CHAPTER-I

INTRODUCTION AND REVIEW OF LITERATURE
INTRODUCTION

Stress: Nature and concept

The advancement in all spheres of life-economic, social, political and technological have made the life of people more challenging and competitive because with the pace of change and development they are invariably exposed to various types of stressors-personal, organizational or environmental which might be perceived or real. It means stress is now unavoidable and inseparable part of one’s life of which people in general cannot remain untouched, as they have to come across various types of stressful events in their day-to-day life. From this explanation it becomes clear that everyone of us inevitably have to experience stress in different magnitude despite our religious or socio-cultural diversities, social status and position. If we look into the historical antecedents regarding the origin of the term stress, we find that stress is not new for humans. It goes with the history of mankind from the era of cave men to the present world and will go along with the people till the world exists. It means stress is associated with every one of us in one form or the other, but the sources may change from time to time and seems to create threats to physical, emotional and psychological well-being of people in every society struggling to live in
peace and harmony. It is quite evident that our ancestors were too under stress due to fear of actual threats which they faced in their lives from wild animal attacks, natural calamities such as drought, flood, earthquake, famine, epidemics and so on. In today's world these threats still prevails, but has lesser effects because we have evolved better protection and now many of the problems have been solved through scientific innovations. Even though we are having some threats from these stressors, but the degree seems to be relatively low. We usually find ourselves in many situations where there may not be real threat to our life, even though one can experience stress because the present world of development is also the world of stress as the demand exceeds to one's capacity. A person may experience stress when he perceives threat, which might be at the level of the body and mind. Many of the life situations that we face and live in, might act as stressors and activate stress mechanism as in some situations of everyday life our body cannot differentiate between actual threats and the threats that we perceive which may not be real. It means stress system creates some sort of reaction, to which our body or mind will not always be at conscious level to perceive it as potentially dangerous. It is a well-accepted fact that most often we do not experience direct threat to our life, but what seems to be threatening may be our imprint in mind the way we think or believe that
what our life should be. If this concept emanates in one’s mind we may experience stress as “the difference between the way we want our life to be and the way it actually is.” It means the specific events, ideas, beliefs or even our own thoughts can also be generated from within and impels us to exhibit an outward physical reactions such as loss, fear of failure, not getting something that we think of as important can also trigger stress within us. When a person wants some particular event, the result that occurs will develop to feel good because what he got, what he wanted. If it does not occur; he is likely to feel bad, sad or unhappy. It means the person’s inner self interprets that he is not getting what he wanted and as a result of it might perceive a threat and the end result may be the sensation that we call anxiety. In this situation, it might be the basis of causing stress in him. Thus, when a person is having greater difference between his ideal self and reality, and greater, the perception whether recognized or not of a threat, the person is likely to show greater degree of stress reactions. A person may perceive an event which may or may not be an obvious threat, but if he perceives it as threat, because Of the defense system, a person is always trying to protect from such type of threats because he himself evaluates which he confronts in his everyday life and happens to him because every event, everything that he has ever heard, seen, felt or thought is stored, so that if he needs this
information, it is available for him for protection. During the process of growing up from time to time, events occur which at first might be threatening but later on, we find a solution and recognizes that in fact it is not really threatening. Later in life something happens to us that remind these past experiences and our body and mind may initially treat it as potential threat at least until it is sure that it is not. This type of situation may also create stress in face of event, which may be related to the peoples’ past experiences. It is not possible to eliminate stress because the life of people is filled with potential threats so as stress becomes inevitable and goes with everyone in day-to-day life relating to one’s personal, social, organizational membership.

The word stress as defined in Oxford Dictionary refers to “a state of affair involving demand on physical or mental energy.” A condition or circumstances (not always adverse), which can disturb the normal physical and mental parlance. In other words it is also defined as a perturbation of the body’s homeostasis. This demand on mind-body occurs when it tries to cope with incessant changes in life. A “stress” condition seems “relative” in nature. The extreme stress conditions, psychologists say, are detrimental to human health but in moderation stress is normal and, in many cases, proves useful. In fact every individual suffers from stress at one point or other. It
means the relationship demands physical as well as mental problems, pressure at work places, meeting deadline, growing up tensions and so many factors or situations are the causes of stress. Certain stressors being faced by individuals may be real or imaginary, related to his/her past or future obstacles or stumbling blocks seem to affect the mental and physical health. An individual might experience stress as a reaction to certain life conditions including both, everyday hassles, as well as tragic happenings. The research review on stress clearly reveals that men, women, children, workers, businessmen, youth, police personnels and health professionals are more prone to stress in one way or the other. Stress if persists in any one’s life seems to create positive and negative feelings. If it has positive influence, it is useful to sustain and improve tolerance to stress. Whereas negative stress may result in to develop the feeling of distress, depression, anxiety and consequently disrupts people’s normal functioning. Therefore, stress is now considered as a serious problem relating to people’s mental and physical health, as a result has attracted the attention of psychologists, medical professionals and management people.

Hans Selye (1936), who is the pioneer in the field of stress research, wrote his first article on the subject. Since then a large number of articles and books related to stress have been published and the meaning and
definition of stress became a debatable topic for the researchers, despite all
efforts even though it is still not clear and concrete in its description. In
physical science, stress was equated with force, pressure or strain exerted
upon a material or object that tend to deform its shape. Hans Selye (1956)
was first person who used the term biologically and applied it to the reaction
of body. However, Rees (1976) argued that Selye’s explanation of
“stressor” is equivalent of the term “stress” as used in physics. Morse and
Furst (1976) defined stress as “mental or emotional disruptive or disuniting
influence distress.” This definition and also many other concepts hold that
stress is negative and disruptive outcome. However, Hans Selye (1956)
pointed out that there are positive as well as negative aspects of stress.
According to him “stress in not necessarily something bad, it all depends on
how you take it. The stress of exhilarating, creative successful works is
beneficial, while that of failure, humiliation or infection of any type is
detrimental.” Selye believed that the biochemical effects of stress might be
experienced irrespective of whether the situation was positive or negative.
Since, then a great deal of further research has been conducted, and ideas
have moved on. Stress if persists and remains unchecked, it is viewed as a
bad thing with the range of harmful biochemical and long -term effects.
These effects have rarely been observed in positive situations. Efforts have
been made by the researchers to define stress that relates to individual in four different ways.

**Stimulus based definitions of stress:**

The main emphasis here is on situation or stimuli that disturb or disrupt the individual. For example, Kahn, Wolfe, Quinnin, Snack and Rosenthal (1964) defined stress as an event or something that places demands on the individual. Homes and Rahe (1976) and Holmes and Masuda (1974) defined stress as “a class of stimuli or situation that typically require adaptation such as marriage, birth of child, divorce, death of loved ones etc.” However, Cox, 1978; McGrath, 1970, criticized these definitions on the ground that people respond differently to the same stressful situations.

**Response based definitions of stress:**

Selye (1956) stated that stress is the non-specific response of the body to any demand placed upon it. The demand ranged from initially physical to psychological and social demands later. From this point of view a wide variety of environmental events, known as stressors can produce the same stress response syndrome. Lazarus (1966) was of the view that stress is a condition or feeling experienced when a person perceives that “demands
exceed the personal and social resources the individual is able to mobilize."
Zimbardo (1988) defines stress as "the pattern of specific and non-specific
responses an organism make to stimuli/ events that disturb its equilibrium
and tax or exceed its ability to cope" Everly (1989) pointed out that stress is
a physiological response. However these response based definitions were
not found to hold good. The response pattern may be associated with
various conditions, for example, passion, excessive fear etc. that for other
reasons we may not want to regard comparable. For instance, the various
physiological conditions vary in their psychological significance. In general
people are motivated to seek and prolong pleasurable conditions, such as
passion, joy etc. Whereas they are motivated to avoid or terminate
unpleasant conditions like fear and anger etc.

Intervening process definitions of stress:

As per these definitions some kind of process occurs in between the
stimulus situation that impinges on the individual and the potential response
of the individual to the situation. Wolff (1968) described stress as an
inherent characteristic of life. He emphasized that different stressors should
have different meanings for different individuals which might be related to
his/her past experiences and personal characteristics. Cox (1978) and
McGrath (1970) defined stress as “the imbalance between the perceived demands placed on an individual and his/her perceived capability to deal with the demands.” Lazarus and Folkman (1984) defined stress as “an encounter with the environment that is appraised by the individual as taxing his/her well-being. The main problem with these definitions is that they focus primarily on external stressors, paying less attention to internal stressors, like disturbing thoughts, desires, memories etc. Another problem with these approaches is that they do not readily accommodate the possibility that a disposition to respond to some stressors may be built into the organism (Zajonc, 1984). A person’s response to such stressors may be influenced little by the person’s perceived resources or capability to deal with them. Finally, it is more difficult to measure stress in terms of the intervening process.

There has been a considerable debate among researchers about how to adequately define stress. Lazarus (1966) was of the view that stress cannot be objectively defined. The way we perceive or appraise the environment determines whether stress is present or not. Singer (1980) has pointed out that there is still limited agreement among researchers regarding the definitions of stress. It has been used to cover a number of dimensions ranging from stimuli or stressors that lead to various types of changes in the
organism to the outcome of such stimuli and the emotional state or experience accompanying a changing social or personal situation (Levine and Scotch, 1973). Mc Lean (1979) concluded that stress is neither a stimuli, nor a response, nor an intervening variable, but rather a collective term which deals with any demands that tax the system (physiological, psychological or social) and the response of that system to the taxing demands.

Traditionally, stress has been defined in terms of its source which may be internal as well as external (Marion, 2003). Internal sources include hunger, pain, sensitivity to noise, temperature, change, crowding, fatigue, and over or under-stimulation from one’s immediate physical environment. External stressors include separation from the family, change in family composition, exposure to arguing and interpersonal conflict, exposure to violence, experiencing the aggression of other, loss of important personal property, exposure to excessive expectation for accomplishment, disorganization in one’s daily life events (Bullock, 2002). Among the most important of these are major stressful life events, such as the death of a loved one or a painful divorce, the all-too frequent minor /major hassles of everyday life, conditions and events relating to one’s job or career, and certain aspects of the physical environment.
Stressful life events first investigated by Holmes and Rahi (1967) can be major stressors, particularly if the changes are negative, and if they force a person to make adjustment (Cohen and Williamson, 1991; Cohen, Tyrrell and Smith, 1991; Price, 1992). Daily hassles are minor irritations, pressure and annoyances, which, if experienced only occasionally, would not be significant stressors. But when experienced more regularly, hassles can have cumulative effects (Bolger et al., 1989). Catastrophic events are shocking, potentially life-threatening experiences, life traumas such as physical or sexual assault, military combat, fire, torture, accidents lead to psychological distress.

The after effects that are associated with the stressed state may be physical, psychological, physiological, behavioral or cognitive. Physical response to stress include rapid breathing, increased heart rate, sweating, and, a little later, shakiness. These reactions are of a general pattern, or syndrome known as the fight-or-flight syndrome. Hans Selye (1956, 1976) suggested that physical reaction to stress occur in three phases, known as General Adaptation Syndrome, or GAS. During the first alarm reaction, the body’s resistance temporarily drops below its normal, ongoing level as it absorbs the initial impact of the stressor. However the resistance, second
phase soon increases dramatically, leveling off in the resistance stage, but ultimately declining if the exhaustion, third stage is reached. The GAS model as proposed by Selye is very much influential, but it has been criticized for underestimating the role of psychological factors in stress, such as a person’s emotional state or the way person thinks about stressors (Appley and Trumbull, 1986; Lazarus and Folkman, 1984). This criticism have lead to the development of psycho-biological models that emphasize the importance of psychological as well as biological variables in regulating and producing stress responses (Depue & Monroe, 1986; Smith & Anderson, 1986). According to psycho-biological models, psychological variables shape the impact of stressors.

The physical responses are accompanied by emotional stress response like feeling of anxiety and depression; increased physical tension and increased psychological tension. In most cases, emotional stress reactions subside soon after the stressors become weak or are gone. However if stressors continue for a long time or come in a tight sequence, emotional stress reactions may persist. Reduction in the ability to concentrate, to think clearly are to remember accurately or typical cognitive stress response. One of the most cognitive stress responses is catastrophizing, which means dwelling on and over emphasizing, the potential consequences of negative
events (Sarason et al., 1986). Catastrophizing is intensified, adding to the total stress response (Darke, 1988; Geen, 1985). People’s physical and emotional stress reaction cues that come from their behavioral reactions like facial expressions, shaky voice, tremors and jumpiness. Even more behavior stress responses appear as people attempt to escape or avoid stressors (Cooper et al., 1992). Aggression is another common behavioral response to stressors. Stress also leads to physiological responses like release of adrenaline and nor adrenaline, shut down of digestive system, increased heart rate and constriction of blood vessels.

The studies conducted by various investigators which has relevance with the present research problem have been reviewed and presented. A study conducted by Murphy, Shirly A. (1985) revealed that the stress levels and health status of 155 18-72 yr old 11 month after they had experienced 1 of 5 magnitude of loss -confirmed death bereavement, presumed death bereavement, loss of home, loss of leisure residence or no disaster-related loss-as a result of volcanic eruption of Mount St. Helens. It was hypothesized that the greater the loss, the greater the stress and poorer the health. The subjects were given the Life Experience Survey, Revised SCL-90, and physical health index. Pair wise comparison did not support the hypothesis adverse loss effects. The 2 bereaved groups were similar and
showed a high incidence of somatic and depressive symptoms when compared to the bereaved Ss, those who lost their homes reported higher incidences of negative life events, anger, blame and financial dissatisfaction. Recreational homeowners did not appear to be affected on any of the outcome measures. Physical health depicts were not reported by any of the loss group.

Steele and Tom (1987) explored the immediate effects of aversive visual stimuli, using 11 males and 13 females, aged 17-42 yrs. Moderating effects of individual differences in locus of control, sex and a requirement to report on the stimuli presented were examined. Results indicate a fractionation of the outcome response with electrodermal measure (EDM) and salivary function showing a sympathetic-type response to war slides, while measures of cardiac activity tended to show increased parasympathetic activity over the response to neural slides. Psychological measures and increase in self-reported stress, higher disturbance rating, and unprompted reports of coping strategies in response to war slides.

Seta et al. (1992) examined how person feels after being exposed to variety of negative events in 3 studies with a total of 190 female undergraduate. Ss reports of stress reflected an average process: Ss reported feelings more negative (stressed) after being exposed to 1 highly negative
and 1 mildly negative event. The report also reflected a summation process: Ss reported feeling less negative after exposed to 1 highly negative and 3 or 4 mildly negative events.

Solomon et al. (1993) assessed the psychological effects of Persian Gulf War on 61 Holocaust survivors (mean age 68.3 yrs) and 131 elderly Ss (mean age 72.9 yrs) without such a background. Subjects were given to complete the State-Trail Anxiety Inventory and measures of sense of safety and symptoms of posttraumatic stress disorder (PTSD). It was found that holocaust survivors perceived higher levels of danger and reported more symptoms of acute distress, as well as displaying higher levels of both state and trait anxiety. The findings did not support an inoculating effect of prior experience with extreme stress but rather an increased vulnerability.

Kushnir and Samuel (1993) assessed the impact of Persian Gulf War on 162 Israeli employees (aged 21-65 yrs) who continued to work during the war. The impact of the intense life situation on these workers was compared with pre war data gathered in health surveys conducted in several industrial plants. Results show increased burnout and physical and emotional distress when compared with pre war levels. This was manifested by increased somatic complaints, tension and restlessness. The subjects also showed increased cognitive weariness, signifying an impaired ability to concentrate
and think clearly. The significant relationship between pre war burnout and wartime worry supports the hypothesis the prewar burnout will affect wartime appraisal of threat.

Orris et al. (1994) examined the mediating roles of 7 domains of chronic stress (marital, parental, filial, financial, occupational, ecological and physical) on a sample of 930 disaster victims of Hurricane Hugo and controls. Results provide strong support for the hypothesis that chronic stress on psychological distress. The main effects of loss, though limited in strength, were completely explained by victim’s higher financial, marital, filial and physical stress. The effect of injury, though quite strong, was largely mediated by these same domains of chronic stress. Likewise the effects of life that were largely mediated by all these domains plus ecological stress.

Sutker (1994) studied the relationship of ODS participation and symptoms of psychological distress in its participants. 215 Army National Guard and ARMY Reserve troops who were activated to service in the Persian Gulf and returned to the US without seeking mental health treatment service were compared with 60 troops from these same units who were activated but not deployed overseas. Negative psychological outcomes were measured within 4 to 10 months from homecoming in 3 domains: Negative
mood stress, symptom of posttraumatic stress disorder (PTSD), and physical health complaints. Results indicate that as war-zone stress exposure increased, the frequencies of severity of psychological symptoms were enhanced. As many as 24% of war zone exposed troops exhibited levels of distress symptom logically sufficiently exaggerated to suggest the presence of mental disorder, specifically clinical depression and PTSD.

Polic et al. (1993) surveyed soldiers, children and refugees who were affected by the war in the former Yugoslavia in the early 1990s. 280 Slavenian soldiers who had not participated in military actions observed that their current distress level was low, but they were not convinced that they would survive the war. Slavenian children aged 7, 11 and 13 yrs were questioned about the causes and nature of the war. 258 refugees from Croatia were found to be highly stressed by their situation, although this war was more apparent for those forced to live in refugee centers. 290 Bosnian refugees were found to be even more stressed and very pessimistic about the future for a joint existence of Muslims, Croats and Serbs.

Singeret et al. (1995) examined the extent to which adolescents (ADLs) were exposed to various types of violence, either as victims or witnesses, and the effects of this exposure on their mental health. The Ss were 3,735 students aged (14-19 yrs) in 6 public high schools: 3 in
Cleveland, Ohio; 2 in Denver, Colorado; and 1 in north east Ohio. Recent exposure to physical violence (PV) was measured on the 10 item scale and trauma exposure symptoms were measured with the help of trauma symptom checklist for children. Results indicate the ADLs had been exposed to considerable PV, especially male ADLs from large city schools. PV exposure was related to depression, anger, anxiety and post traumatic stress.

Perera, L. (1996) assessed children exposed to war related events that the presence of psychological distress, in six communities in parts of Srilanka in variously affected by armed conflict. Community development approach to local capacity building, based on the health initiative as peace initiative model was used to raise national awareness of the psychological effects of armed conflict on children. A follow-up to the study a locally run programmed based on creative play and trauma-healing was established, initially for children involved in the study and was later extended to other children in the district affected by armed conflict.

Farrell et al. (1997) examined the effects of witnessing community violence on emotional distress and frequency of violent behavior across three time points within a predominantly African American sample of 436 sixth-grade students in an urban public school system. A high percentage of students, particularly boys, reported witnessing a variety of violent incidents
(e.g., shooting, beating and stabbings). Comparison of structural equation models revealed a number of significant gender differences in the effects of exposure to violence and in the measurement of violent behavior. Exposure to violence was found related to subsequent changes in emotional distress for either boys or girls. Cross-sectional results replicated previous studies that have found relations between exposure to violence and frequency of violent behavior; however neither variable was related to emotional distress.

Ariyaratne V. (1997) studied the children and adolescents in Sri Lanka who have been exposed to extensive social and military violence unprecedented in its modern history. Many children in Sri Lanka have witnessed the death or disappearance of family members and friends in north and east ethnic conflict during the southern insurgency in 1987-89. It was estimated that over 500,000 children were directly or indirectly affected by the continuing conflict in the north and east. The study examines the link between armed conflict and psychological distress in exposed children at a community level.

Rudenberg et al. (1998) studied many children in South Africa subjected to continually high levels of stress and political violence. The Draw-a-person test and drawings of the stress for area where the children lived were used to examine the possible levels of stress and emotional
difficulties, as well as coping styles and defense mechanisms in a sample of its 8-12 years old children from Gauteng, South Africa during the 1993 pre-election period. A checklist of behavior difficulties was also administered to the teachers, in order to gain information on the children’s overt behavior. The comparison of the Draw-A-person tests showed that violence appeared to be a pertinent stressor. Black South African children from particularly high violence areas showed more distress on their drawings in comparison to white sub-urban children, with girl’s distress levels appearing higher than the boys. However, on drawings obtained from children distributed in areas across Gauteng, boys appeared more vulnerable than the girls. Use of different coping styles and defense mechanisms appeared to influence the effect of stress on children. Social support and denial appeared to assist coping, while feeling of helplessness and internalization of anger appeared detrimental.

Pfefferbaum, Betty et al. (2000) examined the effects of traumatic loss on children who reported a friend or acquaintance killed in the 1995 Oklahoma City bombing of a federal office building among 27 3rd-5th grade children who lost a friend or acquaintance and 27 demographically matched controls were assessed 8-10 months after the bombing. All but 3 of the children continued to experience post traumatic stress symptoms. Those
who lost a friend watched significantly more bombing-related television coverage than those without losses and those who lost an acquaintance. It was concluded that parents and those working with children should be alert to the impact of loss even when it involves no relatives.

Shahinfar, Ariana et al. (2002) examined parent and child perception of the rates and correlates of violence exposure in a preschool sample. A group of 155 parents and their pre school children attending Head start reported on the children’s exposure to community violence, level of distress symptoms and behavioral problems. The behavior correlates were found to differ according to exposure modality: Internalizing problems were more likely in children who witnessed violence and externalizing problems in those victimized by violence. In a study, Ellard, John. (2001) examined the relationship between traumatic stress and psychiatry and between environmental factors and psychological health. The author states “Calamitous experiences can indubitably cause severe psychiatric disorder, which may be long lasting.

Schuster, M.A. et al. (2001) surveyed 560 US adults, who were interviewed about their reactions to terrorist attacks and their perception of their children’s reaction, 3 to 5 days after September 11. 44 percent of the adults reported one or more substantial symptoms of stress; 90 percent had
one or more symptoms to at least some degree. These symptoms include insomnia, nightmares, fearfulness, irritability and distressing recollection of events. Although among the people surveyed, those who were closest to New York had the highest rate of stress reactions, others throughout the country in large and small communities, also reported substantial stress reactions. They coped with their stress by talking with others (98%), turning to religion (90%), participating in group activities (60%) and making donation (36%). 84% of the parents reported that they and other adults had talked to their children about the attacks for an hour or more; 34% restricted their children viewing television. 35% had stress symptoms and 47% were found worried about their safety or safety of their loved ones.

Margoob et al. (2001) reported significant increase in number of individuals seeking treatment at a general hospital psychiatry unit (GHPU) in Srinagar. Their number has risen from a total of 1702 in 1990 (when terrorism in Kashmir was just germinating) to 37860 in year 2001. This marked increase in the psychiatric attendance in OPD cannot be possibly explained by any other factor except the growing impact of terrorism and violence in the valley. In the year 2001, a significant number of patients (2.38%) were diagnosed to be suffering from PTSD. Among those 68.2%
had immediate onset and 31.8% had delayed onset i.e. onset after 6 months of the traumatic event.

Galea et al. (2002) interviewed 1008 adults 5 to 8 weeks after September 11 attack, 7.5% reported symptoms consistent with a diagnosis of current PTSD related to the attacks, and 9.75 reported symptoms consistent with current depression. Among respondents who live south of canal street (near the world trade center), the prevalence of PTSD was 20.0%. Predictors of PTSD were Hispanic ethnicity, two or more prior stressors, a panic attack, a death of friend or relative during the attack and loss of job due to attack.

Sehlenger et al. (2002) assessed the psychological symptom levels in the US following the event September 11 and examined the association between post attack symptoms and indices of exposure to the events. One and 2 months after the attack, 2,273 adults, from New York and Washington metropolitan areas, responded to a web-based survey that included the posttraumatic stress disorder (PTSD) checklist and the Brief Symptom Inventory. Outcome measure included self-reports of the symptoms of PTSD and of non-specific psychological distress, as well as adult reports of symptoms of distress among children living in their households. The prevalence of probable PTSD was significantly higher in the New York City area than in Washington, DC and the rest of the country, overall distress
levels across the country, however were within expected ranges. Sex, age, direct exposure to attack on September 11 and a few days afterward were associated with PTSD symptom levels; sex, the number of hours of TV coverage viewed, and the content of that coverage were associated with the broader distress measure over 60% of adults in New York city households with children reported that 1 or more children were upset by the attack.

Silver et al. (2002) examined the degree to which demographic factors, mental and physical health history, lifetime exposure to stressful events, September 11-related experiences, and coping strategies used shortly after the attacks predicted psychology outcomes (acute stress, posttraumatic stress and global distress). 2,729 adults (78% of a national probability sample) completed a web-based survey between 9 and 23 days after the terrorist’s attacks. A random sample of 1,069 panelists residing outside New York, were drawn from the wave sample (n=2,729) and received a second survey; 933 (87% participation rate) completed it approximately 2 months following the attacks; 5.8% did so at 6 months. High levels of post traumatic stress symptoms were associated with the females, marital separation, pre-September 11 physician’s diagnosed depression or anxiety disorder or physical illness, severity of exposure to the attacks and early
disengagement from coping efforts. Global distress was also associated with severity of loss due to the attacks and early coping strategies.

Rosenheck (2002) compared the average number of daily outpatient visits during the 19 working days before and after September 11 in different clinical groups and geographic locations (excluding weekends, holidays and September 11 itself). The author concluded that although the event of September 11 were profoundly traumatic for those directly involved and clearly distressing for others, they are not necessarily medically significant, and there is no substantial short term change in the use of service, even among more vulnerable patients with mental illness or posttraumatic stress disorder.

Bleich et al. (2002) studied nationally representative sample of Israel. Out of 512 participants 84 (16.4%) were directly exposed to the terrorist attack and 191 (37.3%) had a family member or a friend who had been exposed. 391 (76.7%) had at least one traumatic stress related symptoms. Symptoms criteria for PTSD were met by 48 (9.4%) participants and criteria for acute stress disorder by one participant. 299 (58.6%) reported feeling of depression. Female gender and use of tranquilizers, alcohol and cigarettes to cope were associated with TSR (Traumatic stress related symptoms) as symptom criteria for PTSD.
Gil-Rivas et al. (2004) studied approximately 2 weeks after September 11; adolescents from a national sample of households who were indirectly exposed to the terrorist attacks through the media completed a web-based survey that assessed event-related acute stress symptoms. One year later, these adolescents (N=142) and a randomly selected parent from their household completed survey. On average adolescents reported mild to moderate acute stress symptoms, low psychological distress and functional impairment, and moderate level of positive effect 1 year later. After adjusting for acute stress symptoms reported after attacks, greater parent-adolescent conflict was positively associated with adolescent’s trauma symptoms, distress and functional impairment at 1 year. High levels of adolescent’s positive affect at 1 year were found associated with greater parental support, and higher levels of parenting self-efficacy. Parents may play an important role in adolescent’s response to stressful national events.

Callahan, Kelley, L. et al. (2005) investigated stress response to the September 11, 2001 terrorist attack in a New York City metropolitan college sample after 2 days, 1, 2, 3 and 8 months post trauma. Stress responses from a Midwestern college sample were also assessed 2 days after the attacks. Results revealed substantial stress response in both groups 2 days post-trauma. Only small, but significant differences between the NYC and metro
group and the Midwestern group were found, with the NYC group reporting
lightly higher stress scores on the Impact of the Event Scale. The stress
responses in the NYC metro group decreased significantly overtime however
mean scores 3 or 8 months post-trauma suggest that some individuals
continued to experience considerable stress response.

Estevez et al. (2005) examined the role of adolescents interacting with
both parents and teachers in the relationship between violent behaviors, no
direct effect on psychological adjustment was found. Results showed,
however an indirect effect: violent behavior negatively influenced
communication with parents and interaction with teachers, which in turn,
was related to psychological distress.

Ahern, Jennifer et al. (2005) studied the effects of social support and
traumatic experiences on mental health in conflict situation, which may be
different by gender. The study was conducted in July and August 2001,
after the 2 year of end of war in Kosovo. Of 306 emergency department
patients (87.7% response rate), all were ethnic Albanian, 97.4% had
experienced traumatic events and 89.5% has posttraumatic stress symptoms.
Women and persons who experienced more traumatic events had higher
posttraumatic stress scores. Persons with social support had lower
posttraumatic stress scores. In the final model, social support had a greater
protective effect for women, whereas traumatic events had a greater detrimental effect on men. Two years after the war in Kosovo, there remained a high prevalence of posttraumatic stress symptoms, particularly among women with low social support.

Somer et al. (2006) examined the 2001-2002 terror campaign against Israel’s heartland. The violence touched the lives of countless Israelis and had negatively affected the general mood of many. A random sample of 327 adults, purposely over sampled from the hardest hit areas was surveyed. The results show that more national trauma was not limited to those directly exposed to it.

Hobfoll et al. (2006) conducted a large scale study of terrorism in Israel via telephone survey in September 2003 with 905 adults Jewish and Palestinian citizens of Israel (PCI’S), structural equation path modeling indicated that exposure to terrorism was significantly related to greater loss and gain of psychological resources and to greater posttraumatic stress disorder (PTSD) and depressive symptoms, psychological resource loss and gain associated with terrorism were, in turn significantly related to both greater PTSD and depressive symptoms. PCI’s had significantly higher levels of PTSD and depressive symptoms than Jews. Further PTSD symptoms in particular were related to greater authoritarian beliefs and
ethnocentrism, suggesting low PTSD may lead to a self-protective style of defensive coping.

Shahar et al. (2008) investigated 90 adolescents (in grades 7-9) residing in Dimona, Israel, before and after their exposure to suicide bombing. Bombing related perceived stress was associated with an increase in continuous levels of depression from before to after the bombing.

**Aggression: Meaning, Concept and Literature review:**

The term aggression as described in the Oxford dictionary refers to a forceful act or procedure with an intention to dominate or master. In other words it is the practice of setting upon anyone the making of assault or attack. Almost every one of us is familiar with the term aggression, but it connotes different meaning in understanding the concept in the study of human behavior. Moreover we use the word aggression to define the act of assault by a person upon another. From this point of explanation it becomes clear that aggression is a behavior of person whose intent is to harm another. More specifically it may be described as any sequence of behavior directed towards an individual to cause harm.

The review of literature on aggression reveals that the origin of this word is originated from the Latin word “aggredere” which held a variety of
meanings that include: to attack, to approach, to advance, to assail and to attempt. We often use the terms interchangeably when we refer to such type of behavior of an individual. For instance what ‘X’ did was aggressive. Sometimes we use the term in order to describe one’s mood or a feeling, as all of sudden a person might felt aggressive. Referring to the explanation of the concept of aggression, it is now essential to differentiate between aggression as a personality trait and aggression as behavioral act.

Aggression as a personality trait is often defined as the degree to which an individual acts by means of aggressive behavior in his environment. On the other hand aggression as a behavioral act is any kind of behavior of one animate individual directed upon another animate individual with the goal to physically or psychologically harm another individual.

Aggression has been the focus of considerable attention of various scholars. However, researchers have not been able to arrive at a single commonly agreed definition of aggression. Attempts were made to define aggression that ranged from classificatory schemes of unitary nature (e.g. Dollard, Doob, Miller, Mower and Sears, 1939) to those which subdivide aggression responses into discrete categories. The basis of categorization may be stimulus situations (Moyer, 1971), mode of delivery (Buss, 1971), harm intent (Weiss, 1969), or coercive power (Tadeschi, Smith and Brown,
1974) to name just a few. However, some social psychologists have defined aggression in terms of intent and attempt, physically or socially to harm another individual or, in some cases to destroy an object. This definition seems to appear fairly satisfactory for many situations, but it has some limitations too. Refusing to speak does not fit well into the definition, since it is not an active attempt to harm someone. A person staging a sit down strike on doorstep also is not trying to injure another individual. Most psychologists put these two behavior into a special category of aggressive responses and call them “passive-aggressive behavior”, since they are generally interpreted as being aggressive in intent, while the behavior itself is passive and indirect.

Some researchers have defined aggression as any response that occurs when an individual is angry, as many aggressive responses occur in the context of the anger. This definition is not satisfactory as anger may be followed by a variety of non-aggressive behavior too and aggression may also occur in the total absence of anger. If anger can occur without aggression and aggression can occur without anger, then anger cannot be a defining property of aggression. The various definitions given to aggression incorporates either of the four attributes of the behavior assumption about
the instigator, emotional aspects, intent to injure and a chance of harm being done to the victims.

Dollard et al. (1939) defined aggression as any sequence of behavior, the good response of which is the injury of the persons toward whom it is directed.” The behavior they pointed out, need not be overt, but may occur in thoughts as well and fantasies, symbolic or direct attacks on inanimate as well as animate objects or for that matter, may not seem to be aimed at any target at all. This definition too has certain weaknesses. It includes an implicit tendency to attack the frustrating agent, and excludes assertiveness and accidental injury to others from the aggressive acts.

Gilula and Dniels (1969) defined aggression as “the entire spectrum of assertive, intrusive and attacking behavior” and they pointed out that this definition includes “overt and covert attacks, such as defamatory acts as sarcasm, self directed attacks, and dominance behavior,” as well as “such assertive behaviors as forceful and determined attempts to master a task and accomplish an act.”

There has been a constant effort to conceptualize the many varieties of human aggression, Buss (1971) attempted to classify aggressive behavior into three categories: Physical-Verbal and Direct-Indirect although this
scheme of classification has some exceptions and overlaps. Yet it clearly
demonstrates how different it is to categories human aggressive behavior.

Feshbach (1964, 1971) while going through various definitions of
aggression has noted that although, aggression can be defined as injury at the
descriptive level, some type of aggression is necessary at the construct level.
He has classified aggression as intentional and unintentional. Although,
they result in injury, but still unintentional aggressive acts are not contingent
upon their injurious consequences for their commission. In defining
aggression he has delineated expressive, hostile and instrumental, as three
intentional reasons for committing aggression. Hostile aggressive behavior
is directed primarily to injure another person.

Dollard et al. (1939); Berkowitz (1962) have concentrated upon
aggressive behavior serving this function. Instrumental aggressive behavior
is directed toward attaining a non-aggressive goal; it refers to an aggressive
act that attempts to attain a reinforcer from the victim or from source
external to the victim (Bandura, 1969; Borden, Bowen and Taylor, 1971;
Buss; Milgram, 1963; Silvermabn, 1971). According to Bandura (1973) an
adequate definition of aggression must include both injurious behavior of the
perpetrator and the social judgment of the victim. Bartol (1980) including
both performer and the victim defined aggression as “the intention or
attempt top harm another individual physically or psychologically or to destroy an object." This definition seems to be quite satisfactory as it includes many varieties of aggression act.

The focal point of various researchers was mainly concerned to provide a clear cut understanding of the concept of aggression and how it originates. Many of them gave their explanation within the perspective of the inner person and some others have observed that it is by nature, by instinct, by heredity, we aggress to our fellows stating that conflict is phylogenetic in origin and violence is a part of our nature. Others have emphasized that aggression is only potentially manifested through a particular psychological procedure and process. They hold different views regarding the concept of aggression, however everyone is admitting that heredity provides the possibility, but others see that conflict, aggression and violence is the outcome of one’s blocked drives, needs and desires. There has been a lot of discussion on the topic and various prepositions were given to refer to aggression by specifying that whether it is instinctual or learned, appetitive desire or an instrumental action, a character syndrome or cultural manifestation, has been a controversial issue before the researchers while giving explanation of the term aggression.
It has been a common concern for all to understand the reason why an individual acts aggressively towards other individuals. One of the possible reasons that impel an individual to behave aggressively is because of his culture of the way he has brought up in the society. The person who behaves in this way cannot be attributed to instinct alone, because aggression is also moulded and learned. One cannot deny that a person behaves aggressively may be due to both environmental and instinctual factors. The natural instincts which people desires are food, rejecting certain things, escape from danger, fighting if challenged, sex desire, care for the young, dominate and to experience and accept inferior status. It is true that the combination of instinct and environment determines the individual’s behavior. It is well established fact that everything which humans do are learned from other human beings, so they also learn aggression and it may be said that aggression is not there from birth. In spite of uncontrollable instinct a person’s behavior is something, which is taught to him. For example a newly born baby is breathing because it is an involuntary reflex, but on the other hand, a father tells his young son to beat up the school bully who is speaking to him. In this situation, the child is taught to deal with the situation by using some sort of violence. From this explanation it appears that a person displays
aggression because he is driven by instinct interacting with the surroundings of that person.

Some psychologists emphasized that the instinct is innate psycho-physical disposition that determines its possessor to perceive and to pay attention to objects of a certain class, to experience emotional excitement of a particular manner. From this explanation it appears that people do have different reactions for different stimuli so that they are prone to act in certain way whenever they are stimulated to do so. As far as the behavior of people are concerned, the customs which they are taught also comes in the way because customs may seem to be cruel or repulsive to others so as the person may behave aggressively towards others. Aggressiveness may be also learned in the society. If a child is brought up in a hostile environment, he will behave accordingly. A child may also learn hostility form their parents and acts in the same way. The origin of aggression lies in factors such as society and culture. It means aggression is a learned emotion affected by different factors in a person’s environment. By describing aggression one has to emphasize that whether the environment, society and culture creates aggressive behavior, because it is the person’s natural instinct that impels a person to behave aggressively driven by these factors.
In order to resolve the controversy, the nature vs nurture theories were found to be helpful in making clarity in understanding the concept of aggression. The prominent among the psychological theories of aggression is that of Sigmund Freud. He emphasized that aggression is instinctual and inevitable. Initially Freud’s theory was dominated by self preservation and sexual instincts (with ego instinct and eros) but with the idea of death instinct, Freud (1948) developed a particularly biological conception that all living things are driven by two competing instincts. One was a life instinct (eros) driving to create, maintain and unify living things into larger systems. The second one is the death instinct (thanatos) driving towards breaking up living systems and dissolving them into quiescence. The death instinct is directed towards extinguishing the organism. To preserve organism, the libido does battle with the death instinct and directs it outward, where upon it becomes external aggression, the drive for mastery, the will to power. Aggression is therefore secondary, a deflection of the death instinct away from the self.

Psychoanalysis has been an influential approach for understanding the behavior, but few have accepted the idea of death instinct. It is such a concept as eros, libido, ego, id, superego and catharsis that have been found useful. The view of Adler and modern neo- Adlerians stand in marked
contrast to psychoanalytic thought. According to Adler aggression is a superordinate drive that dominates motor behavior and consciousness.

An analytical work on aggression was carried out by Erich Fromm (1973) by revising the notion of the death instinct. According to him, we instinctually protect ourselves against threats to our survival, our freedom and other basic values. The destructiveness that results from this defense is unintended of purely instrumental. Thus, aggression is reactive, not appetitive. It is aroused by stimuli, not internally generated by an increase in tension.

On the other hand ethnologists gave the explanation of aggression in terms of inherited instinct which is found in both humans as well as animals too. The most prominent scientist associated with this approach is Konrad Lorenz (1966). From his perspective aggression is a driving power common to both animals as well as humans. It has also been emphasized that aggression is an invariable, genetically determined and highly specific response pattern. Aggression thus comes from within, it is not learned. It means man is innately aggressive and his response is purely and simply evolutionary extensions of his biological past. However, this approach fails to account for the enormous range of stimuli which can evoke aggressive responses in man.
Another contrasting explanation of aggression was provided by social learning theorists (Rotter, 1954; Mower, 1950: Bower, 1973). Being an innate drive in search of gratification, it is also said that aggression is acquired through experience, behavioral models and through reward and punishment. This theory of aggression is fundamentally behavioral because it is mainly concerned about one’s goals and intentions but the focus is on stimulus response, on observable response contingent experiences, on patterns of reinforcement. The theory fails to explain the physiological determinants of aggression.

This behavioral approach is shared by those who hold their view that aggression is a consequence of our frustrated goals, desires, needs or drives which is perhaps the dominant view of aggression today. Dollard et al. (1939), a prominent figure in this approach postulated frustration-aggression hypothesis, which claim that frustration always produces aggression and aggression is always a result of frustration. He believed that aggression would only be aroused by frustrating situations and events.

Miller (1941) modified the frustration-aggression theory suggesting that frustration is an instigator of aggression, but could also be seen as a source for regression, depression and lethargy (Seligman, 1972). Berkowitz
(1962) also produced a number of modifications of this theory claiming that frustration yields anger rather than aggression.

Another aspect of learning theory highlights that humans are born with the cognitive and morphological potential to behave aggressively, but whether or not they do depend on what happens within this environment (Lenza, 1983). Thus, social psychologists basically see frustration as one possible instigator of aggressive behavior, but instinct that aggression is socially learned behavior rather than an automatic response to stimulus.

Cognitive Neo association theory assumes that cues present during an aversive event become associated with the event and with the cognitive and emotional responses triggered by the event. Negative affect produced by unpleasant experiences automatically stimulates various thoughts, memories, expressive motor reactions and physiological responses associated with both fight and flight tendencies the fight associations give rise to rudimentary feelings of anger, whereas the fight associations give rise to feelings of anger whereas fight associations give rise to feeling of fear (Berkowitz, 1993). Higher order cognitive processes such as appraisal and attributions have also been found to contribute to aggressive by these theories. If people are motivated to do so, they make causal attributions and consider the
consequences of acting on their feelings. Such deliberate thought produce feelings of anger, fear or both.

Another approach to aggression is the “script theory” by Huesmann (1986, 1998). The theory reveals that a person first selects a script (highly associated concepts in memory, often involving causal links, goals and action plan, (Abelson, 1981; Schank and Abelson, 1977) to represent the situation and then assumes a role in the script. Once a script has been learned, it may be retrieved at some later time. Thus, when a person witnessed instances of aggressive episodes is likely to have a very accessible script that has generalized across many situations.

Some theorists argued that the foundation of aggression is biological. They were of the view that genetic factors may be responsible for aggressive behavior. In the 1970’s it was suggested that men who are born with an extra Y chromosome are likely to display more episodes of aggressive behavior than those who are not born with this extra chromosome. Hormones have also been found to play some indirect role in aggression. Neurotransmitters, brain messengers, nor adrenalin, dopamine and serotonin, have all been found in increased concentration in the limbic system in the brain, and have been associated with fighting behavior in the animals (Siann, 1985). Other factors including learning difficulties, minimal brain damage, brain
abnormalities such as temporal lobe epilepsy and social factors as crowding and poverty have been suggested to contribute to aggressive behavior.

Cultural anthropologists such as Alexander (1972) held the view that aggression is seated within the culture. The cultural approach in contrast to learning theory is less concerned with the individual and some determinate variables than with the total of norms, meanings and values within which certain behavior pattern develop.

The further explanation of aggressive behaviors proposed by some researchers classified it as instrumental aggression and hostile aggression. Any aggressive act being used as an instrument or bearing a motive could be considered as instrumental aggression. Thus in this case the individual has another main goal than hurting another individual but creates a sub goal of hurting the other individual to achieve this main goal. Hostile aggression on the other hand bears no motive for the act (Berkowitz, 1993; Geen, 2001).

Boppel (2002) classified aggression into self-preservative and destructive aggression. As far as self-preservative aggression is concerned, it is innate way of behavior which evolved from selection or mutation through evolution. This form of aggression serves the preservation and expansion of the resources for living. Destructive aggression on the other hand is mainly concerned with harming or damaging behavior with the
purpose to get material profit, social acceptance, power, inner satisfaction or stimulation. Another classification was made by Dodge and Coli (1987). These researchers distinguished between reactive and proactive aggression. The reactive aggression refers to any aggressive reaction upon an aggressive action of another individual, whereas proactive aggression is an aggressive act which is initiated by the individual in a situation which objectively was not bearing the necessity for aggressive behavior.

Aggression has been classified as direct and displaced aggression. Direct aggression is expressed directly against the individual or object that is the source of frustration. The expression of aggression for children may be physical and for adults it may be verbal. When circumstances block direct attack on the cause of frustration, aggression may be displaced. Displaced aggression is an aggressive action against innocent person or object rather than against the actual cause of frustration. Another classification with regard to aggression was related to gender (Grotpeter, 1995). It was previously assumed that boys primarily used overt form of aggression, whereas girls strictly used relational aggression. Research reveals that levels of overt aggression are found higher among males; however, the levels of relational aggression are almost equal between males and females (Berkowitz, Lagerspetz and Kaukiainen, 1991). On the basis of results, it
does not meant that females are always less aggressive that the males. Instead females and males choose their primary form of aggression in order to maximize the effects of the aggression. Males typically use overt form of aggression and gradually integrate relational form of aggression into their behavior as they tend to value instrumental goals such as status in the peer hierarchy (Gropeter and Crick, 1996). The choice of aggression could be linked to the social roles of males and females, the verbal maturity or the social dynamics on peer relationships. A number of researches were carried out to find out aggressiveness among different group of people across the world. Cahoon et al. (1985) studied 48 male college students who were exposed either to weapons or to no weapons following positive, neutral or negative personal evaluation. The aggressiveness of the subjects was measured by means of a specifically constructed behavior control inventory. The results obtained revealed that the presence or absence of weapons did not show relationship to aggressive responding.

Felson (1992) examined the interrelationship between stressful life events, negative affects, and aggression in 2 studies on 245 adults selected from the general population, 148 adults’ ex-mental patients, 141 adults ex-criminal offenders, and 1,886 10th-11th graders. Expression of grievance and informal social control were found to be the acts of aggression, thus favoring
social interactionist (SI approach). It has also been found that some forms of
delinquency not usually associated with aggression having aggressive goals.

Calvert and Sui-Lan (1994) compared the effects of playing versus
observing violent video games on young adult’s arousal levels, hostile
feelings and aggressive thoughts. Results reveal that college students who
have played a violent virtual reality game had a higher heart rate, reported
more dizziness and nausea, and exhibited more aggressive thoughts in a post
test than those who played a nonviolent game.

Irwin and Alan (1995) attempted to identify the effects of playing an
“aggressive” versus “non aggressive” video game on second grade boys.
Boys who had played the aggressive game compared those who had played
the non aggressive game displayed more verbal and physical aggression to
inanimate objects and playmates during a subsequent free play session.
Moreover, these differences were not related to the boy’s impulsive or
reflective traits.

Liddell et al. (1995) conducted a study on a sample of 20 children of 5
years old drawn from each of the 4 different communities in South Africa
during their everyday pattern of play and social participation. The children
from more violent communities were found significantly more likely to be
involved in aggressive episodes particularly when the children had more contact with older boys and men.

Durant et al. (1995) hypothesized that adolescent’s exposure to violence and personal victimization will be associated with the frequency with which they engage in fighting behaviors. Questionnaire data were collected from 225 black adolescents (mean age 14.4 yrs). Data support the hypothesis. Previous exposure to violence and victimization, school grade and number of sexual partners accounted for 16.2% of the variations in frequency of fighting during the last year. Exposure to violence and victimization and a family with an unemployed head of household accounted for 11% of the variation in domestic fighting exposure to violence and victimization. Hopelessness and anticipated SES accounted for 15% of the variation in the frequency of gang fighting.

Roboteg et al. (1995) investigated the effects of the stress of war and terror on children’s aggressive and prosocial behavior. Teachers of 686 younger children (mean age 5.5 yrs) and 482 older (mean age 6.3 yrs) Croatian kindergarteners completed the children’s Aggressive and Prosocial Behavior Rating Scale (PROSAG) before the Croatian war and again 15 months later, during the Croatian war. Findings revealed that prosocial behavior increased, but aggressive behavior does not change. During the
war, older Ss showed more prosocial behavior in comparison to the younger ones.

Krist, Steven (1997) investigated the effects of playing a violent versus non-violent video game. After playing these games, third and fourth graders were asked questions about a hypothetical story. On three of six questions, the children who played the violent video game responded more negatively about the harmful actions of a story character than did the other children. The results of the study suggest that playing violent video games may make children more likely to attribute hostile intentions to others.

Farver et al. (1997) compared story narratives of 32 females and 32 males (4-yr-old preschoolers) who were directly exposed to the 1992 Los Angeles riots with narratives told by the control group of 128 children living in other US cities who had no direct exposure to the riots. Ss were matched for sex, age, ethnicity and SES. Findings suggest that children’s narrative reflected their exposure to violence and their expression of that experience.

Mak et al. (2004) tested the thesis of pathologic adaptation for youth exposed to community violence, where high levels of exposure to community violence lead to increased aggressive behavior but decreased psychological distress. Four hundred seventy-one 6th graders and 1 of their parents were interviewed. The results showed, for a small but important
subgroup of youths, that high levels of exposure to community violence were associated with more child-and parent-reported aggressive behavior and less child-reported psychological distress.

Sherer et al. (2005) compared attitudes and behaviors reflecting aggression and violence among Israeli Jewish and Arab youths in relation to their experience of aggression and violence in their families, neighborhood and schools. The sample consisted of 865 Israeli Jewish and Arab youths. Seven scales from among the battery of instruments of the longitudinal national study on attitudes of Israeli youths were used. The results showed that the youths from both nationality and gender were found to differ from each other. On the one hand, Arab teachers and parents were found more aggressive than their Jewish counterparts. On the other hand, despite the attitude of Arab youth that support aggression and justify parents hitting their children, the Jewish youths were more aggressive and violent. The results also showed that males were found to be more violent than females.

Steward et al. (2006) studied the behavioral effects of media violence. The review includes positive influence of exposure to media violence, though the main findings are that exposure to aggressive and violent material, increases aggressive thoughts, feelings and behavior. The review presents research on violence depicted in films, videogames, comic books
and song lyrics, and assesses its impact on aggressive and inappropriate behavior; it also addresses exposure to weapons.

Klinesmith et al. (2006) examined whether interacting with a gun increased testosterone levels and later aggressive behavior. Thirty male college students provided saliva sample (for testosterone assay), interacted with either gun or children’s toy for 15 minutes, and then provided another saliva sample. Next, subjects added as much hot sauce as they wanted to a cup of water they believed another subject would have to drink. Males who interacted with the gun showed significantly greater increase in testosterone and added more hot sauce to the water than did those who interacted with the children’s toy. Moreover increase in testosterone partially mediated the effects of interacting with the gun on his aggressive behavior.

Lambert et al. (2006) examined youth aggressive behavior in relation to community violence exposure among community epidemiologically defined sample of 582 (455 female and 117 male) Urban adolescents. Internalizing behaviors, deviant peer affiliation and parental monitoring were examined as moderators of the association between aggressive behavior and exposure to community violence.

Jan H. et al. (2008) compared dream narratives of children and adolescents living under conditions of enduring interpersonal violence (n =
220) versus those living in peaceful surroundings (n = 99). As predicted, children and adolescents living in circumstances of enduring violence reported higher proportion of aggressive objects in their dreams.

**Concept of Mental health and related studies:**

The word Mental health as defined in Webster’s dictionary refers to “a state of emotional and psychological well-being in which an individual is able to use his/her cognitive and emotional capabilities, function in society and meet the ordinary demands of everyday life. In order to have clear understanding of the concept of mental health, it is imperative to describe the words mental and health separately and relate them with one’s experiences and situations. The word ‘mental’ means ‘of the mind’, it describes an individual’s thoughts, feelings, understanding about himself and the world around him. The word ‘health’ is generally described in terms of working order of body and mind. But when we talk of one’s mental health, it means we are referring to the working order of the mind of an individual concerning to the problems that how he thinks, feels and behaves. The mental health problem is very crucial because it is related to the overall well-being of an individual, irrespective of one’s status, age, gender, race or social background. With the pace of growth and development one of the
biggest challenges a nation has to face is in dealing with health related problems of the countrymen. In order to make the concept of mental health more clear and understandable, when we look it in this perspective that Man is made up of body and soul and each of these two has its innate needs. The body’s innate needs are to be reasonably satisfied from time to time and essentially required for an individual to live and survive. The innate need of man’s soul is to express his spiritual longings for knowing God, belief in Him and worshipping Him. The equilibrium between these two components of the personality gives a direction to a normal person to enjoy mental health, however, if there arises conflict between these two components, man suffers from mental health problems. In true sense Mental health is a core component of psychological well-being, and hence everyday life, so an individual’s good mental health seems to be key factor in one’s successful psychological and social functioning. If we trace the history of mental health it is found closely related to the growth of the mental hygiene in United States with the process of the development of psychotherapeutic practice and personality research. The concept of “mental health” gained its first adherent at the beginning of twentieth century. The subject of Mental Hygiene concerns with the origin or cause of mental problems or disorders with a view to find ways and means of preventing them and if they occur, to
find ways and means to effect, as much cure as possible, by proper
diagnosis. In its broader perspective the mental hygiene is also concerned
with the maintenance and enhancement of mental health, just as medicine
and physical hygiene look after the physical side of human beings to keep
human body free from illness and to effect cure when some illness does
occur to restore the vigor, zest and zeal for living. In 1920’s interest shifted
to promoting “mental hygiene” and establishing child-guidance clinics.

The term “Mental Health” began to replace “Mental Hygiene” in the
1930’s and by the late 1940’s assumed an independent status with a growing
enthusiastic social movement operating in its name. The shift in this
direction clearly signifies the inclination of researchers concerning to the
prevention of mental disorders and broadening the area to focus on all forms
of problems of people relating to social and psychological or psychotic. The
movement began to promote “positive” mental health as a goal, which is
somewhat different from the elimination of mental illness. There are a
number of characteristics associated with a mentally healthy person who is
like a spinning top at once, stable and active and keep on going without
losing the balance of mind. The person is flexible by nature and amenable to
change with rational control. He is well adjusted to himself, to the members
of family, relatives, friends and colleagues. He has wider contacts and
interests. The person is able to be submissive/aggressive, cooperative/resistant, and spectator/performer according to the requirements of the situations.

It is quite evident from the research literature that the concept of mental health has been explained in different perspectives. As far as psychoanalytic viewpoint is concerned it refers to an individual’s function of intrapsychic development and dynamics. It maintains that an individual acquires good mental health as a consequence of fortunate early socialization; psychoanalysis or some other form of psychotherapy can be corrective measure for unfortunate early development. Thus, the individual remains the unit of analysis, and psychological health is seen as a function of the individual’s unique, private intrapsychic development and life history. Subsequently, the unit of analysis was extended to include the patterning of an individual’s interpersonal relations.

Another view of mental health was proposed by the proponent of social psychiatry. Psychologists like Fromm (1955) and Frank (1948), presented a comprehensive view of mental health as a function of the total society-its norms, values and general style of life. In fact mental health is a very ambiguous term, so as it is difficult to agree on its general application in a single context. It has been used in many different ways and it is not to
be used in a very precise way, it needs to acquire scientific status. When we talk of the word “mental” it often implies something which seems to be purely related to the cerebral functioning of a person, and incorporates one’s emotional affective states, the relationships he establishes with others, and a quite general quality that might be called a person’s equilibrium in his/her socio-cultural context. The word “health” refers to more than physical health; it also connotes the individual’s intrapsychic balance, the fit of his psychic structure with the external environment, and his social functioning. Efforts have been made to define health, but there is no unanimously accepted definition of health. The WHO definition (1948) states that health is a state of complete physical, mental, social well-being and not merely the absence of disease or infirmity (Monopolis et al., 1977). It is universally accepted truth that health has been considered indispensable quality in human being. It has been described as soil from which the finest flowers grow. Health is the indicator of an individual’s psychosomatic well-being. To Bhatia (1982) “Health is a state of being hale, sound or whole in body and mind. Research literature reveals that mental health has been described as the ability of a person to make psychosocial adjustment. A mentally healthy person is a productive and unalienated person, a person who relates himself to the world lovingly, and who uses his reasons to grasp reality objectively;
who experience himself as unique individual entity, and at the same time identifies with his fellow man; who is not subject to irrational authority and accepts willingly the rational authority of conscience and reason; who is in the process of being born as long as he is alive, and considers the gift of the life most precious chance he has. According to Laddell mental health refers to the ability of a person to make adequate adjustment to his/her environment, on the plane of reality.

Mentally healthy person is characterized by proper insight and understanding of himself through self-knowledge and self-evaluation. He accepts himself according to his/her own motives, emotions, capacities and intellectual peculiarities, handicaps and failure. A mentally healthy person is consistent in his thinking, feeling and willing and capable of making adjustment of his desires and impulses in harmony with approved social goals. He accepts his relationships in the group by recognizing the variability and flexibility of his status. A mentally healthy person is characterized by social adaptability to get along with people and to attain and maintain harmonious relationships in the family, community, school, workshop or office.

Meninger (1945) defined mental health as the adjustment of human beings to the world and to each other with a maximum of effectiveness and
happiness... it is the ability to maintain, even temper, an alert intelligence, social considerate behavior and a happy disposition. A mentally healthy person has all aspects of his being, physical, mental, and social or super individualistic well coordinated into a balanced and harmonious whole in relationship with the total environment. A healthy person has a state of mind that enables him to experience the greatest amount of happiness and to attain the maximum efficiency with the minimum amount of strain or conflict. He, however, does not have the anxiety to live or clinging attitude that everything must happen as suits his design. He is not grabbing and hoarding to have so many mouthfuls of pleasure himself but gives away more than taking and shares with others his time, energy, wealth and whatever he has.

Wilkinson and O’Connor (1982) defined Mental health as a congruent relationship between a person and his/her surrounding environment. In otherwords , the mentally healthy person interacts with environment in a manner in which the requirements and resources are congruent with the needs and capabilities of the individual.

According to Bhatia (1982) considers mental health as ability to balance feelings, desires, ambitions and ideals in one’s daily living. It means the ability to face and accept the realities of life. Some psychologists
and psychiatrists presented different criteria of positive mental health. They have suggested certain measures on the basis of which, it is possible to assess the mental health of individuals. As suggested by Maslow and Mittelmann (1951), suggested certain criteria to be considered while making assessment of person’s mental health as adequate feeling of security, adequate self evaluation, adequate spontaneity and emotionality, efficient contact with reality, adequate bodily desires and the ability to gratify them, adequate self knowledge, integration and consistency of personality, adequate life goals, ability to learn from experiences, ability to satisfy the requirements of the group and adequate emancipation from the group or culture.

Another psychologist Jahoda (1958) presented six aspects of mental health as i.e. attitudes of an individual towards his own self-the accessibility of the self to consciousness, the correctness of the self concept, and its relation to the sense of identity and the acceptance by the individual of his own self, growth, development, self actualization, integration, autonomy, perception of reality and environmental mastery. Schultz (1977) suggested seven criteria for the assessment of healthy personality as- extension of the sense of self, warm relation of self to others, emotional security, realistic
perception, skills and assignments, self objectification and unifying philosophy of life

Psychologists defined “Mental Health” by focusing on its negative aspects, that is, absence of pathological symptoms such as tensions, anxiety, depression, emotional imbalance, anti-social habits, and drug-addiction. A person who does not display these symptoms may be considered as mentally healthy. This operational definition of mental health seems to be quite adequate, since it is tied up with normality. In common parlance it is assumed that a normal person is well adjusted so, he must be mentally healthy. However it is a difficult task to describe the normality itself because it does not exist independently. It can only be conceived with reference to a specific culture, so as there is no world wide common standard of normality. Therefore this type of argument leads us to the conclusion that a universally accepted definition of mental health is a mere myth.

Like the negative characteristics of mental health, some psychologists have prepared a list of positive qualities of mental health as sociability, emotional maturity, effectiveness of human relationships, etc. Psychologists made all endeavors in this direction so in modern psychology several more
or less independent systems have emerged and each one seeks to explain human nature. In each system attempts have been made to solve problems arising out of the complexity of the human nature and most of these problems are very much concerned with mental health. These different systems are grouped into the mechanical, the dynamic and the humanistic models.

The mechanical model looks upon mass as a reactive being and considers him as merely one more creature of nature whose behavior can be understood, predicted and controlled through such processes as conditioning, reinforcement, generalization etc. This model uses S-R connectionism with the several modifications as the guiding principle in the study of various human problems including mental health. Most of the experiments which are based on this model are conducted on animals not the human beings. This methodology is undoubtedly a scientific one but their primary postulate that specifies that man is simply a reactive organism is not scientific and it does not provide any effective solution to the problems of mental health.

The dynamic model was presented by Freudian analytical school of psychology. According to this model, behind the benign exterior of a man, there lurk those wishes, urges and impulses which man himself is ashamed to recognize. Since man’s nature is essentially animal, he has to repress
such impulses for the sake of social and cultural adjustment. Such adjustments become possible only by resorting to a number of defense mechanisms. Among those of great importance is the influence of childhood experiences, especially sexual in nature, at different stages of development, each stage being dominated by a special mode of achieving maximum pleasure. The secret of mental health is not to repress the animal desire so that mental conflict is avoided.

Humanistic model looks upon man as a being in the process of becoming that lays special emphasis on his mental tendencies towards self-direction, self-fulfillment. The significant factor which affects the individual is not reality as such but rather his interpretation of reality. This means that the reality for any individual is basically the private world of his perceptions. The consistent and organized self is developed through his experience that he gains as a result of interaction with others. Unimportant experiences are ignored and those, which are acceptable, are incorporated self-structure. The acceptable experiences later prove a threat to the self, which requires that it should be protected from such threats. A person becomes maladjusted when he perceives himself at odds with his important experiences. The state of tension that makes the situation worse and as a result of it he loses his mental health.
From this description it appears that attempts have been made to give attention to the problem of mental health but have failed to provide an effective solution to the problems concerning one’s mental health.

White, Marni et al. (1988) conducted a 3-yr panel study to examine the impact of the residential environment on the mental health (MH) of the respondents and their children. This report focuses on the influence of crime in the neighborhood on the well being of 377 black and Hispanic women and their children. Ss were interviewed 2 or 3 times annually in their homes. The findings suggest some adverse effects of crime on mental health of the adults only. Few interactive effects of crime with other residential and social environmental parameters were observed.

Cairnset al. (1989) reviews clinical studies, psychiatric admission and referral rates/ communities studies, and statistical studies to explore the possible relationship between the mental health of children and adults in North Ireland and the potential violence there. Data indicates that only a very small proportion of the population in North Ireland has suffered mental disorders as a result of political violence. It appears that a greater proportion has suffered from mild forms of stress of relatively brief duration.

Westermeyer, Joseph et al. (1990) studied 100 adult Hmong refugee who had been in the US for 8- yrs to compare the 29 Ss currently on warfare
with 71 Ss not on warfare. Indices of mental health were measured by a test battery and compared with current welfare status and the duration of time on warfare. Older mean age was associated with both welfare status and longer duration on warfare. Longer duration of warfare was associated with greater societal isolation and increased health concerns.

Ebata, Keisuke et al. (1990) conducted a mental health survey among 121 male and 31 female Vietnamese refugees who settled in Japan using the Carnell Medical Index-Health Questionnaire (CMI). Findings indicate that significantly more females (64.5%) than males (37.2%) displayed emotional disturbances. Ss who had experienced concentration camps or life threatening situations had significantly higher CMI scores than Ss without such experiences. CMI scores for Ss residing in Japan for 4 or 5 yrs were markedly lower than those for Ss residing there for 2 or 3 yrs.

Farhood, Laila et al. (1993) addresses the impact of war related stressful life events on the physical and psychological health of 540 families, living in war conditions in Lebanon for the past 12 yrs. Economic impact, daily hassles caused by the breakdown of community services, and restricted contact with friends and relatives caused more stress than the constant threat of violence, high level of somatization and psychological
symptoms, increased conflict in interpersonal relationship, and positive level of marital relationship were also found.

Obradovic et al. (1995) collected data of 102 children (aged 8-19 years) who were refugee from Bosnia, Herzegovina, and Croatia and living in refugee centers. Stressors include being in exile, being in war zone, having other family members in war zone, having family members killed or wounded or captured, and having one’s home destroyed. Ss indicated increased sadness, worry, tension and loss of pleasure. They also indicated neuronegative symptoms like lack of appetite, disturbed sleep, excessive perspiration, headache and cardiac and respiratory complaints.

Mollica, Richard F. et al. (1997) examined the effect of war trauma on the functional health and mental health status of Cambodian adolescents living in the refugee camps on the Thai-Cambodian border. One adult (aged 18+yrs) each from 1000 house holds, and 182 adolescents (aged 12-13 yrs), along with one parent were interviewed. Culturally sensitive instruments were used, including the Cambodian version of the child behavior check list (CBCL) and the youth self (YSR). Results show that parents and adolescents reported the later as having experienced high levels of cumulative trauma. 53.8% had total problems scores in the clinical range by parent report on the CBCL and 26.4% by adolescents report on the YSR.
The most commonly reported symptoms were somatic complaints, social withdrawal, attention problems, anxiety and depression. The close effect relationship between cumulative trauma and symptoms was strong for parents reporting on the CBCL, the sub scale on both YSR and CBCL for Anxious/ Depressed and attention problems revealed close-effect associations.

Miller, Kenneth E, (1997) examined the mental health and the psychosocial development of 58 Guatemalan Mayan Indian children (aged 7- 16 yrs) living in 2 refugee camps in Chiapas, Mexico. Assessment instrument and semi structured interviews were utilized to gather phenomenological dated from Ss regarding developmental, socio-cultural, and political topics. Results show minimal evidence of psychological trauma in this sample. A positive relationship between Ss mental health and the physical and mental health status of the mother was found. A strong association between depressive symptomatology in girls and poor health status in the mothers was also found.

Walton, Joan Riley et al.(1998) studied the mental health impact of the Salvadaran civil war on 54 12 year-old exposed to different levels of war violence, as mediated by personal characteristics (intelligence, conforming
and caring nature, sociability), family and social support and support from
the environment (religion, war perception, SES). Half of the Ss came from
the repopulated country village (high war experience) and half from the
industrial neighborhood near the capital city (low war experience). Ss from
the repopulated village reported lower mental health. The personal/social
impact of war was more important than family togetherness or war intensity
in determining mental health. Intelligence was highly related to surviving
with higher mental health. Higher SES and education of parents was related
to better mental health, controlling for intelligence, Ss who experienced the
highest personal-social impact of war showed the poorest mental health. Ss
with high war experience were most likely to have difficulty in imagining
the future.

Samaon, Rodney A. (2000) studied the positive and negative
influences of socio-economic factors, cultural and ethnic characteristics, and
racial differences on mental health of children. Review of literature on the
influence of race, ethnicity and poverty on the mental health of children
found that (1) child whose parents are in poverty or who have experienced
severe economic loses are more likely to report or be reported to have higher
rates of depression, anxiety and anti-social behavior; and (2) after
controlling for socio-economic status, African American, Native American,
and Hispanics are less likely to report or be reported or to have such mental health problems.

Tang, Sharon S. & Fox, Steven H. (2001) conducted preliminary investigation into the experiences and mental health of Senegalese refugees. 80 adult refugees (18 yrs of age and older) from the Casamance region of Senegal were randomly selected from refugee camps in the Gambia. The Harvard Trauma Questionnaire and the Hopkins Symptom checklist-25 were used to assess the levels of dramatization and mental health status. Typical of refugee war, participants reported suffering a large number of various traumas. High prevalence rates of anxiety, depression and post-traumatic stress disorder were also found in the group. The authors conclude that a substantial mental health problem exists within the Senegalese refugee population that may signify potential human crises.

Brown, Elissa J. (2002) discusses mental health trauma response to the events of September 11th. The author maintains that like most trauma responses, reactions to the events of September 11 occurred in three phases: crises intervention, short term reactions, and long term planning. The steps taken and the challenges that resulted, along with the lessons learned daily each phase, are discussed. The author reflects on observation as a New York city (NYC) mental health professionals, director of trauma services and
program evaluation for the New York University child study centers, child
and family recovery program, and as NYC resident. It is concluded that
mental health professionals have not yet began to understand the mental
health impact of Sep 11\textsuperscript{th} on the children of NYC and around the country,
and that as needs are identified strategies for service delivery must continue
to change.

Eisenman, David P. et al. (2003) studied the political violence
exposure among 638 (69\%) Latin immigrant adults’ primary care patients.
Patients reported political violence had greater mental health problems
compared with patients not reporting political violence. Those exposed to
political violence were more likely than those exposed to symptom crises to
post-traumatic stress Disorder, depression, and had significantly worse
health related quality of life. Among 267 (54\%) participants who reported
experiencing political violence visits health care professionals, only 7(3\%)
ever told a physician about it.

Flannery, Daniel J. et al. (2004) examined the relationship between
exposure to violence at school and the child reports of psychological trauma
symptoms and violent behavior. The sample consisted of children in grade 3
through 12 in 17 public schools from two different states. Rates of
witnessing violence ranged from 56\% of elementary school students
witnessing someone else being beaten up to 87% of witnessing someone else being hit, slapped, or punched at school in the past year. Nearly half (44%) of middle school youth were threatened at school. After accounting for demographic effects, witnessing violence at school accounted for more variance than being victimized by violence at school in predicting both psychological trauma symptoms and violent behavior. Students who were exposed to high levels of violence at school also were significantly more likely to experience clinical levels of trauma symptoms than students who were exposed to low level of violence at school.

Flannery, Daniel, J. et al. (2004) examined the coping strategies, Exposure to violence and psychological trauma symptom of violent adolescents compared to less violent and non-violent adolescents in the community sample. An anonymous self-report questionnaire was administered to students in six public high schools (grade 9-12). The 10% most violent adolescents were identified and compared to their less violent and non-violent peers. A total of 3,724 students represented 68% of adolescents in all targeted schools. Ages ranged from 14 to 19 years; 52% were female; and 35% were African-American, 34% Causasian and 23% Hispanic. Analysis revealed that violent adolescents compared to less violent and non-violent peers employed more maladaptive coping strategies, were
exposed to higher levels of violence and reported higher clinical levels of psychological trauma symptoms. Maladaptive coping was also significantly associated with psychological trauma symptoms and violent behavior, even after controlling for the influence of demographic factors.

Ozer, Emily, J et al. (2005) examined schools connection and family support as protective factors for adolescents mental health in the context of exposure to violence. After controlling for seventh grade functioning, recent exposure to violence uniquely predicted worsening of functioning from seventh to eight grade across multiple self-and teacher-reported measure including self-reported competencies. Adolescents who felt more connected to school showed decreased psychological problems from seventh to eight grade. Perceived school connection, however, did not moderate the relationship between exposure to violence and psychological functioning. Findings highlighted family support as a moderator of the relationship between exposure to violence and adolescent’s mental health.

Buckner et al. (2005) examined the association between exposure to violence and different indexes of mental health among 95 extremely poor children (age range = 8-17 years) and analyzed potential moderators and mediators. Findings indicate that 62% of youths had been exposed to at least 1 form of violence controlling for other explanatory factors, exposure
to violence was significantly associated with internalizing symptoms (e.g. depression, anxiety) across all children, but the relation was stronger for girls compared with boys. Externalizing problem behaviors were also associated with exposure to violence, but sub group differences are not detected.

Krupnick et al. (2005) disentangle some of the confounding effects of multiple trauma exposure by exploring the unique contribution to mental health outcomes made by specific type and dimensions of trauma. This report compares the psychological outcomes of college women who experienced different types of trauma during adolescence, including traumatic bereavement, sexual assault and physical assault. Young women who had experienced a single event of one of these types were compared with peers who had experienced multiple single events, ongoing sexual and/or physical abuse, as well as those who had experienced no trauma. Results based on structural clinical interviews, and self report measures showed that there were some significant differences in mental health outcomes based on trauma type. However, trauma exposure versus no exposure and the cumulative effects of exposure versus one-time experience played the key role in differentiating the groups.
Turner et al. (2006) examined the cumulative prevalence of victimization and its impact on mental health in a nationally representative sample of 2,030 children aged 2-17 in USA. The telephonic interview conducted with both caregivers and youth revealed socio-demographic variations in lifetime exposure to most forms of victimization, with ethnic minorities, those lower in socio-economic status, and those living in single parent and stepfamilies experiencing greater victimization. Sexual assault, child maltreatment, witnessing family violence, and other major violence exposure each made independent contribution to levels of both depression and anger/aggression. Other non-victimization adversities also showed substantial independent effects, while in most cases; each victimization domain remained a significant predictor of mental health. Results suggest that cumulative exposure to multiple forms of victimization over a child’s life-course represents a substantial source of mental health risk.

Demaris et al. (2006) studied a sample of 7,700 women drawn from the survey of violence and threats of violence against women and men in the United States 1994 to 1996 to test the violent victimization on women’s mental and physical health. Outcome variables were depressive symptoms, concern for current safety. Self-assessed health and the occurrence of heavy
episodic drinking. The experience of child maltreatment appeared to be as important as other forms of victimization in presaging poor health outcomes.

Ozer et al. (2006) studied exposure to violence as the predictor of mental health and perpetration of violence in a sample of 71 Chinese American young adolescents from nine urban middle schools. Separate hierarchical multiple regression were used to predict self reported symptoms of depression and posttraumatic stress disorder (PTSD). Perpetration of violence, and teacher-reported symptoms of anxiety, depression and adaptive functioning. After controlling for daily hassles, exposure to violence is associated with worse mental health and more perpetration of violence among Chinese American adolescents living in urban areas.
Rationale and objectives of the study:

In the changing socio-political environment, violence, terrorist attacks/insurgency in many societies is increasing globally, arising due to socio-political conflicts, group dominance, economic disparity, denial of rights, creating fear, sense of insecurity and pressure in the minds of common people who directly or indirectly exposed to violence resulting in the loss of life and property. In fact violence in every society is inevitable but whenever the frequency of violence increases in any society/region/state, the sense of security and safety erodes both at the individual as well as the community level. Every individual irrespective of his faith tends to live in peace and harmony, but the occurrence of violence undoubtedly creates threat to one’s life and property which would have serious psychological consequences. Research review on violence reveals that violence of any type creates long lasting mental health problems in the people of all segments. Natural disasters too have its effects on the mind of people, but the degree is relatively low in comparison to the deliberate acts of violence, which leaves its long lasting ill after effects on individuals psyche, leading to anger, frustration, feeling of helplessness and desire for revenge, which in turn develops an aggressive behavior and feeling of distress. In any violence prone area, individuals are vulnerable to traumatic stress and consequent
upon, they may likely to perceive threat of being a victim; induce the feeling of negativism, hostility, powerlessness, suppressed anger and fear, which seem to change human rationality and behavior. The 9/11 terrorist attack in U.S, an example of mass destruction of life and property has opened new avenues in social science research taking into consideration the far reaching ill effects of such type of attacks. It is globally accepted phenomenon that the insurgency/terrorist attacks are viewed as major threat for peace, development and existence of mankind so all possible, measures to be taken to protect people from such type of violent hazards. The present research work to be undertaken is related to Kashmir valley where disturbances took place and people living in the valley witnessed the terrorist attacks and insurgency more often in the span of 2-3 decades. The problem became so intense that people started fleeing from one place to another to protect themselves from being victims. Despite all measures taken by the state and central government, peace could not prevail and it is still a disturbed state. In this period almost every family is affected in one way or the other. Killing of their near and dear, loss of property, injuries time and again is the order of the day. People have to experience the stress in different magnitude and develop psychosomatic problems as they are living in a disturbed state with full sense of insecurity, depression and anxiety. Health experts believe
that the impact of these traumatic events caused by separatist militants, state machinery and central security forces in the Himalayan region changed the life style of Kashmiris' who are traditionally peace-loving people, now living under agony and severe strain. The psychological impact of such type of conditions seems to be experienced in several ways. The new generation had been the target of both militants and law enforcing forces. They witness the horrible realities and live with the painful memories. Taking into consideration all these factors in mind, the present research was an attempt to examine the level of stress, aggressiveness and mental health of adolescents in Kashmir valley. The sample of adolescents is an important feature of this research because at this stage of life, individuals are not matured enough in making decisions regarding their future and thus are more affected psychologically. Their feelings due to the prevailing conditions are to be studied taking samples from Jammu and Kashmir regions through this small peace of research work.

**Research objectives**

The objectives of the study are as follows:

1. Study of the impact of ongoing insurgency on the level of stress, mental health and aggressiveness of adolescents separately.
2. Study of the difference of stress level with consideration of regions (Jammu and Kashmir) and gender.

3. Study of difference of mental health score with consideration of regions (Jammu and Kashmir) and gender.

4. Study of difference of aggressiveness with consideration of regions (Jammu and Kashmir) and gender.

**Research Questions:**

1. Is there any significant difference between the mean scores of stress with consideration of regions (Jammu and Kashmir)?

2. Are there any significant differences between the mean scores of Mental Health and its subscales with consideration of region?

3. Are there significant differences between the mean scores of aggression and its subscales with consideration of regions?

4. Is there significant difference between the mean score of studied variables with consideration of gender and regions?

5. What is the regression equation of mental health on stress, aggression and its subscales?