STATEMENT OF THE PROBLEM

The study attempt to determine the effect of insurgency in the psychological adjustment of the Mizo and explicate the level of anxiety, depression, frustration caused by the insurgency among those volunteers and non-volunteers who experienced fatal and non-fatal situations and it attempt to find out how they cope with the experience.

The greatest shortcoming face by any state is the inability to meet the psychological needs by the general populations, especially a sense of meaning during the stressful periods of rapid change which is associated with development. The shortcoming generated frustration, discontent, societal stresses, etc. Mizoram also gone through 20 years dreadful insurgency from 1966 to 1986, and no authentic research has been conducted to examine the effect of insurgency so far, though human history witnesses the adverse effect of war (insurgency) in human behaviour along with physical problems.

When looking into the human history, war played a major part constantly. The effects of war are extremely detrimental. Soldiers endure extreme stress during combat, which some cannot mentally overcome afterwards, and may developed Post traumatic stress disorder, that some sadly resort to suicide. Soldiers are not the only one affected by wars; members of the family also experiences mental hardships when their loves ones are sent to war.

Life changed for everybody during war time, the war years were a time of anxiety as it was a period of family separation and for many, it was a period of deep personal loss.

Due to stressors caused by the ongoing war in Wanni in the North of Sri Lanka, the people have become quite anxious and impatient and manifestation of mutual anger and irritation are easily observed on the roads, in public places and in family relationships. Many civilians have been treated for clinical depression and for
anxiety disorders at the mental health unit at Maththalan hospital. Many are losing their zest for life and suicidal ideations are widely found among these patients. Since many are going through traumatic experiences, there is the danger of more patients to be identified with PTSD (Post Traumatic Stress Disorder).

Up to 31 percent of soldiers returning from combat in Iraq experience depression or post-traumatic stress disorder that affects their jobs, relationships, or home life, according to a new study by Army researchers.

Clearly the gulf war had profound stress-related effects on Iraqi military personnel and civilians living in Iraq and surrounding Middle Eastern countries. In general the rates of death, physical, and psychological injury have not been reported accurately in scientific literature. However, there have been a number of publications related to the effects of the Gulf war on American and Israeli civilians as well as Vietnam veterans and Holocaust survivors.

For as many as 14 percent of these veterans, depression and PTSD (Anxiety disorder) cause severe problems in their daily life. These problems are often accompanied by alcohol misuse and aggressive behavior, the study found.

The researchers analyzed mental health surveys from more than 13,000 Army and National Guard infantrymen who fought in Iraq. The soldiers completed the surveys between 2004 and 2007; three and 12 months after returning to the U.S. Between 9 percent and 14 percent of the soldiers were diagnosed with PTSD or depression resulting in serious impairment, while 23 percent to 31 percent were deemed to have some impairment. (The rates varied depending on the diagnostic criteria the researchers used.)

Soldiers not only suffered on the battlefield. Veteran ofteh needed long-term care owing to the physical and psychological impact of war. During the second world war (1939-1945), many soldiers demonstrated symptoms of high levels of stress, a condition referred to as battle fatigue, the effect of the battle were very hard on the soldiers. Anxiety and fear symptoms predominated in combat soldiers in Vietnam (Jones, 1977).
A variety of psychological responses similar to those described by Kubler-Ross (1969) in the dying patient such as, denial, anger, bargaining, depression and acceptance were found on severely disabled soldiers. Stress casualties presented with hysterical syndromes, psychomotor disturbances, and fear, as well as depressed affect during world war I.

The loss of comrades not only provokes anxiety about one’s own mortality but also represents a loss of social reinforcement with subsequent anger and depression. During World War II, Sobel (1949) referred to such casualties as “the old sergeant syndrome.” In the Vietnam conflict, an examination of psychiatric syndromes among soldiers seen at a rear-echelon care facility staffed by a mobile psychiatric detachment (KO Team) early in the war before drug abuse and disillusion became widespread reveals a large number of anxiety-type symptoms. In non-wounded soldiers, Bowman (1967) found predominance of dissociative, anxiety, and conversion symptoms, and in wounded soldiers anxiety dreams and neurological symptoms. Similarly, Jones found that anxiety and fear symptoms predominated in combat soldiers in Vietnam.

Frequently soldiers endure more psychologically after war than during it, even aside from coping with any enduring physical damage, such as a missing hand or leg, profuse scarring or disfigurement, or faulty wounded internal organs. Many of them relive the war, through nights of little sleep and occasional flashbacks fired by the slightest trigger of remembrance, until the day of their death.

Soldiers deployed as peacekeepers can experience anxiety, frustration and helplessness from their peacekeeping role and can be exposed to events that are potentially traumatizing, e.g. mass killing, injured civilians, and landmines. Although the majority may cope well with the demands of a peacekeeping deployment, exposure to peacekeeping stressors is also associated with PTSD, depression and problems with aggression.

Many of the Iraq and Afghanistan veterans displayed symptoms that were noted consisted of depression, frustration and anger, guilt, memory problems, anxiety, lack of self-esteem and motivation.

Essentially, insurgency and terrorism are the “perfect” traumatic stressor, because it combines the elements of malevolent intent, actual or threatened extreme
harm, and unending fear of the future. Indeed, the very purpose of terrorism fully meets Criterion A of the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV; American Psychiatric Association, 1994) diagnostic classification of posttraumatic stress disorder (PTSD), of injuring or threatening self or others, and involving “the experience of intense fear, helplessness, or horror” (Meek, 1990; Merskey, 1992; Miller, 1994, 1998a; Modlin, 1983, 1990; Weiner, 1992).

Much of our clinical knowledge of how to evaluate and treat victims of terrorist trauma and their surviving loved ones must be adapted from work with analogous cases of traumatic bereavement, such as family members of victims of murder, ambush, and shootings (Miller, 1998a).

According to the Department of Veterans Affairs, 10 to 18 percent of Iraq and Afghanistan war veterans may have post-traumatic stress disorder, or PTSD. The sleeplessness, anger, anxiety and sense of isolation that can accompany the disorder pose tremendous challenges for veterans and their families, and there's an enduring stigma around mental health care that still discourages many from seeking help.

In non-wounded soldiers, Bowman (1967) found a redominance of dissociative, anxiety, and conversion symptoms, and in wounded soldiers anxiety dreams and neurological symptoms. Similarly, Jones (1977) found that anxiety and fear symptoms predominated in combat soldiers in Vietnam.

Posttraumatic stress disorder (PTSD) and depression are serious problems for soldiers who return home from the wars in Iraq and Afghanistan, according to a new study published in the Archives of General Psychiatry.

For many survivors, the experience of combat fighting strikes a mortal blow to the self, evoking their own sense of personal loss. Family members are typically preoccupied with the nature of the injuries inflicted on the victim, the brutality of the killing, the types of weapons used, and the victim's suffering. Families may clamor for information about the identity of the murderers and any possible relationship to the victim they may have had (Ressler, Burgess, & Douglas, 1988). Any kind of combat fighting including murder, always involves a human perpetrator, and the greater the perceived intentionality and malevolence of the killing, the higher the distress is in the survivors (Carson & MacLeod, 1997).
Even more common than anger is a pervasive “fear of everything” that begins to loom in the survivors' consciousness, beginning with their first awareness of their loved one's death and persisting for several years or more. Survivors' heightened sense of their own vulnerability may spur them to change daily routines, install house and car alarms, carry weapons, refuse to go out after dark, or to shun certain locales. There may be phobic avoidance of anything related to the trauma, including people, places, certain foods, music, and so on. Survivors may experience psychophysiological hyper startle responses to such ordinarily nonthreatening stimuli as crime shows on TV, shouting in the street or among family members, the sound of airplane engines, or news stories about terrorism or about any, even unrelated, accident or tragedies.

The survivors' usual range of territorial and affiliative activity becomes constricted as the home is turned into a protective fortress, strangers are avoided, and unfamiliar surroundings are circumvented. All family members may be outfitted with pagers and cell phones and may have to submit daily schedules of activity, as there develops a compulsive need for family members to be close at hand or reachable at a moment's notice. Older children and adolescents, especially, may resent this “babying” restriction of their autonomy and independence (Rynearson, 1988; Rynearson & McCreery, 1993; Sprang & McNeil, 1995). Everybody's health suffers. Common psychophysiological disorders include appetite and sleep disturbances, gastrointestinal problems, cardiovascular disorders, decreased resistance to infectious disease, and increased anxiety and depression. A significant number of family members die within the first few years of any kind of violent criminal homicide (Schlosser, 1997; Sprang & McNeil, 1995).

Grief work is the term often used for the psychological process that moves the person from being preoccupied with thoughts of the murdered victim, through painful recollections of the loss experience, to the final step of settling the loss as an integrative experience (Parkes, 1975; Parkes & Brown, 1972). Those who appear to adapt best to stressful experiences in general typically have a range of available coping strategies and resources that permit greater flexibility in dealing with the particular demands of the traumatic event (Bowman, 1997, 1999; Miller, 1998b; Silver & Wortman, 1980).
The psychological impact has been very significant. We all felt—and still feel to some extent—the shock and grief that came in the immediate aftermath of the attacks on 9/11. As trauma experts predicted, we experienced the worst of the trauma responses months after the attack (Levant, Barbanel, & DeLeon, 2011). Those most affected by the attacks were more likely to experience more profound psychological trauma. In addition to the trauma resulting from the attacks themselves, fears arose from the spate of anthrax incidents and the continuing threat of biological and chemical terrorism. We also witnessed the work of copycats, hoax perpetrators, and domestic terrorists (e.g., the mailing to family-planning clinics of suspicious, but thankfully not anthrax infected, envelopes). In addition to these very serious threats, the daily fabric of our lives has been disrupted. As some have said, the terrorists put sand into the gears of everyday life. U.S. citizens now have to cope with increased difficulties and disruptions in air travel and postal deliveries, airport and building evacuations, and the like. Clearly, the psychological toll of this war is likely to be considerable.

Deborah Mitchell (2007) note that when utilizing the least stringent definition of PTSD, they found rates ranging from 20.7 to 30.5 percent, and depression rates ranging from 11.5 to 16 percent. When they employed the strictest definitions of both conditions, they found a PTSD prevalence of 5.6 to 11.3 percent and for depression, 5 to 8.5 percent. Aggressive behavior or alcohol misuse was also present in about 50 percent of the soldiers who had PTSD or depression.

In a study done by Black et al, One-hundred-ninety-two (32%) of the 602 surveyed veterans met criteria for a current or lifetime depressive disorder (major depression, dysthymia, depressive disorder—not otherwise specified).

Study done by Msnbc.com about mental health on Soldiers suffer from stress after coming home found out that almost a third of the more than 88,000 returning soldiers in the study had signs of depression, post-traumatic stress disorder, conflicts in relationships or other problems after six months.

A study done by Cardozo and friends (2004) used a national multistage, cluster, population based survey including 799 adult household members aged 15 years and above. Sixty-two percent of respondents reported experiencing at least four
trauma events during the previous ten years. Symptoms of depression were found in 67.7% of respondents, symptoms of anxiety in 72.2%, and post-traumatic stress disorder (PTSD) in 42%. The disabled and women had a poorer mental health status, and there was a significant relationship between the mental health status and traumatic events. Coping strategies included religious and spiritual practices.

Study done by Scholte and colleagues (2004), using a cross-sectional multicenter sample, was conducted in the Nangarhar province of Afghanistan, to estimate the prevalence of psychiatric symptoms, identify resources used for emotional support and risk factors, and assess the present coverage of basic needs. About 1011 respondents aged 15 years and above formed the sample. Nearly half of the population had experienced traumatic events. Symptoms of depression were observed in 38.5% of respondents, symptoms of anxiety in 51.8% and PTSD in 20.4%. High rates of symptoms were associated with higher numbers of traumatic events experienced. Women had higher rates than men. The main sources of emotional support were religion and family.

A study done by Mollica and colleagues (1999) among Bosnian refugees demonstrated an association between psychiatric disorders (depression and PTSD) and disability. A three-year follow-up study on the same group concluded that former Bosnian refugees who remained living in the region continued to exhibit psychiatric disorders and disability after initial assessment (Mollica et al, 2001).

In a study of the mental health and nutritional status among the Serbian ethnic minority in Kosovo, the General Health Questionnaire (GHQ)-28 scores in the subcategories of social dysfunction and severe depression were high, with women and those living alone or in small family units being more prone to psychiatric morbidity (Salama et al, 2000). In a community sample of 2,796 children aged between 9 and 14 years, high levels of post-traumatic symptoms and grief symptoms were reported (Smith, et al., 2002). This was related to the amount and type of exposure. Girls reported more distress than boys.

A household survey of 993 adults from Site 2, the largest Cambodian displaced-persons camp on the Thailand-Cambodia border, found that more than 80% felt depressed and had a number of somatic complaints despite good access to
medical services (Mollica et al, 1993). Approximately 55% and 15% had symptom scores that correlated with Western criteria for depression and PTSD, respectively. However, despite high reported levels of trauma and symptoms, social and work functioning were well preserved in the majority of respondents. Cumulative trauma continued to affect psychiatric symptom levels a decade after the original trauma events (Mollica et al, 1998.). This study also reported that there was support for the diagnostic validity of PTSD criteria, with the notable exception of avoidance. The inclusion of dissociative symptoms increased the cultural sensitivity of PTSD. Psychiatric history and current physical illness were found to be risk factors for PTSD (de Jong et al, 2001).

Lebanon has been ravaged by a civil war (1975-1990) and by an Israeli invasion in 1978 and 1982. The mental health impact of these conflicts has been studied extensively. A random sample of 658 people aged between 18 and 65 years was randomly selected from four Lebanese communities exposed to war (Karam et al, 1998). The lifetime prevalence of DSM-III-R major depression varied across the communities from 16.3% to 41.9%. Exposure to war and a prior history of major depression were the main predictors for current depression. The correlation between mother's distress and child's mental health was explored in a study in Beirut (Bryce et al, 1989). The level of perceived negative impact of war-related events was found to be strongly associated with higher levels of depressive symptomatology among mothers. The level of depressive symptomatology in the mother was found to be the best predictor of her child's reported morbidity. In a study carried out in 224 Lebanese children (10-16 years), the number of traumatic experiences related to war was positively correlated to PTSD symptoms, with various types of war traumas being differentially related to the symptoms (Macksoud MS, Aber JL., 1996).

A study conducted by the Gaza Community Mental Health Programme among children aged 10-19 years (Sarraj and Qouta 2005) revealed that 32.7% suffered from PTSD symptoms requiring psychological intervention, 49.2% from moderate PTSD symptoms, 15.6% from mild PTSD symptoms, and only 2.5% had no symptoms. Boys had higher rates (58%) than girls (42%), and children living in camps suffered more than children living in towns (84.1% and 15.8% respectively).
The physical and mental health problems of the survivors of the genocide in Rwanda have been well documented (Gourevitch P., 1999). In a recent community-based study examining 2091 subjects (Pham et al, 2004), 24.8% met symptom criteria for PTSD, with the adjusted odds ratio of meeting PTSD symptom criteria for each additional traumatic event being 1.43.

Sudanese refugees fled into northern Uganda in two major waves in 1988 and 1994. Symptoms of PTSD and depression were found to be highly prevalent among Sudanese children living in the refugee camps (et al, 1999). Refugees had higher rates of individual psychopathology than the general population, and it was observed that the cumulative stress grew as the years in exile progressed. The consequences of long-term exile were still present 5-15 years later, with an increase in the rates of suicide and alcohol use.

The conflict between the majority Sinhala and minority Tamil population in Sri Lanka has been ongoing for nearly 30 years. One of the first studies that looked into the psychological effects of the conflict on the civilian population was an epidemiological survey (Somasundaram and Jamunanatha, 2002), which reported that only 6% of the study population had not experienced any war stresses. Psychosocial sequelae were seen in 64% of the population, including somatization (41%), PTSD (27%), anxiety disorder (26%), major depression (25%), alcohol and drug misuse (15%), and functional disability (18%). The breakdown of the Tamil society led to women taking on more responsibilities, which in turn made them more vulnerable to stress (Steel et al., 1999). Children and adolescents had higher mental health morbidity (Somasundaram and Sivayokan, 1994).

The “short-timer’s syndrome,” the development of superstitious dread that one’s chances of being killed are increased followed by phobic anxiety and attempts to avoid all risks even when called for by the military mission, was described as a frequent occurrence in most combat and many combat-support soldiers in Vietnam in the final weeks before rotation home. This syndrome had been described in other situations in which exposure to combat is limited by length of time (9 month of combat in the Korean conflict) or number of missions (a fixed number of bombing runs by aircrews during World War II). Its appearance in Vietnam was, therefore, not surprising; however, its widespread occurrence, affecting even those in minimal
danger, may have reflected disaffection and a sense of hopelessness in fighting the war.

When such repeatedly traumatized combat veterans emerge as psychiatric casualties, they usually present with some variant or mixture of anxiety or depressive symptoms. The “startle reaction,” for instance, may represent conditioned muscle tension and other physiological arousal to loud noises (as from exploding mortar, artillery, or bomb attacks). Soldiers presenting with lethargy, decreased self-esteem, and insomnia may be responding with depression to repeated losses and fatigue from repeated arousal.

PTSD is an anxiety disorder that sometimes affects people who have survived life-threatening events, such as combat, violent crimes, terrorist attacks or natural catastrophes. Symptoms can be mild or severe and include nightmares, flashbacks, depression, anxiety, anger and extreme avoidance behavior.

A study released April 17 by the Rand Corp. reported that 18.5 percent of the 1.6 million U.S. troops who have served in Iraq or Afghanistan -- or 300,000 people -- said they had symptoms of depression or PTSD because of their overseas service.

Nineteen percent -- 320,000 -- reported they had suffered head injuries, which, research shows, sharply increases these troops' likelihood of later developing PTSD. Only about half the troops had sought treatment for their mental health or head wounds, according to the report.

So far, about 120,000 Iraq and Afghanistan veterans have sought help from the Department of Veterans Affairs for mental health complaints, including depression and alcohol abuse. Of that number, about 70,000 have been diagnosed with some level of PTSD, VA records show (Russ, 1917).

Typically when we think about being exposed to traumatic events during a war, we think of the experiences of the military, for example, being fired upon, becoming a prisoner of war, sustaining an injury, or witnessing serious injury or death. However, civilians who are not directly involved in the war effort are also frequently confronted with war related stressors.
A number of investigators have studied the relationships between negative emotions, particularly depression, and pain. It is well accepted among pain experts that negative emotions such as depression are related to pain perception and experience (Holzberg, Robinson, Geiser, & Gremillion, 1996).

In addition to depression, anxiety is often identified as a correlate of chronic pain. There is evidence that suggests that states of anxiety can lead to lower pain tolerance (James & Hardardottir, 2002) and higher perceptions of pain (Tripp, Stanish, Coady, & Reardon, 2004). However, this relationship may be moderated by several factors such as gender (James & Hardardottir, 2002). Sullivan, Thorn, Rodgers, and Ward (2004) suggested that trait anxiety leads to higher levels of state anxiety, which leads to catastrophizing, which then in turn leads to increased pain perceptions.

In a study done by Spitzer, Kroenke and Williams (1999), prevalence rates were calculated to evaluate the proportion of soldiers scoring beyond clinically significant cutoff scores for symptoms of depression, anxiety, and somatic concerns. The prevalence of possible PTSD in this sample was also examined using the National Center for PTSD Checklist.

The proportion of soldiers reporting five or more clinically significant symptoms consistent with major depression was 11.5%. This prevalence rate did not differ significantly between Veterans (8.1%) and Non-Combat soldiers (11.8). However, when the criteria were relaxed to only require endorsement of two to four symptoms (i.e., Other Depressive Syndrome), 22.1% of the soldiers scored in this range. Moreover, there was a significant difference between the rates of Other Depressive Syndrome between the two combat experience groups. Significantly fewer Veterans (12.1%) scored positive for Other Depressive Syndrome compared with Non-Combat soldiers (23.1%).

Overall, the proportion of soldiers meeting diagnostic criteria for Other Anxiety Syndrome according to the Physical Health Questionnaire (PHQ) criteria was 15.0%. The prevalence rates between the Veterans (10.4%) and Non-Combat (15.4%) groups were not significantly different.
The proportion of soldiers meeting symptom criteria consistent with probable somatoform disorder was 8.7%. Veterans (8.1%) were no more likely to meet this diagnostic criterion than Non-Combat soldiers (8.7%).

In their sample, 4.7% of the soldiers met the strict criteria for possible PTSD using the scoring criteria outlined by W.D.S. Killgore et al (2006). The prevalence rates for possible PTSD between the Veterans (4.6%) and Non-Combat (4.7%) groups were nearly identical scored positive for Other Depressive Syndrome compared.

Their findings suggested that soldiers with prior combat experience reported fewer symptoms of anxiety and depression but greater reports of somatic complaints relative to soldiers without previous exposure to combat. These findings are consistent with theories of stress and repressive processes, suggesting that soldiers with prior combat experience may be more prone toward an attenuation of overt emotional symptom expression in conjunction with a selective amplification of somatic complaints relative to soldiers without such experience. Medical personnel and mental health practitioners should be aware of the potential for differential expression of stress as a function of prior combat history. Accordingly, it is recommended that Veterans be screened routinely for somatic symptoms as potential indicators of emotional stress that may not be communicated through overt self-report channels. When treating Veterans, tailoring intervention approaches to focus initially on treating the somatic symptoms may reduce defensiveness and facilitate treatment compliance.

The clinical report done by Sutker and colleagues (1994) describes symptoms of psychological and physical distress and psychiatric disorders in 24 Army Reservists who served war zone graves registration duty in support of Operation Desert Storm. Troops underwent comprehensive assessment for evidence of psychopathology that might be associated with war zone duty as one component of a debriefing protocol scheduled during regular drill exercises eight months after their return to the United States. Troops endorsed items suggestive of high war zone stress exposure, common symptoms of anxiety, anger, and depression, and multiple health and somatic concerns. Almost half of the sample met criteria for post-traumatic stress disorder, and diagnosis of this disorder was strongly associated with evidence of depressive and substance abuse disorder. The gruesome aspects of body recovery and
identification in the war zone setting were cited as stressor elements of significant negative impact.

High levels of somatic complaints were found in Israeli combat veterans with combat stress reactions and PTSD. Israeli combat veterans with PTSD reported significantly more somatic symptoms than combat veterans without PTSD (controls), but did not differ from controls on their physical examination. In a population of U.S. Vietnam War veterans, PTSD symptom severity and somatization were significantly related to self-report of health problems, but only PTSD symptom severity was related to physician-rated health. Patients with PTSD in a health-screening clinic for U.S. Persian Gulf War veterans reported more combat exposure and a greater number of physical symptoms than nontreatment-seeking veterans on active duty. Among the veterans with PTSD, the most commonly reported symptoms were fatigue, nausea, muscle aches, dizziness, back pain, stomach-ache, and numbness. Somatic symptoms may have a particular relationship to the specific stressor or to exposure to death and the dead. Increased reports of somatic symptoms in mortuary workers may persist for months. Reports of traumatic events in Gulf War veterans were associated with both PTSD and somatoform diagnoses. Veterans who handled dead bodies had a three-fold increased risk of receiving a somatoform diagnosis.

Among 131 Gulf War Veteran studied, Labbate, Cardeña, Dimitreva and Roy, Engel (1998) found that 69% had axis I conditions. Major depression, undifferentiated somatoform and posttraumatic stress disorders were the most common diagnoses. Reports of traumatic events were associated with both posttraumatic stress disorder (p < 0.05) and somatoform diagnoses (p < 0.05). Veterans who handled dead bodies had a 3-fold risk of receiving a somatoform diagnosis (p < 0.05).

In active-duty military recruits and in Vietnam veterans (and couples) seeking therapy, there were alarmingly high rates of violence against partners (Jordan et al., 1992). The studies suggest that the presence of PTSD, not the war veterans’ experience of combat in itself, is associated with greater hostility and increased physical violence against the female partner (Watson et al., 1982).

Veterans of Operation Iraqi Freedom who suffer from symptoms of PTSD are likely to have difficulties with anger regulation given the centrality of anger in the
human survival response. Research among military veterans has consistently shown that those with PTSD are higher in anger, hostility, aggression, general violence, and relationship violence and abuse than those without the disorder (e.g., Jordan et al., 1992). One study examined the effects of combat exposure and posttraumatic stress disorder (PTSD) on dimensions of anger in Vietnam veterans. Vietnam combat veterans were compared with Vietnam era veterans without war zone duty on the Multidimensional Anger Inventory (MAI). Combat veterans were not significantly more angry than their veteran peers who did not serve in Southeast Asia. Additionally, various parameters of war zone duty were not highly associated with anger scores. However, combat veterans with PTSD scored significantly higher than veterans without PTSD on measures of anger arousal, range of anger-eliciting situations, hostile attitudinal outlook, and tendency to hold anger in. These results suggest that PTSD, rather than war zone duty, is associated with various dimensions of angry affect.

War situations urge people to cling together. They form numerous small, medium, or large informal groups, whose psychological functioning is dominated by regressive phenomena – the regression meaning turning back to the earlier and more primitive forms of mental functioning and being halted at the previously fixated moments. When entering such an unfamiliar and insufficiently structured group, one inevitably goes through the stages of heightened anxiety before reaching adaptation. After the process of adaptation is accomplished, the anxiety alleviates, but the regression process persists. Finally, the regression of group members comes to a halt at certain primitive forms of psychological functioning. This process was especially manifest in informal groups formed by Croatian war veterans, which were characterized by intense feelings of loss. When entering such a group, the veterans felt helpless and threatened. Not knowing what was expected from them, they reacted with high anxiety and intense regression. In this way, the war circumstances promoted anxiety and regression not only in groups as a whole but also in individuals. Moreover, unexpected and often multiple combat injuries and consequent disability caused sufferings, which also induced strong anxiety and severe changes in self-image of the disabled veterans.
The civilian victims of war may suffer the greatest psychological harm, for they have not been prepared by the expectation of military training to manage the stress, shock, and fright of violence and loss as soldiers have. Some typical civilian stressors including life threat; being bombed, shot at, threatened, or displaced; being confined to one's home; losing a loved one or family member; suffering from financial hardships; and having restricted access to commodities such as food, water, and other supplies as a result of war. Particularly horrific stressors experienced by some civilians during war include: torture, beatings, rape, forced labor, witnessing sexual abuse or violence to a family member, and mock execution.

Most of the evidence on the effects of war on civilians has been conducted on refugee samples and people who were displaced as a result of war. Relative to other war-exposed civilians, these individuals’ experiences may be more severe due to the hardships of not only the situations that led to their exile, but also to stressors experienced in refugees camps and the process of resettlement. In general, refugees exhibit high rates of PTSD and depression as well as other psychiatric problems, particularly if they were tortured (de Jong, Scholte, Koeter, & Hart, 2000). For example, in a survey of Bosnians from a refugee camp in Croatia who experienced on average more than six traumatic events, approximately one-third had depression and one-quarter had PTSD. Twenty percent met criteria for both disorders. Refugees with both depression and PTSD were five times as likely to report being physically disabled, compared with refugees with no psychiatric symptoms (Mollica et al., 1999).

PTSD and other problems are prevalent in non-refugee samples as well. An article featured in a recent issue of the Journal of the American Medical Association reported on PTSD in survivors of war or mass violence in four low-income countries in (de Jong, et al., 2001). Rates of PTSD were 37.4% in Algeria, 28.4% in Cambodia, 17.8% in Gaza, and 15.8% in Ethiopia. These rates are considerably higher than the US population rate of 8% (Kessler, Sonnega, Bromet, & Nelson, 1995). One suggested explanation for the high rate in Algeria is that the terrorist attacks were still ongoing when PTSD was assessed. Several risk factors for PTSD were identified, including torture and the experience of trauma after the age of 12.
Results from refugees and impoverished countries may be difficult to generalize to Western cultures. However, findings from more industrialized settings such as Israel and Beirut may be relevant. Studies from the Gulf War suggest that there was a marked rise in stress during early weeks of the war for all ages that dropped off within a few weeks (Milgram, 1994). For example, data were collected on all casualties that arrived in the emergency departments of 12 local hospitals after actual missile attacks and false alarms. Almost 75% of admissions were for stress reactions or unjustified atropine injections. Another study found that while approximately half of a sample reported sleep problems during the war, there was significant improvement 30 days after the war ended (Askenasy & Lewin, 1996). Similar results were found in a study of following the 1982 Lebanon-Israel war. Almost 12,000 Israelis were interviewed regarding their mood on eleven different occasions between 1979 and 1984. Outbreak of war coincided with an increase in depression. Depressed mood peaked at the time of the Palestinian massacre at the refugee camps, then dropped below baseline, even though conflict continued. Thus, many civilians respond to prolonged war with various stress symptoms, but as time passes people seem to be resilient and stress levels return to normal.

Although most civilians who are exposed to war stress will not develop long-term mental health problems, some will, particularly if they have been exposed to severe stressors. Much research on this topic has been conducted with Holocaust survivors. In a study of 124 Jewish Holocaust survivors, 46% met criteria for PTSD. In a community sample of Israelis age 75 and older, 27% of male and 18% of female Holocaust survivors met criteria for PTSD as compared to 4% percent of males and 8% of females who did not experience the Holocaust (Landau & Litwin, 2000). Thus, it is clear that the prevalence of PTSD will persist throughout their lifetimes. Similarly, data from a long term follow up study of civilians in Holland 50 years after World War II indicates that 4% of the population exposed to a war related event has PTSD, as compared to 1.5% of non-exposed individuals (Bramsen & van der Ploeg, 1999).

The literature that is available suggests that children, just as adults, are affected but that the majority will not suffer from long term consequences. For example, following the period of SCUD missile attacks in Israel during the Gulf War,
children ages 10-15 were asked to describe what they thought life would be like for children their age next year. Their dominant perception was positive (73%). However, children who reported greater post war reactions also held more pessimistic views (Schwarzwald, Weisenberg, Soloman, & Waysman, 1997). Several months after the war children ages 10-15 reported that they were more concerned about traffic accidents, relations with friends, and their studies than with missile attacks (Greenbaum, Erlich, & Toubiana, 1993). A one-year follow up of children showed that high school students from high-risk areas reported no war symptoms, except sensitivity to loud noises, which was reported by about one fifth of children (Klingman, 1995). As is the case with adults, children living in refugee camps experienced more psychological problems than non-refugee children (Paardekooper, de Jong, & Herman, 1999). Both clinical and empirical reports have identified numerous negative outcomes in all domains of personal and social functioning, including grief, guilt, anxiety states, panic syndromes, anger and revenge, depression, trauma symptoms, insufficient support, and frustration with the criminal justice system (Amick- McMullan, Kilpatrick, Veronen, & Smith, 1989). In addition to trauma symptoms, bereavement responses consist of rage, revenge toward the killer, and frustration with the criminal justice system (Masters et al., 1988).

The Anxiety reaction taken among the children during the Gulf war indicated that among grade 5 settler children, girls showed more anxiety reactions than boys, whereas among the city children there were no gender differences. Girls who were children of settlers reported more intense coping responses and gave more intense expressions of relief at the end of the war than did boys who were children of settlers.

Just prior to the Gulf War in 1991, a large-scale research study was conducted with spouses of U.S. soldiers who had deployed to the Persian Gulf (Rosen, Teitelbaum, & Westhuis, 1996). Based on interviews with families and community leaders, a survey was developed and completed by approximately 1,000 spouses living on different military installations. The survey included key stressors and supports related to the sudden deployment. Three measures of stress were developed that addressed the following areas: (1) the emotional impact of the deployment (e.g., concerns about the soldier's safety and living conditions, problems with communication, uncertainty about deployment length); (2) life event problems
relating to the deployment (e.g., budget management, childcare costs); and (3) stressful life events occurring in the previous year. Emotional stress from the deployment, which included fear of injury, was found to be the highest predictor of psychological symptoms. A major strength of the study was the follow-up survey of spouses conducted ten months following the soldiers’ return home. Results indicated that although the majority of spouses were no longer symptomatic, approximately 30 percent of them still reported high symptom levels. The author proposed that the lack of recovery in the latter group may have related to higher reported rates of pre-deployment life stressors combined with reunion problems (Rosen, et al, 1996). The finding suggests that there may be military spouses who are at greater risk for longer term health consequences given a configuration of stressful life circumstances occurring as a background context to a dangerous deployment.

Studies of both children and adults following the Gulf War indicate that stress levels returned to normal shortly after the end of the war. A consistent finding is that people who experience more extreme stress will display more severe symptoms than those who experience less intense exposure or only a threat of violence. Therefore, civilians who directly experience or witness terrorist attacks, or who had a close friend or family member killed, will likely exhibit more extreme stress responses. And, for this subset of civilians, their reactions may be intense and long lasting.

According to the American Academy of Pediatrics, children of deployed members of the military experience a broad range of reactions to the stress of family deployment. Their reactions may include anger, sadness, fear, confusion and feelings of abandonment, loss, anxiety, and depression. These reactions can lead to significant problems such as school absenteeism and failure, social isolation, family emotional abuse and violence, psychosomatic medical complaints, and depression.

In American civilians, it has been reported that the Gulf war was associated with mild to moderate symptoms of anxiety and depression, particularly in those who has a relationship with a deployed-soldier. In children of deployed American soldiers, a major predictor of psychological symptoms was level of symptoms of other household members. Although deployment rarely provoked pathological levels of symptoms in healthy children, it was associated with increases in symptoms of depression, especially among younger children. In study of Israeli civilians that was
conducted during the war, Solomon and co-workers found that 80% of individuals whose homes had been destroyed by Iraqi missiles described symptoms consistent with DSM-III-R criteria for PSTD.

In Vietnam veterans, no consistent response to the Gulf war has been described. Reported responses have included support for the war, anger at the U.S. government for starting another war, irritability, intrusive thoughts, and increased depression and suicidality. In study of 76 female Vietnam veterans with PSTD, Wolfe and colleagues reported some ex-aeration of symptoms in most subjects, with the greatest increases in those who had high levels of pre-existing PSTD symptoms. In study of Holocaust survivors living in Israel during the Gulf war, Robinson and colleagues reported that many were still vulnerable 50 years after WW-II and reported a revival of feelings and memories associated with the Holocaust.

Several other studies of military spouses have identified factors that exacerbate concerns about safety and result in increased psychological symptoms. For example, a study of spouses' reactions when U.S. soldiers deployed to Operation Just Cause in Panama in 1989 described spouses' anger at the secrecy of the mission, since families could not be told where (or when) the soldier would be sent given the classified nature of the mission. The lack of information, combined with fears that the service member would be maimed or killed, or emotionally scarred by their combat experiences, resulted in recurring nightmares and symptoms of depression and anxiety (Scurfield & Tice, 1992). Similar findings were reported by spouses of Israeli soldiers who described living with the fear of death, compounded by minimal, if any, communication with the soldier to verify his safety (Solomon, 1988). Correspondingly, Milgram and Bar (1993), in their study of spouses of Israeli reservists activated during the Palestinian uprising in 1988, demonstrated a link between fear and health-related problems, finding that concern for their husbands' safety was highly correlated with anxiety, depression, and somatic symptoms.

Soldiers less exposed to combat and presenting with personality problems may be called loneliness and frustration casualties. Huffman (1970) reported that only 48 of 610 soldiers (8%) seen in Vietnam from 1965 to 1966 suffered combat-related stress, while Jones found combat-related stress in 18 of 47 soldiers (38%) seen in a
similar hospital setting (September–December 1966). These 18 cases, however, were given character and behavior disorder diagnoses.

Statistics show that when a nation is at war, its people are more likely to commit aggressive acts against one another. Crime rates since 1900 show that nations who have gone to war have had homicide rates rise much higher than other, peaceful nations.

Sample consisted of 139 Israeli soldiers who participated in the 1982 Lebanon War and were followed up 3 yr after their participation in combat. Statistical analyses revealed that a pervasive use of emotion-focused coping was generally found to be related with the presence of psychiatric symptoms. In addition, it was found that a high level of problem-focused coping moderated the detrimental effects of emotion-focused coping on mental health. (Solomon et al, 1989)

As it can be seen from the previous studies done by many researchers their present certain level of anxiety, frustration, stress, depression among the combat soldiers as well as among the civilians in the zone. We have seen many books and articles about Mizoram insurgency, but the study about the impact it had made on the psychological aspect of the individuals have not been done till now. The present study attempts to determine the psychological impact of the Insurgency among the generation experiencing the episode in Mizoram.

In view of the foregoing theoretical background, the present study was designed to meet the following objectives:

1. To evaluate the anxiety and depression level of the insurgents (volunteers) for comparison with civil (non-volunteers) participants.

2. To compare the frustration of the insurgents (volunteers) for comparison with civil (non-volunteers) participants.

3. To evaluate the coping styles of the insurgents (volunteers) for comparison with civil (non-volunteers) participants.
4. To evaluate the anxiety and depression level of the insurgents (volunteers) and civil (non-volunteers) for comparison on the ‘suffering’ in the family variable (fatal and non-fatal).

5. To compare the frustration of the insurgents (volunteers) and civil (non-volunteers) for comparison on the ‘suffering’ in the family variable (fatal and non-fatal).

6. To evaluate the coping styles of the insurgents (volunteers) and civil (non-volunteers) comparison on the ‘suffering’ in the family variable (fatal and non-fatal).

The followings are the theoretical expectations set forth for the conduct of the present study (Hypotheses):

1. Insurgents (volunteers) may exhibit greater anxiety scores than civilians (non-volunteers).

2. Insurgents (volunteers) may exhibit greater depression scores than civilians (non-volunteers).

3. Insurgents (volunteers) may exhibit greater mean score on frustration measures than civilians (non-volunteers).

4. Insurgents (volunteers) are expected to manifest either or both of task and emotion oriented coping styles, while civilians (non-volunteers) are expected to manifest avoidance oriented coping styles.

5. Bereaved insurgents and civil (Fatal) may exhibit greater anxiety scores than non-bereaved insurgents and civilians (Non-Fatal) counterparts.

6. Bereaved insurgents and civil (Fatal) may exhibit greater depression scores than non-bereaved insurgents and civilians (Non-Fatal) counterparts.
7. Bereaved insurgents and civilians (Fatal) may exhibit greater mean score on frustration measures than non-bereaved insurgents and civilians (Non-Fatal).

8. Bereaved insurgents and civilians (Fatal) are expected to manifest emotion oriented coping styles, while the non-bereaved insurgents and civilians (Non-Fatal) are expected to manifest avoidance oriented coping styles.

The analysis of the ‘Insurgents x Civilians’ interaction effect is exploratory in nature, but is expected in conformity of the foregoing hypotheses.

The methods and procedure that were aimed to be incorporated to achieve the objectives of the study are outlined in the next chapter on ‘Methods and procedure’