, these activities lead to a reduction in everyday stress levels and boost a feeling of joy and serenity. They also increase one’s ability to stay calm and collected under pressure.

AUTOGENIC TRAINING

Autogenic training is a relaxation technique developed by the German Psychiatrist Johannes Heinrich Schultz and first published in 1932. The technique involves the daily practice of sessions that last around 15 minutes, usually in the morning, at lunch time and in the evening. During each session, the practitioner will repeat a set of visualization’s that induce a state of relaxation. Each session can be
practiced in a position chosen amongst a set of recommended postures (for example, lying down, sitting meditation, sitting like a rag doll). The technique can be used to alleviate many stress-induced psychosomatic disorders.

MEDITATION

Meditation is generally an inwardly oriented, personal practice, which individuals do by themselves. Prayer beads or other ritual objects are commonly used during meditation. Meditation may involve invoking or cultivating a feeling or internal state, such as compassion, or attending to a specific focal point. The term can refer to the state itself, as well as to practices or techniques employed to cultivate the state (Feuerstein, 2006).

DEEP BREATHING

Diaphragmatic breathing, abdominal breathing, belly breathing or deep breathing is breathing that is done by contracting the diaphragm, a muscle located horizontally between the chest cavity and stomach cavity. Air enters the lungs and the belly expands during this type of breathing.

This deep breathing is marked by expansion of the abdomen rather than the chest when breathing. It is considered by some to be a healthier and fuller way to ingest oxygen and is sometimes used as a therapy for hyperventilation, anxiety disorders and stuttering.

YOGA

The practice of yoga relaxation has been found to reduce tension and anxiety. The autonomic symptoms of high anxiety such as headache, giddiness, chest pain, palpitations, sweating, abdominal pain respond well.

Yoga Nidra refers to the conscious awareness of the deep sleep state, referred to as "Prajna" in Mandukya Upanishad by Swami in 8th century.

BIOFEEDBACK

Biofeedback is the process of becoming aware of various physiological functions using instruments that provide information on the activity of those same systems, with a goal of being able to manipulate them at will (Durand and Barlow, 2009). Processes that can be
controlled include brainwaves, muscle tone, skin conductance, heart rate and pain perception.

Biofeedback may be used to improve health or performance and the physiological changes often occur in conjunction with changes to thoughts, emotions and behaviour. Eventually, these changes can be maintained without the use of extra equipment (DeCharms et al, 2005). Biofeedback has been found to be effective for the treatment of headaches and migraines.

**PROGRESSIVE MUSCLE RELAXATION**

Progressive Muscle Relaxation (PMR) is a technique for reducing anxiety by alternately tensing and relaxing the muscles. It was developed by American physician Edmund Jacobson in the early 1920s. The physical component involves the tensing and relaxing of muscle groups over the legs, abdomen, chest, arms and face. With the eyes closed and in a sequential pattern, a tension in a given muscle group is purposefully done for approximately 10 seconds and then released for 20 seconds before continuing with the next muscle group. PMR entails a physical and mental component. Jacobson trained his patients to voluntarily relax certain muscles in their body in order to reduce anxiety symptoms. He also found that the relaxation procedure is effective against ulcers, insomnia and hypertension. Jacobson's Progressive Relaxation has remained popular with modern physical therapists (Jacobson, 1938).

**THOUGHT AWARENESS, RATIONAL THINKING AND POSITIVE THINKING**

Thought awareness is the process by which one observes his thoughts and becomes aware of what is going through his head. To use the technique, one has to observe his “stream of consciousness” as he is thinking about the upcoming event by not suppressing any thoughts. Instead, just letting them, run their course while he makes note of them.

The next step in dealing with negative thinking is to challenge the negative thoughts that he has written down using the Thought Awareness Technique. Thought Awareness helps to understand the fear and negative thinking that may damage the self-confidence in the time leading up to an event.

Rational Positive Thinking is done by challenging the negative thoughts that has been identified using the Thought Awareness technique. Writing it down and
challenging it rationally, asking one-self whether the thought is reasonable. When one challenges negative thoughts rationally, he should be able to see quickly whether the thoughts are wrong or whether they have some substance to them. Wherever there is some substance found, he needs to take an appropriate action this will help one change the way he perceives stressful situations apparently. Rational Thinking is a technique that helps to challenge the negative thoughts and either learn from them, or refute them as incorrect.

After using Rational Thinking to identify incorrect negative thinking, it is useful to prepare rational, positive thoughts and affirmations to counter these negative thoughts. Positive affirmations help to build self-confidence and change negative behaviour patterns into positive ones. By basing one’s affirmations on the clear, rational assessments of fact that one made using Rational Thinking, one can use them to undo the damage that negative thinking may have done to one’s self-confidence. This set of tools helps to manage and counter the negative thinking that can undermine a good performance. Positive Thinking is a technique used to create positive affirmations that can be used to counter negative thoughts, neutralizing them and building self-confidence.

DEPRESSION

“Depression is nourished by a lifetime of ungrieved and unforgiven hurts.”

- Penelope Sweet

“An illness that involves the body, mood and thoughts, which affects the way a person eats and sleeps, the way one feels and thinks about oneself and the way one thinks about things.” A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be wished away. People with a depressive disease cannot merely ‘pull themselves together’ and get better. Without treatment, symptoms can last for weeks, months or years. Appropriate treatment, however, can help most people with depression.

DEFINITION OF DEPRESSION

Depression is a psychological disorder that affects a person's mood changes, physical functions and social interactions (Roome, 2008). “In the psychiatry and
psychology fields, depression refers both to the pathologically chronic and severe or expected level of perceived helplessness, sadness, loss of pleasure or interest and other related to behaviours and emotions."

Depression is a disturbance of mood characterized, variously by chronic mood swings of long-standing duration (Coleman, Butcher and Carson, 1984).

Depression is an illness in which factors such as genetics, chemical changes in the body and external events may play an important role. It is a psychological condition that changes how one thinks and feels and also affects the social behaviour and sense of physical well-being (Peterhutch, 2008).

SIGNS AND SYMPTOMS OF DEPRESSION

It includes loss of interest in activities that were once interesting or enjoyable, including sex, loss of appetite (anorexia) with weight loss or overeating with weight gain, loss of emotional expression (flat affect), a persistently sad, anxious or empty mood, feelings of hopelessness, pessimism, guilt, worthlessness or helplessness, social withdrawal, unusual fatigue, low energy level, a feeling of being slowed down, sleep disturbance with insomnia, early-morning awakening or oversleeping, trouble concentrating, remembering or making decisions, unusual restlessness or irritability, persistent physical problems such as headaches, digestive disorders or chronic pain that do not respond to treatment, thoughts of death or suicide or suicide attempts. Alcohol or drug abuse may also be the signs of depression.

TYPES OF DEPRESSION

Depressive disorders are mood disorders that come in different forms, just as other illnesses, like heart disease and diabetes. Three of the most common types of depressive disorders are:

Major depression

Dysthymia

Bipolar Disorder (Manic Depression)
CAUSES OF DEPRESSION

External event often seems to initiate an episode of depression. Thus, a serious loss, chronic illness, difficult relationship, financial problem or any unwelcome change in life patterns can trigger a depressive episode. Very often, combinations of genetic, psychological and environmental factors are involved in the onset of a depressive disorder. Stressors that contribute to the development of depression sometimes affect some groups more than others. For example, minority groups more often have an impact on them due to discrimination and being disproportionately represented. Socio-economically disadvantaged groups have higher rates of depression compared to their advantaged counterparts. Immigrants to the United States may be more vulnerable to develop depression, particularly when isolated by language. Regardless of ethnicity, men appear to be particularly sensitive to the depressive effects of unemployment, divorce, low socioeconomic status and having few good ways to cope with stress. Women who have been the victim of physical, emotional or sexual abuse, either as a child or perpetrated by a romantic partner are vulnerable of developing a depressive disorder as well. Men who engage in sex with other men seem to be particularly vulnerable to depression when they have no domestic partner, they do not identify themselves as homosexual or of being a victim of multiple episodes of antigay violence. However, it seems that men and women have similar risk factors for depression.

Women are twice as likely to become depressed as men. However, scientists do not know the reason for this difference. Psychological factors also contribute to a person's vulnerability to depression. Thus, persistent deprivation in infancy, physical or sexual abuse, clusters of certain personality traits and inadequate ways of coping (maladaptive coping mechanisms) all can increase the frequency and severity of depressive disorders, with or without inherited vulnerability. The effect of maternal-fetal stress on depression is currently an exciting area of research. It seems that maternal stress during pregnancy can increase the chance that the child will be prone to depression as an adult, particularly if there is a genetic vulnerability.

THEORIES OF DEPRESSION

Behavioural theories of depression, there are numerous theories of depression, such as, Behavioural Activation (BA) it is an idiographic and functional approach to
depression. It argues that people with depression act in ways that maintain the depression such as avoidant behaviour. Treatment revolves around discovering the contingencies that lead to maintenance of the depression and experimentation with changing one's behaviours according to an agreed upon plan. BA uses functional analysis to identify the three-terms, contingency of antecedents, behaviours and consequences.

Practitioners using Cognitive Behavioural Therapy (CBT) are likely to believe that depression has its roots in negative cognitions. Beck (1976) attributed depression to a cognitive triad: a negative view of self, the world and the future. Cognitive biases may also exist which cause situations to be interpreted in skewed way (e.g. overgeneralization, magnification, personalization, selective abstraction, arbitrary inference and categorical/dichotomous thinking). These result in a pessimistic explanatory style - that is, seeing problems as one's fault, as permanent and as pervasive. Depression can be resolved by changing one's pattern of thinking, although this requires both cognitive restructuring as well as some behaviour modification such as desensitization or exposure therapy to overcome avoidance.

BECK'S COGNITIVE THEORY OF DEPRESSION

Beck's theory features a Cognitive Model of Depression showing the formation of Dysfunctional Beliefs. Beck's Cognitive Model of Depression shows how early experiences can lead to the formation of dysfunctional beliefs, which in turn lead to negative self-views, which in turn lead to depression. One interesting study on this aspect is Reed's (1994) study on reducing depression in adolescents. Reed's study amazingly shows a large number of female whose cognitive thinking prevented them from recovering from depression, while the males adjusted much better due to the experiences between males and females. Males, he believes "run a fairly structured and consistent developmental course. Depressed males often appear either physically awkward or lacking in social/interpersonal skills. Responses to this awkwardness by adults and peers usually consist of strong sanctions, punishment and negative reinforcement. Moderate improvement in male functioning will usually receive positive responses from both peers and adults. Additionally, male social networks tend to be flexible and based primarily on current functioning. Therefore, male adolescents can improve their social status as their interpersonal functioning improves". His conclusion is that because males are
developing healthy beliefs, they are able to cope with depressive feelings. They do not generally develop depression due to lack of negative thoughts about the self, because the social structure correctly rewards them for having positive thoughts, which prevents depression. On the other hand, the female adolescent social structure is much different and they are more prone to develop irrational and dysfunctional beliefs. Reed explains, "Female adolescents run a less structured and more inconsistent developmental course. Responses from peers and adults to the female’s incompetence are variable. Improved behaviour of female adolescents also receives inconsistent feedback. Adolescent females in general are expected to be competent interpersonally. Therefore, a female adolescent who had been depressed, upon achieving appropriate functioning, would receive only minimal attention for her accomplishment. Consequently, improved functioning will often not facilitate immediate social acceptance by females" (Reed, 1994).

TREATMENT

Regardless of the medication that may be used to treat depression, practitioners have become more aware that different ethnic groups may have different responses and have different risks for side effects than others.

ANTIDEPRESSANT MEDICATIONS

Selective Serotonin Reuptake Inhibitors (SSRIs), Dual-action Antidepressants, Atypical Antidepressants, Monoamine Oxidase Inhibitors, Tricyclic Antidepressants (TCAs) and Electroconvulsive Therapy (ECT).

PSYCHOTHERAPIES

Many forms of psychotherapy are effectively used to help depressed individuals, including some short-term (10 to 20 weeks) therapies. Talking therapies (psychotherapies) help patients gain insight into their problems and resolve them through verbal give-and-take with the therapist. Behavioural therapists help patients learn how to obtain more satisfaction and rewards through their own actions. These therapists also help patients to unlearn the behavioural patterns that may contribute to their depression.

Interpersonal and cognitive/ behavioural therapies are two of the short-term psychotherapies found to be helpful for some forms of depression.
Psychodynamic therapies are sometimes used to treat depression. They focus on resolving the patient’s internal psychological conflicts that are typically thought to be rooted in childhood.

ANGER

“Anger will never disappear so long as thoughts of resentment are cherished in the mind.

Anger will disappear just as soon as thoughts of resentment are forgotten.”

- Buddha

Anger is an emotion. Some view anger as part of the fight or flight brain response to the perceived threat or harm. Anger becomes the predominant feeling behaviourally, cognitively and physiologically when a person makes the conscious choice to take action to immediately stop the threatening behaviour of another outside force. The English term ‘Anger’ originally comes from the term ‘angr’ of Old Norse Language (The American Heritage Dictionary of the English Language, 2000). Anger can have many physical and mental consequences. The physical effects of anger include increased heart rate, blood pressure and levels of adrenaline and noradrenalin. Anger is a natural feeling, experienced when one feels frustrated, hurt, rejected or hostile. It is a powerful emotion and unless it is managed properly, it can have a devastating effect on their family, their work and their overall well-being.

The external expressions of anger can be found in facial expressions, body language, physiological responses and at times in public the acts of aggression. Humans and animals for example make loud sounds, attempt to look physically larger, bare their teeth and stare. Anger is a behavioural pattern designed to warn aggressors to stop their threatening behaviour.

Anger can mobilize psychological resources for corrective action. Uncontrolled anger can, however, negatively affect personal or social well-being. Anger is viewed as a form of reaction and response that has evolved to enable people to deal with threats. Three types of anger are recognized by Psychologists. The first form of anger, named ‘hasty and sudden anger’ by Butler an 18th century English Bishop, is connected to the impulse for self-preservation. It is shared between humans and animals and occurs when tormented or trapped. The second type of anger is named ‘settled and deliberate’ anger
and is a reaction to perceived deliberate harm or unfair treatment by others. These two forms of anger are episodic. The third type of anger is however dispositional and is related more to character traits than to instincts or cognitions. Irritability, sullenness and churlishness postures are examples of the last form of anger.

**DEFINITION OF ANGER**

An emotion commonly expressed in response to irritating, threatening, unpleasant, or frustrating situations. Anger typically manifests itself in facial expressions, body language, physiological responses (e.g. increased heart rate and pupil dilation) and sometimes in overt acts of aggression (Kent, 2007).

Anger is a natural and healthy response that has evolved to enable us to deal with threats, but uncontrolled anger in sport is often associated with poor performance. When an athlete becomes angry, the cause of the anger often becomes the focus of attention. This may lead to a lack of concentration on the task at hand and performance deteriorates.

Like fire, anger is a good servant but a bad master. If suppressed, it can eat away a person inside or burst out destructively in unexpected places. If given free rein it may overwhelm and frighten a person and those around him. If properly processed and honestly expressed, it can become the basis of assertive action. People habitually suppress anger; its effects may turn inwards, producing physical symptoms such as tension headaches, back pain and digestive disorders. Suppressed anger is also likely to surface unexpectedly and vent itself in a totally unrelated situation (Birch, 2003).

**TYPES AND NATURE OF ANGER**

Anger varies in intensity, ranging from mild irritation to violent rage. Like other emotions, feelings of anger have an effect on the rest of the body like the heart starts to beat faster, adrenaline levels increase and blood pressure and temperature rise. Different people deal with difficult situations in different ways. This can vary from being calm to becoming aggressive and appearing unable to cope. One may react immediately to what has caused him to be angry, while others may suppress their feelings. Built-up feelings can explode when it becomes too much. Anger can lead to intimidating, violent or bullying behaviour making those around him feel worried and frightened.
Anger can be of one of two main types that is **Passive anger** and **Aggressive anger**. These two types of anger have some characteristics.

**PASSIVE ANGER**

Secretive behaviour such as, stockpiling resentments that are expressed behind people’s backs, giving the silent treatment or under the breath mutterings, avoiding eye contact, putting people down, gossiping, anonymous complaints, poison pen letters, stealing and cunning.

Psychological manipulation such as, provoking people to aggression and then patronizing them, provoking aggression but staying on the sidelines, emotional blackmail, false tearfulness, feigning illness, sabotaging relationships, using sexual provocation, using a third party to convey negative feelings, withholding money or resources.

Self-blame such as, apologizing too often, being overly critical, inviting criticism.

Self-sacrifice such as, being overly helpful, making do with second best, quietly making long suffering signs but refusing help or lapping up gratefulness.

**Ineffectualness**, blaming self and others for being a failure, choosing unreliable people to depend on, being accident prone, underachieving, sexual impotence and expressing frustration at insignificant things but ignoring serious ones.

**Dispassion** such as, giving a cold shoulder or phony smiles, looking unconcerned, sitting on the fence while others sort things out, dampening feelings with substance abuse, overeating, oversleeping, not responding to another’s anger, frigidity, indulging in sexual practices that depress spontaneity and make objects of participants, giving inordinate amounts of time to machines, objects or intellectual pursuits, talking of frustrations but showing no feeling.

**Obsessive behaviour** such as, a need to be clean and tidy, making a habit of constantly checking things, over-dicting or overeating, demanding that all jobs be done perfectly.

**Evasiveness** such as, turning back in a crisis, avoiding conflict, not arguing back, being phobic.
AGGRESSIVE ANGER

Threats such as, frightening people by saying how one could harm them, their property or their prospects, finger pointing, fist shaking, wearing clothes or symbols associated with violent behaviour, tailgating, excessively blowing a car horn, slamming doors.

Hurtfulness such as, physical violence, verbal abuse, biased or vulgar jokes, breaking a confidence, using foul language, ignoring people's feelings, willfully discriminating, blaming, punishing people for unwarranted deeds, labeling others.

Destructiveness such as, destroying objects, harming animals, destroys a relationship between two people, reckless driving and substance abuse.

Bullying such as, threatening people directly, persecuting, pushing or shoving, using power to oppress, shouting, using a car to force someone off the road, playing on people's weaknesses.

Unjust blaming, accusing other people for one's own mistakes and feelings, making general accusations.

Manic behaviour, that is speaking too fast, walking too fast, working too much and expecting others to fit in, driving too fast and reckless spending.

Grandiosity such as, showing off, expressing mistrust, not delegating, being a sore loser, wanting center stage all the time, not listening, talking over people's head, expecting kiss and make-up sessions to solve problems.

Selfishness such as, ignoring other's needs, not responding to requests for help, queue jumping.

Vengeance, is by being over-punitive, refusing to forgive and forget and bringing up hurtful memories from the past.

Unpredictability such as, explosive rages over minor frustrations, attacking indiscriminately, dispensing unjust punishment, inflicting harm on others for the sake of it, using alcohol and drugs, illogical arguments.
CAUSES FOR ANGER

Usually, those who experience anger explain its arousal as a result of ‘what has happened to them’ and in most cases the described provocations occur immediately before the anger experience. Such explanations confirm the illusion that anger has a discrete external cause. The angry person usually finds the cause of his anger in an intentional, personal and controllable aspect of another person's behaviour. This explanation, however, is based on the intuitions of the angry person who experiences a loss in self-monitoring capacity and objective observables as a result of their emotion. Anger can be of multicausal origin, some of which may be remote events, but people rarely find more than one cause for their anger.

Anger can be caused by the way we react to things such as other people or situations or by worrying about personal or financial problems. Unsettling memories from the past can also lead to angry thoughts and feelings. It is important to understand that it is not people or events that make one angry, but ones reaction to them.

SUPPRESSION

Modern Psychologists point out that suppression of anger may have harmful effects. The suppressed anger may find another outlet, such as, physical symptom or something more extreme (Kemp and Strongman, 1995).

PHYSIOLOGY

The external expression of anger can be found in facial expressions, body language, physiological responses and at times in public acts of aggression. The facial expression and body language are as follows, the facial and skeletal musculatures are strongly affected by anger. The face becomes flushed and the eyebrow muscles move inward and downward, fixing a hard stare on the target. The nostrils flare and the jaw tends toward clenching. This is an innate pattern of facial expression that can be observed in toddlers. Tension in the skeletal musculature, including raising of the arms and adopting a squared-off stance is preparatory actions for attack and defend. The muscle tension provides a sense of strength and self-assurance. An impulse to strike out accompanies this subjective feeling of potency (Kemp and Strongman, 1995).
**Physiological responses to anger** include an increase in the heart rate, preparing the person to move, an increase in blood flow to the hands, preparing them to strike. Perspiration increases (particularly when the anger is intense). A common metaphor for the physiological aspect of anger is that of a hot fluid in a container. Everyone feels angry at times, but it is important to know how to express feelings in a healthy way without lashing out, shouting or becoming violent (Ekman, 2004).

**THEORIES ON ANGER**

Two Theories on Anger Resolution: "Build-up/Blow-up" and "Expressive Anger"

One way to consider anger is what he calls the "Build-up/Blow-up Theory of Anger." At the turn of the century Freud (1921) relied on the popular scientific theory of his day, hydraulic theory, to explain how psychic energy worked. In hydraulic theory, a pressure or force is either released or it causes pressure in some other part of the system.

The example of a pressure cooker was used to link anger and hydraulic theory. Imagine a pressure cooker with a flame underneath and the pressure building up. The steam inside the cooker is equivalent to anger and one of the ways to release the steam is to take the lid off the pressure cooker.

Expressive therapy, often associated with encounter groups and psychodrama, encourages the pounding of pillows, yelling and screaming or psychodrama with players representing people in at one’s past that one was angry at. In psychodrama, one is encouraged to yell and tell these people how a person really feels. The cathartic model in psychotherapy was the first path he chose in his attempt to get the destructive aspects of his anger under control. In Los Angeles in the late 1960s and early 1970s, proponents of this model believed that their culture had been too restrictive about anger. They needed to "let it out" and "express them." "Let those feelings out!" the facilitators would cheer on as he screamed by rage.

This approach was believed to be a good antidote to the leftover repression of the Victorian era. The idea was that one could heal and become whole if one just let go his trusted impulses.
PSYCHOSOCIAL THEORY RELATED TO ANGER

Sad experiences like the loss of a loved one, frustrations, failures and the loss of the love and support of others, create a mark on a person's life particularly on the way a person perceives life. If a person grew up in a family where love and support were not freely given, he will feel that his life is not worth living. The notion of neglect will make the person angry at his family and the life he has. If his issues are not resolved during his childhood years, the child's anger usually will stay hidden until his adult years. Suppressed anger will then lead to deeper problems like aggression and violence.

ANGER MANAGEMENT

Self help, if anger builds up, deal with it. Do not let it simmer up until one has a violent outburst. If possible, taking oneself away from the anger situation and thinking about it.

Lifestyle changes, finding a pleasurable active way to let off the steam, which prevents tension, builds-up and increases one’s self-confidence.

Looking after one, by making sure that one has a healthy balanced diet, enough sleep, as hunger and lack of sleep makes one feel irritable. One of the best ways to relax is to enjoy and have some fun. Give self treats and rewards for positive actions, attitudes and thoughts. Even simple pleasures such as relaxed bath, a pleasant walk or an interesting book can help the individual to manage anger.

Learning to remain calm that is by breathing deeply from the diaphragm (just below the lungs) in long slow breaths, giving heartbeat a chance to slow down. This breathing technique may help to feel more relaxed. Sitting or lying in a comfortable position, taking a deep breath in, holding it and counting up to three, slowly breathing out continuing this until one feels more relaxed and then carrying on with what one is doing, with a calmer frame of mind will also help to manage anger.

Getting professional help, there are several types of therapies or counselling which can help to look at why an individual becomes angry. This can help to work through the problems and gain a greater understanding of his feelings and actions.
Modern therapies for anger involve restructuring thoughts and beliefs in order to bring about a causal reduction in anger. These therapies often come within the schools of Cognitive Behavioural Therapies (CBT), this is a type of counselling which helps to change the way one thinks about certain situations and how one behaves. Unlike some other therapies, it focuses on ‘here and now’ problems and difficulties. Instead of focusing on the causes of distress or symptoms in the past, it looks for ways to improve the state of mind by boosting self-esteem and confidence.

**RATIONAL EMOTIVE BEHAVIOUR THERAPY (REBT)**

Research shows that people who suffer from excessive anger often harbor and act on dysfunctional attributions, assumptions and evaluations in specific situations. Research proved that by a trained professional, individuals can bring their anger to more manageable levels. The therapy is followed by the so-called ‘stress inoculation’ in which the clients are taught ‘relaxation skills to control their arousal and various cognitive controls to exercise on their attention, thoughts, images and feelings. They are taught to see the provocation and the anger itself as occurring in a series of stages, each of which can be dealt with’ (Kemp and Strongman, 1995).

**ASSERTIVENESS TRAINING**

In this technique it will be taught how to express feelings and needs in a calm considered way that is respectful to the other people around. If problems are due to difficulty in expressing anger, it helps to express anger constructively.

Other than the above mentioned therapies, one can mitigate one's anger by transference. Transfer one's anger to inanimate objects like a punching bag, going inside an empty room and counting up to 10. If at any time one is thinking about doing something that would hurt self or other people, it is better to get help immediately. If one feels anger taking over, remove oneself from the situation before things become too heated. Recognize that sometimes anger is justified and may need to come out, realizing that there are productive ways to let out anger instead of lashing out at others is important. Sometimes, instead of talking to someone directly, it is more appropriate to write a letter. Practicing yoga can be a long-term solution to anger problems, allowing a focus on feelings to release stress. Having 8-hours of sleep or 5-minutes walk can also
help. Time gives distance from the issue, allowing one to put things into perspective. Finding a creative outlet, such as writing, drawing etc. where one can expend his energy. Hobbies help elevate the mood and allow one to channel energy that he would usually spend dwelling on issues that he was not able to resolve. Imagining what one could do with the energy he expend in anger if he channeled it into something else, trying to release bottled up feelings in positive forms like art, exercise, or some other hobby. There is a difference between controlling anger and holding it in until later. If one is unable to avoid feelings of anger. Try thinking of things that one is thankful for. One can't be truly angry and thankful at the same time. Meditation is a useful way to release stress or anxiety, which are often prerequisites to anger. One should not meditate when he is angry, as this could have a negative effect on his anger. Instead, meditating when he has calmed down and is in complete control of thoughts and emotions is better.

GENERAL WELL-BEING

“The ultimate end of all revolutionary social change is to establish the sanctity of human life, the dignity of man, the right of every human being to liberty and well-being.”

- Emma Goldman

Among all the very many things created by God in the world, man is considered as the crown of His creation. In the human body, there is unlimited power and energy. The potentiality of the human mind is beyond our estimation. A strong and steady mind is the greatest asset of a human being and a flimsy mind, shaken by every passing fancy will retard fulfillment in every department of life. Thus a healthy mind leads to a better quality of life (Grimaldi, 2001).

DEFINITION OF GENERAL WELL-BEING

The term quality of life is used to evaluate the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare and political science. Quality of life should not be confused with the concept of standard of living, which is based primarily on income. Instead, standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation, leisure time and social belonging by ecological economist (Costanza et al, 2008).
Complete mental health can be conceptualized via combinations of high levels of emotional well-being, psychological well-being and social well-being (Keys and Lopez, 2002).

While Quality of Life (QOL) has long been an explicit or implicit policy goal, adequate definition and measurement have been elusive. Diverse ‘objective’ and ‘subjective’ indicators across a range of disciplines, scales and recent work on Subjective Well-being (SWB) surveys and the psychology of happiness have spurred renewed interest. Also frequently related are concepts such as freedom, human rights and happiness. However, since happiness is subjective and hard to measure, other measures are generally given priority. It has also been shown that happiness, as much as it can be measured, does not necessarily increase correspondingly with the comfort that results from increasing income. As a result, standard of living should not be taken to be a measure of happiness.

Quality of life is an important concept in the field of international development, since it allows development to be analyzed on a measure broader than standard of living. Within development theory, however, there are varying ideas concerning what constitutes desirable change for a particular society and the different ways that quality of life is defined by institutions therefore shapes how these organizations work for its improvement (The world Bank, 2009).

Organizations such as the World Bank, for example, declare a goal of working for a world free of poverty, where poverty is defined as ‘a low quality of life.’ Using this definition, the World Bank works towards improving quality of life through neoliberal means, with the stated goal of lowering poverty and helping people afford a better quality of life (The World Bank, 2009).

Because of the differences in the theory and practice of development, there are also a wide range of quantitative measures that are used to describe quality of life. The term quality of life is also used by politicians and economists to measure the liveability of a given city or nation.

Some crimes against property (e.g., graffiti and vandalism) and some ‘victimless crimes’ have been referred to as ‘quality-of-life crimes.’ Social scientists, James and
George (2007) encapsulated this argument as the Broken Window Theory, which asserts that relatively minor problems left unattended (such as public urination by homeless individuals, open alcohol containers and public alcohol consumption) send a subliminal message that disorder in general is being tolerated and as a result, more serious crimes will end up being committed.

**Mental Health** is a term used to describe either a level of cognitive or emotional well-being or an absence of a mental disorder. From perspectives of the discipline of positive psychology or holism mental health may include an individual’s ability to enjoy life and procure a balance between life activities and efforts to achieve psychological resilience.

The World Health Organization (2001) defines mental health as ‘a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.’ It was previously stated that there was no ‘official’ definition for mental health. Cultural differences, subjective assessments and competing professional theories all affect how ‘mental health’ is defined.

The American Heritage Dictionary of the English Language (2000) defines Well-being as ‘The state of being healthy, happy or prosperous.’

According to Collins English Dictionary, (2003) well-being is ‘the condition of being contented, healthy, or successful.’

Researchers at the University of Toronto’s Quality of Life Research Unit define quality of life (2009) as ‘The degree to which a person enjoys the important possibilities of his or her life.’

‘The state or condition of being well; welfare; happiness; prosperity; as, virtue is essential to the well-being of men or of society (Webster’s Revised Unabridged Dictionary, 1913)

General Well-being refers to the state of being or doing well in life. Well-being has many aspects, it is based on self-esteem and how one feels about oneself and behaviour that is appropriate and healthy.
CHARACTERISTICS OF AN EMOTIONALLY HEALTHY PERSON

- Understands and adapts to change
- Cope with Stress
- Positive Self-concept
- Ability to love and care for others
- Act independently to meet the needs

THEORIES ON WELL-BEING

Existential theory of well-being is guided by Heidegger’s (1993) later writings on ‘home coming.’ Well-being is both a way of being-in-the-world, as well as a felt sense of what this is like as an experience. Drawing on Heidegger’s notion of Gegnet (abiding expanse), they characterise the deepest possibility of existential well-being as ‘dwelling-mobility.’ This term indicates both the ‘adventure’ of being called into expansive existential possibilities, as well as ‘being-at-home-with’ what has been given. This deepest possibility of well-being carries with it a feeling of rootedness and flow, peace and possibility. However, they also consider how the separate notions of existential mobility and existential dwelling as discrete emphases can be developed to describe multiple variations of well-being possibilities. They wish to show that this theory of well-being has some interesting and valuable practical applications in that various kinds of ‘dwelling’ and various kinds of ‘mobility’ are possible as potential resources in ones lives.

DYNAMIC EQUILIBRIUM

Heady and Wearing (1986, 1987, 1988, 1989; Heady, 2008) argued the stability of well-being, coupled with positive life satisfaction, can partly be ascribed to a dynamic equilibrium model. Specifically, the mood and satisfaction of individuals may, arguably, be governed by a psychological system that evolved to maintain self-esteem. In particular, this system ensures that self-esteem and thus mood and satisfaction, remains at fairly high levels. For example, self-esteem must be elevated enough to ensure that individuals feel sufficiently confident to engage in suitable behaviours. Nevertheless, self-esteem should not be too high, because otherwise individuals might feel complacent and essential resources would not be accrued.
HOMEOSTASIS

Cummins (1998) applied the term homeostasis to characterize the regulation of mood as well as satisfaction and, hence, the stability of well-being. Similar to homeostasis in the regulation of bodily states such as temperature, Cummins (1998) assumed that homeostasis of subjective well-being comprises several features (Moss, 2010).

ENHANCEMENT OF GENERAL WELL-BEING

The sacredness of life, demands that we make every effort to make its quality better. The inalienable dignity of each person, the preciousness of each one’s potential, the specificity of each situation of need, is met by the solidarity with others. People can choose their moods. Indeed if they could not they would have no control over their life at all. Moods habitually entertained produce the characteristic disposition of the person concerned and it is this disposition that finally makes or mars a person’s happiness. In order to have a general well-being people must train themselves in the habit of thought selection and thought control (Emmet, 1977).

A human being is a positive asset and a precious national resource which need to be cherished, nurtured and developed with tenderness and care, coupled with dynamism. Each individual’s growth presents a different range of problems and requirements at every stage from the womb to the tomb. The catalytic action of discovering the whole person for well-being involves appreciating oneself, identifying the inner self, living in the present and a mature retrospection (Kuriapilly, 1996).

The Doctrine of Karma is a direct outcome of the extension of the age-old and well-established principle ‘as you sow, so you reap’ to the spiritual sphere. According to the karma doctrine the course of life of every living being here and hereafter is determined by his Karma or his deeds and a pious life leads to comforts, contentment and general well-being in the present life and rebirth in higher and better forms of existence (Kuldeep, 2008).

THERAPIES

"Controlled scientific studies have established that relaxation can help relieve depression, fatigue and anxiety” (Martin, 2008).
The term Relaxation Response was coined in the late 1960’s by Cardiologist, Benson. Relaxation training is a skill and like any other skill it takes time to gain the maximum benefits from it; it needs to be practiced on a regular basis, not just when a person is having difficulty. The benefits of relaxation are cumulative; it can take a few weeks before a person start to feel the benefits and regular relaxation practise supplies the greatest benefits. Relaxation is a chance to re-charge our batteries and is an important technique for helping to improve the stress and depression resistance. Relaxation is an excellent cushioning technique. There are some stressors that are impossible to remove from our lives but that doesn’t mean there is nothing a person can do to reduce their impact. Practicing relaxation techniques on a regular basis can help to reduce the impact of these stressors.

"Regular elicitation of the relaxation response has been scientifically proven to be an effective treatment for a wide range of stress related disorders. In fact, to the extent that any disease that is caused or made worse by stress the Relaxation Response can help”.

There are a whole host of different types of relaxation techniques that induce the relaxation response. The relaxation response can be stimulated by any relaxation technique such as, Progressive Muscle Relaxation, Autogenic Training, Massage, Tai Chi, Guided Imagery etc (Benson, 2000).

➢ “Autogenic training is a series of mental exercises which brings about profound relaxation similar to certain meditation states. The exercises allow the mind to calm itself by switching off the body’s stress response.”

➢ “Guided imagery has been found to be very effective for the treatment of stress. Imagery is at the centre of relaxation techniques designed to release brain chemicals that act as the body’s natural brain tranquilisers, lowering blood pressure, heart rate and anxiety levels.”

➢ Progressive Muscle Relaxation: “Muscle tension can be dissipated by the use of muscle relaxation techniques such as passive and progressive muscle relaxation, which will help to switch off the fight/flight response. Progressive Muscle Relaxation is a relaxation technique that was developed in the 1920’s and 1930’s by
Dr Edmund Jacobson. It is often referred to as tense/release relaxation. In this form of relaxation individual muscle groups are tensed for 5 – 10 seconds and then quickly released and relaxed for 30 seconds; one need to concentrate on the difference between the tension and the relaxation in the muscle.”

**POSITIVE THERAPY**

Though the above mentioned therapies have their own advantages, Positive therapy is proved to be more effective as it is a package, which combines the Eastern Techniques of Yoga and the Western Techniques of Cognitive Behaviour Therapy which has four strategies namely, Relaxation Therapy, Counselling, Exercises and Behavioural Assignments. The assumption of Positive Therapy is that the perception of a situation or a person as a problem is owing to one’s own perception, rather than the actual situation or the person. Thus it aims at modifying negative thoughts, beliefs, emotions and behaviour by using a number of techniques, focusing on the present.

**POSITIVE THERAPY AND STRESS**

Yasodha and Gayatri Devi (2010) conducted a study on ‘Management of Stress in Entrepreneurs through Positive Therapy’. Forty Entrepreneurs from Podanur, Coimbatore, Tamil Nadu, were selected for the study through Purposive Sampling. The age range of the sample was 21–40 years. They were assessed using Case Study Schedule (Hemalatha, 2009) and Stress Inventory (S.I), (Hemalatha and Nandini, Revised 2005). Five sessions of Positive Therapy were given over a period of two weeks after which, they were reassessed using Case Study Reassessment Schedule and S.I. The results revealed that majority of the sample had ‘High’ / ‘Very High’ stress before Positive Therapy where as none of them had ‘High’ / ‘Very High’ stress after Positive Therapy.

Rohini and Saranya (2010) did a research on ‘Management of Stress and Enhancement of Self-esteem in School Teachers through Positive Therapy’ at Navarasam Matriculation Higher Secondary School, Erode (N=50). The sample consisted of female teachers with the age range of 25 to 50 years. Case Study Schedule (Hemalatha, 2008), Stress Inventory (Hemalatha and Nandini Revised, 2005), Rosenberg Self-esteem Scale (Rosenberg, 1965) and Case Study Reassessment Schedule (Hemalatha, 2008) were used to collect the data. Positive Therapy was given to reduce
stress and enhance the self-esteem of teachers. The results indicated that the mean stress reduced from 16.52% to 4.38 after intervention. The self-esteem increased from 9.34 to 22.92 after intervention.

Sivasakthi and Preetha (2010) conducted a study on, ‘Management of Stress and Enhancement of Emotional Intelligence in IT Professionals through Positive Therapy’. Forty five IT Professionals, Coimbatore, were screened using Case Study Schedule (Hemalatha, 2009), Stress Inventory (S.I), (Hemalatha and Nandini, Revised 2005) and Emotional Intelligence Test (Chadha and Dalip Singh, 2004). Out of them, 40 (22 males and 18 females) were selected by Purposive Sampling. They were in the age range of 22-29 years, mostly belonging to urban areas. Six sessions of Positive Therapy were given in two weeks, with each session lasting for one hour. After two weeks, the subjects were reassessed using the Case Study Reassessment Schedule, S.I. and Emotional Intelligence Test. After Positive Therapy, the stress level reduced from high to low and emotional intelligence increased from ‘Moderate’ (211) to ‘High’ (255).

A study on ‘Management of Stress in Parents of Special Children through Positive Therapy’ was conducted by Thenu and Hemalatha (2009). The sample for the study was from the Special Education Department of Avinashilingam University for Women, Coimbatore, 40 parents of mentally retarded children were screened using Case Study Schedule (Hemalatha, 2008) and Stress Inventory (S.I.), (Hemalatha and Nandini, Revised, 2005). Out of them, 35 subjects were selected by Purposive Sampling. They were 10 males and 25 females with the age range of 25-50 years. The sample was divided into 3 batches of around 12 in a batch for Positive Therapy. Six sessions of Positive Therapy was given in two weeks. Each session lasted for one hour. After two weeks, the subjects were reassessed using the Case Study Reassessment Schedule and S.I. After Positive Therapy, the stress level reduced from ‘Very High’/ High to Moderate level.

Mary and Hemalatha (2009) conducted a study on, ‘Management of Stress in Nurses through Positive Therapy’, from KG Hostel, Coimbatore, Tamil Nadu, India, 40 female nurses were screened using Case Study Schedule (Hemalatha, 2008) and Stress Inventory (S.I.), (Hemalatha and Nandini, Revised 2005). Out of them, 32 subjects with ‘Very High’ / ‘High Stress’ were selected by Purposive Sampling and were given the psychological intervention called Positive Therapy. Positive Therapy was given for 6 sessions thrice a
week for 2 weeks. The duration of each session was 1 hour. After 2 weeks of Positive Therapy, they were reassessed using Case Study Reassessment Schedule (Hemalatha, 2008) and S.I. Positive Therapy reduced the stress level from Very High to Low level.

A study on ‘Management of Stress in Tea Estate Workers through Positive Therapy’ was conducted by Gayatridevi and Preetha (2011). The sample for the study was from Devi Tea Estate, Pallada, Nilgiris. Fifty Tea Estate workers were screened using Case Study Schedule (Hemalatha, 2008) and Stress Inventory (Hemalatha and Nandini, Revised 2005). Thirty two subjects (23 Female and 9 male) with the age range of 17-50 years were selected by purposive sampling method. The sample was divided into 3 batches of 10 to 11 in each batch and was given Positive Therapy for one hour per session. Five sessions were given for five consecutive days. Two weeks after the therapy, the sample was reassessed using Case Study Reassessment Schedule and Stress Inventory. The results showed that significant reduction in the mean stress of sample from ‘High’ to ‘Low’. Thus, there was a great influence of Positive Therapy in reducing the stress, symptoms and negative emotions of the selected Tea Estate Workers.

Management of Stress in Diabetic Patients through Positive Therapy was conducted by Saranya and Gayatridevi (2009). The sample was chosen from the Sri Sai Trust, Coimbatore. Fifty diabetic patients were screened using Case Study Schedule (Hemalatha, 2008) and Stress Inventory (S.I.), (Hemalatha and Nandini, Revised 2005). Out of them, 35 were selected by purposive sampling method. They were the age ranges of 34-78 years. The Case Study Schedule was used to obtain information from the sample. The information gathered includes the demographic details, risk factors, negative emotions and effects of stress. Stress Inventory was administrated to the sample to assess their level of stress. The entire sample was provided with the Psychological Intervention called Positive Therapy. Six sessions of Positive Therapy was given in two weeks. Each session lasted for one hour. After two weeks, the subjects were reassessed using the Case Study Reassessment Schedule and S.I. There was a significant reduction in the mean stress from ‘High’ (15.77) to ‘Moderate’ (2.69) level.

Vandana and Hemalatha (2008) did a research on, ‘Management of Stress and Pain in IT Professionals through Positive Therapy,’ seventy eight IT Professionals from ORACLE and Customer Driven Company, Bangalore, Karnataka were screened using
Case Study Schedule (Hemalatha, 2007) Occupational Stress Index (Srivatsava and Singh, 1981) and Patient Pain Questionnaire (P.P.Q) Betty R. Ferrell, 1998). Out of them, 30 subjects (18 males and 12 females) were selected by purposive sampling. Positive Therapy (Hemalatha, 2004) was used as the psychological intervention, which was given for 6 sessions to help the sample manage job stress. The results revealed that initially, the entire sample had ‘High Job Stress’ and ‘High Pain’. After the administration of Positive Therapy, 53% had ‘Low Job Stress’ and 47% had ‘Moderate Job Stress’. There was a statistically significant reduction in the job stress.

In a study conducted study by Divya and Hemalatha (2007) on ‘Management of Job Stress in IT Professionals through Positive Therapy’, 50 IT professionals from Hewlett Packard, Bangalore, Karnataka, were screened using Case Study Schedule (Hemalatha, 2003) and Occupational Stress Index (Srivastava and Singh, 1981). Through purposive sampling, 32 subjects (23 males and 9 females) were selected within the age range of 24-38 years. The sample was divided into 3 batches of 10 to 11 in each batch and was given Positive Therapy for one hour per session. Five sessions were given on 5 consecutive days. Two weeks after the therapy, the sample was reassessed using Case Study Reassessment Schedule and Occupational Stress Index. After the administration of Positive Therapy, most of the subjects (81%) had ‘Low’ job stress. There was a statistically significant reduction in the job stress of the sample from ‘High’ to ‘Low’ and negative symptoms and negative emotions were reduced.

Rajakumari and Hemalatha (2006) conducted a study on ‘Management of Stress in Nurses through Positive Therapy’. Out of 60 registered female nurses, with the age range of 22-33 years, from Ramakrishna Hospital, Coimbatore, Tamil Nadu, were selected and 30 were assigned to experimental group and 30 to control group. They were assessed using Stress Questionnaire (Latha, 1984). Initially, stress was high in both the groups (165 and 160 respectively). After the administration of the Positive Therapy for 10 sessions in 5 weeks, there was a significant reduction in the stress of the experimental group, where as there was a slight increase in the stress of the control group.

Umamaheshwari and Hemalatha (2006) conducted a study on ‘Management of Stress in Bank Employees through Positive Therapy’. Thirty officers and clerical staff were selected from Bank of Baroda, Coimbatore. There were 18 males and 12 females
with the age range of 26-56 years. Assessment was done using Stress Inventory (S.I. Revised, Hemalatha and Nandini, 2005) and it was found that 60% had ‘High’ stress and 3% had ‘Very High’ stress. The remaining 37% had ‘Moderate’ stress. Positive Therapy was used as the psychological intervention for 6 sessions, for 2 weeks, on alternate days. Results showed that after the administration of Positive therapy 47% had ‘Low’ stress, 50% had ‘Moderate’ stress and only 3% had ‘High’ stress. The mean stress, which was ‘High’ (11.50), reduced to ‘Low’ (4) after Positive Therapy.

In a study ‘Management of Stress in Accident Patients through Positive Therapy’ by Prashanthi and Hemalatha (2006), 30 accident patients (20 males and 10 females) between the age ranges of 20-80 years from Rex Ortho Hospital, Coimbatore, were assessed using Stress Inventory Revised (S.I.) (Hemalatha and Nandini, 2005). Initially, the sample had either ‘High’ (50%) or ‘Moderate’ (50%) stress. Positive Therapy was given for one hour, on alternative days for 2 weeks. After the administration of the Positive Therapy, 43% did not have stress, 40% had ‘Low’ stress and remaining 17% had ‘Moderate’ stress.

‘Management of Stress and Enhancement of General Well-being in Recovered Alcoholics through Positive Therapy’ was conducted by Suchitra and Hemalatha (2006). The sample chosen was from Bangalore, 46 recovered male alcoholics, 37 with ‘High’ stress and 9 with ‘Moderate’ stress were selected. They were within the age range of 24 to 47 years. After the administration of Positive therapy for 10 sessions in 2 weeks, stress had reduced remarkably in most of the subjects. The stress level reduced from ‘High’ to ‘Low’ after Positive Therapy. The General Well-being had also improved in most of the subjects, indicating the beneficial effects of Positive Therapy.

Latha and Rohini (2006) conducted a study on ‘Management of Stress in Wives of Alcoholics through Positive Therapy’, in which, 35 wives of alcoholic patients from Krishna Rehabilitation Centre for Alcoholics, Coimbatore, Tamil Nadu, served as the sample. The sample was within the age range of 30-50 years. Results revealed that initially, majority of the sample (51%) had high stress. But after the administration of Positive Therapy for 2 weeks, for 6 sessions of one hour each, on alternate days, there was a significant reduction in the mean stress from ‘High’ (M=19.09) to ‘Low’ (M=4.09).

Yogatha and Gayatridevi (2006) conducted a study on ‘Management of Stress in Stress-induced Diabetes through Positive Therapy’. The subjects selected were 50
diabetes patients (15 males and 35 females) with the age range of 25-65 years, from SKY Spiritual Trust, Coimbatore. Assessment was done using Stress Questionnaire (Latha, 1984). It was found that the entire sample had ‘High’ level of stress. The subjects were provided with Positive Therapy for one hour per session, three times a week, for one month. Results showed that Positive Therapy had helped to reduce the mean stress from ‘High’ (143.76) to ‘Low’ (27.38). It was amazing that 90% of the sample had ‘Very Low’ stress and the remaining 10% had ‘Low’ stress.

Kavitha and Hemalatha (2005) conducted a study on ‘Management of Stress and Enhancement of General Well-being in Haemodialysis Patients through Positive Therapy’ from K.G Hospital, Coimbatore. Thirty six haemodialysis patients, with the age range of 20-65 years were served as the sample. Initially, the entire sample had ‘High’/’Very High’ stress (22.55). Positive Therapy was administered for one hour per session, on alternate days for two weeks, involving 6 sessions. Results revealed that after the administration of Positive Therapy, the mean stress of the sample came down to ‘Low’ level (6.22).

Praveena and Hemalatha (2004) conducted a study on ‘Assessment and Management of Stress in Working Women through Positive Therapy’. Out of 100 women, 60 women who had ‘Very High’/’High’ stress, aged between 17 and 50 years were selected from small-scale industries in Coimbatore, Tamil Nadu. Out of them 30 were assigned to the experimental group and 30 to the control group. Positive Therapy was given in smaller groups of 10 members in a group, for one hour per session, 6 sessions were given over a period of three weeks. Results indicated that Positive Therapy had helped to bring down the mean stress of the experimental group from ‘High’ (22.5) to ‘Moderate’ (10.5) levels. The mean stress of the control group had increased slightly in the retest and continued to be ‘High’ (22.20 to 23.80).

Dhara and Hemalatha (2003) conducted a study on ‘Management of Stress in Primary School Teachers through Positive Therapy’. Out of 60 female teachers selected, 30 were assigned to experimental group and 30 to control group, with the age range of 25-36 years, from Mani Feeder’s School and Vivekalaya School in Coimbatore, Tamil Nadu. Initially, mean stress was ‘High’ on both the groups. Positive Therapy was given in two groups of 15 subjects in each group for 6 sessions on alternate days for
40 minutes. Results revealed that Positive Therapy had helped in bringing down the stress significantly to ‘Low’ level in the experimental group, whereas in the control group, the stress continued to be ‘High’.

Preetha and Hemalatha (2002) conducted a study on, ‘Management of Stress in IT Professionals through Positive Therapy’. Sixty IT (Information Technology) professionals (30 males and 30 females) were selected by purposive sampling from four IT companies of Bangalore, Karnataka. Their age ranged between 23-36 years. Assessment was done using Case Study Schedule (Hemalatha, 2000), Stress Questionnaire (Latha, 1984) and Glazer Stress Control Life Style Questionnaire (2000) were administered on the entire sample. Then the 30 subjects were assigned to the experimental group and 30 to the control group (15 males and 15 females in each group). Positive Therapy was given to the sample in the experimental group for 7 days and they were asked to practice Relaxation Therapy and Exercises daily at home. After 3 weeks, all the subjects were reassessed using the same tools. Positive Therapy had proved to be effective in reducing the level of stress in the experimental group, whereas the stress remained unaltered among the control group.

The literature reviewed clearly shows that a number of researches have been conducted on Positive Therapy and Stress, proving the efficacy of Positive Therapy in the management of stress. Whereas it was not clear the positive therapy will be able to help the Nursing students reduce their stress. This needs to be explored.

POSITIVE THERAPY AND DEPRESSION

Rohini and Nikketh (2010) conducted a study on ‘Management of Stress and Depression in Women Facing Violence through Psychological Intervention called Positive Therapy’. Forty seven women victims from Upahaar Social Service Organization, Dharapuram and Tamil Nadu were selected for the study through purposive sampling. The age range of the sample was 19-58 years. The tools used for the study was Case Study Schedule by Rohini (2009), Stress Inventory constructed and standardized by Hemalatha and Nandini (2005) and Beck’s Depression Inventory by Beck (1971). After the assessment, six session of Positive Therapy was given to the entire sample. They were reassessed after a week using Case Study Reassessment.
Schedule, Stress Inventory and Beck’s Depression Inventory. After the Positive Therapy there was a significant reduction in stress and depression level.

Rajalakshmi and Hemalatha (2007) conducted a study on ‘Management of Depression and Enhancement of Well-being in Cancer Patients through Positive Therapy’. Thirty two cancer patients, 15 males and 17 females, with the age range of 25-65 years, from GKNM Hospital, Coimbatore, Tamil Nadu were screened and were found to have high depression and low well-being. The entire sample was given 10 sessions of Positive Therapy for 2 weeks. Results showed that the depression level reduced from ‘High’ to ‘Low’ and the General Well-being improved from ‘Low’ to ‘High’.

Management of Depression in Depressive Patients through Positive Therapy was conducted by Gayathridevi and Gayathridevi (2007). Thirty depressive patients, with the age range of 18-58 years, from Illakunavar Mental Health Clinic, Madurai, Tamil Nadu were selected as the sample for study. The subjects were given 5 sessions of Positive Therapy. The results revealed that after Positive Therapy the mean depression had come down from 29.83 to 23.83.

Venkateswari and Rohini (2006) conducted a study on the ‘Management of Pain and Depression in Institutionalized Geriatrics through Positive Therapy’. A sample of 41 institutionalized geriatrics from Coimbatore, Tamil Nadu were selected for study, out of which 20 were males and 21 were females, aged 60-80 years. After the administration of Positive Therapy on the entire sample for 5 sessions on consecutive days, the mean pain reduced from 7.10 to 3.42 and the mean depression reduced from 21.10 to 12.37.

Sangeetha and Vijayalakshmi (2003) conducted a research on ‘Assessment and Management of Geriatric Depression through Positive Therapy’. Sixty subjects (30 males and 30 females) were selected from the ‘Home for the Aged’, Thindal, Erode, Tamil Nadu. The samples were within the age range of 60-80 years. They were assessed by Case Study Schedule (Vijayalakshmi, 2001) and Geriatric Depression Scale (Lenore Kurlowicz, 1997). Depression was moderate level for the entire sample before treatment. After treatment, the depression level of the subjects in the experimental group had reduced significantly from ‘moderate’ to ‘normal’ level, whereas the depression level of the control group continued to be at moderate level.
Sivasankari and Rohini (2003) conducted a study on ‘Post-partum Depression and Anxiety through Positive Therapy’. Sixty new mothers from Cosmopolitan Hospital and Gowreesha Hospital, Trivandrum, Kerala served as the sample. They were within the age range of 19-35 years. Case Study Schedule (Hemalatha, 2002), Zung’s Depression Questionnaire (1965) and Zung’s Anxiety Questionnaire (1971) were used for the assessment. They were classified into 2 group - experimental and control. Positive Therapy was given individually to the subjects in the experimental group for 7 days, after which they were asked to practice Relaxation Therapy and Exercises daily at home for 3 weeks. All the subjects were reassessed with the same tools after 3 weeks. Initially, 10% of the sample had severe depression and 20% had severe anxiety. After the treatment namely, Positive Therapy, there was a significant reduction in the mean depression as well as anxiety in the experimental group, clearly proving the efficacy of Positive Therapy in the management of post-partum depression and anxiety. No such difference was found in the control group between I test and retest.

Depression among various subjects such as women, cancer patients, Geriatric Depression, and new mothers have only exhibited that there is a dearth of study among Nursing students especially with positive therapy to alleviate the depression is yet to be researched, there it is highly imperative to study the Depression among Nursing students.

**POSITIVE THERAPY AND ANGER**

In the study conducted on ‘Management of Anger in Policemen through Positive Therapy’ by Ramya and Hemalatha (2003) 60 policemen were selected by purposive sampling method from Armed Reserve Police Station, Karur, Tamil Nadu. The Sample was within the age range of 25-45 years. They were assessed using the Case Study Schedule (Hemalatha, 1999) and STAXI (State Trait Anger Expression Inventory, Spielberger, 1998) and were divided into experimental and control groups with 30 in each group. Positive Therapy was provided to the sample of experimental group for 8 sessions over two weeks. Initially, the level of anger was high for the entire sample. The main sources for their anger were higher authorities, spouse, friends, politicians, parents and law-offenders. Reassessment using STAXI revealed that Positive Therapy had helped in bringing down significantly the mean Anger-State Anger, Trait Anger and Anger Expression in the experimental group, whereas in the control group, the mean
anger continued to be high in all the 3 dimensions in the re-test. Thus Positive Therapy had proved to be effective in the management of anger in the selected policemen.

Anger was an aspect that is not researched among the Nurses as well as Nursing students, moreover positive therapy was able bring down anger among other subjects that were studied in the previous studies also gives a direction for one to consider administering Positive therapy to Nursing students.

**POSITIVE THERAPY AND GENERAL WELL-BEING**

Thowheetha and Gayatridevi (2010) conducted a study on ‘Management of Anxiety and Enhancement of General Well-being in Coronary Heart Disease Patients through Positive Therapy’. Thirty five Coronary Heart Disease Patients were selected by purposive sampling method using Case Study Schedule (Hemalatha, 2008), Manifest Anxiety Inventory (M.A.I, Hemalatha, 2000) and WHO General Well-being, 1998) from Balaji Hospital, Coimbatore. They were in the age range of 30-70 years. Six session of Positive Therapy were given on alternative days for two weeks. After two weeks, the entire sample was reassessed using Case Study Reassessment Schedule, Manifest Anxiety Inventory and WHO General Well-being. There was significant reduction in the anxiety from high to low level and General Well-being increased from low to high. Positive therapy proved to be effective in reducing their negative emotions.

Management of Depression and Enhancement of General Well-being in Institutionalized Senior Citizens through Positive Therapy was conducted by Pushpaveni and Gayatridevi (2010). Forty Senior Citizens from Missionaries of Charity, Coimbatore, Tamil Nadu were selected for the study through Purposive Sampling Method. The age range of the sample was 60 and above. The tools used for the study were Case Study Schedule by Hemalatha (2009), Beck Depression Inventory by Beck (1971), WHO General Well-being Index (1998). After the assessment, five sessions of Positive Therapy was given to the entire sample. They were reassessed after two weeks using Case Study Reassessment Schedule, Beck Depression Inventory and WHO General Well-being Index. Positive Therapy helped the Senior Citizens to manage depression and enhanced their General Well-being.
Chandrika and Gayatri Deep (2010) conducted a study on ‘Management of Stress and Enhancement of General Well-being in Hypertension Patients through Positive Therapy’. One Hundred and Twenty Five (63 males, 62 females) were screened and selected through purposive sampling from Government Hospital, Ooty, Tamil Nadu. They were in the age range of 45-70 years. The tools used for the study were Case Study Schedule (Hemalatha, 2009), Stress Inventory (Hemalatha and Nandini, Revised, 2005) and WHO General Well-being Index (1998). Eight Sessions of Positive Therapy was given in alternative days for one hour. After two weeks the subjects were reassessed using the Case Study Reassessment Schedule and S.I. There was a significant reduction in the Hypertension and Stress from ‘High’ (male=20.44 and female=19.67) to ‘Low’ (male=5.94 and female=5.93) and drastic improvement in General Well-being (100%).

The review of literature ravels that the positive therapy and general well-being are well studied among patients, geriatric and hypertension patients, whereas there are no studies done on the Nursing students especially to enhance general well-being among nursing students using positive therapy.

The research stressed that nursing students have increased workload, poor self-esteem, exams, being freshers in nursing college, finding new friends, responsibilities and strict hospital procedures were found to be the causes of stress and depression. The quoted studies reviewed show that depression, anger and low general well-being result in physiological symptoms such as sweating, fatigue, nervousness, insomnia, headache and psychological reactions such as confusion, irritability, restlessness, lack of interest, lack of attention and concentration. All these in turn lead to poor academic performance. Various approaches to manage stress, depression, anger and enhance well-being in nursing students such as Psychotherapy, Yoga, Meditation, Counselling, Cognitive Behaviour Therapy and Rational Emotive Behaviour Therapy were analysed. Unfortunately, most of the researches have been carried out in the West. In India, the studies conducted on Positive Therapy show that the strategies of Positive Therapy helped various subjects to manage their stress, depression, anger and enhance general well-being. In the present study, a genuine attempt is made to provide Positive Therapy to the selected nursing students to help them manage stress, depression, anger and enhance their general well-being.