Resilience among Kashmiri migrants: A study of stress, coping and health

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Migrant populations are extremely diverse, and exhibit varied experiences and likely diverse acculturation trajectories as these relate to the process of cultural adaptation. Individuals can vary greatly in the time and preparation devoted to planning their migration, as well as in their intrinsic desire, voluntary or forced, to leave their homeland. Resilience theory provides a useful framework for understanding how exposure to terrorism. In the present study resilience, stress, coping and health are studied among a sample of 150 (75 males and 75 females) non-camp Kashmiri Hindu migrants in the age range 30-50 residing in Jammu city. Tools used were Resilience Scale, Perceived Stress Scale, Coping Strategies Inventory and Adult Health Checklist. Resilience was found to be positively correlated to problem solving, social contact and express emotion coping and negatively correlated with problem avoidance and social withdrawal coping, perceived stress and health symptoms. Results also revealed significant gender differences in resilience, perceived stress, problem solving, express emotion, social contact coping, self-criticism, social withdrawal coping strategies and health complaints.

Keywords: resilience, stress, coping, health, Kashmiri migrants

Resiliency, there are several existing definitions that share in common a number of features all implicating resiliency with human strengths, some type of disruption and growth, adaptive coping, and positive outcomes following exposure to adversity (e.g., Bonanno, 2004; Connor et al., 2003; Friborg et al., 2003; Matsen et al., 1999; Richardson, 2002).

Stress has been described as "the relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984). The causes of such an appraisal are called stressors. Perceived stress is the outcome variable measuring the experienced level of stress as a function of objective stressful events, coping processes, personality factors, etc. (Cohen, Kamarck & Mermelstein, 1983).

Coping refers to specific thoughts and behaviors that a person uses to manage the internal and external demands of situations appraised as stressful, in order to be protected from psychological harm (Folkman & Moskowitz, 2004; Lazarus & Folkman, 1984). Coping is defined as the process of managing external and/or internal demands that tax or exceed the resources of the person (Folkman, 2008; Lazarus, 1981, 2003). Coping, thus, is a process explanation for differences in stress outcomes. According to the model of Lazarus and Folkman (1984), there are two broad styles of coping: emotion-focused or problem-focused. Emotion-focused coping refers to efforts to reduce the negative emotions aroused in response to a threat by changing the way the threat is attended to or interpreted and often includes attempts to alleviate distress by ventilating feelings, denial, distraction and avoiding the situation(s) that caused it. Emotion-focused coping is usually seen as less effective because it focuses on the symptom rather than treating the cause and might be illustrated by crying or talking to a friend. Problem-focused coping refers to efforts to resolve a threatening problem or diminish its impact by taking direct action. Recently, a third type coping i.e., appraisal-focused coping has been added wherein the emphasis is on reappraising the stressful situation and increasing one's inner resources. The latter two methods (i.e.,...
oblem-focused and appraisal-focused) of coping are considered ore effective because they generate solutions or alter one's reception of the stressor (Wills, 1986).

Calnan (1987), Calnan and Johnson (1985) defined health in terms: getting through the day, never being ill, feeling strong, feeling fit, eing active, being energetic, getting plenty of exercise, having a rain state or attitude of mind, being able to cope with life's rises/stresses, and not being overweight. On the other hand healthiness has been defined as: being below normal continually, aving a poor lifestyle, having a lack of energy, being ill, having a serious illness, having a chronic illness, having an incurable illness, eing in bed or in the hospital, going to the doctor, being depressed or appy, not coping with life, losing weight, being dependent on thers, and being unable to work.

The World Health Organization (WHO) embraces a definition of health as 'physical, mental and social well-being and not merely absence of the disease or infirmity' (WHO, 1948; 2005). Thus the term health epitomizes the overall well-being of an individual in terms this fully functioning physical, psychological and relational self.

**Objectives of the study**

- To determine the relationship between resilience and perceived stress for both males and females.
- To determine the relationship between resilience and health complaints for both males and females.
- To ascertain the relationship between resilience and health complaints for both males and females.
- To study gender differences in resilience, perceived stress, various coping strategies and health complaints.

**Hypotheses of the study**

- It is expected that resilience will be negatively related with perceived stress for both males and females.
- It is expected that resilience will be positively related with problem solving, cognitive restructuring, express emotion and social context coping strategies for both males and females.
- It is expected that resilience will be negatively related with problem avoidance, wishful thinking, self-criticism and social withdrawal coping strategies for both males and females.
- It is expected that resilience will be negatively related with health complaints for both males and females.

**Method**

The participants consisted of 150 adult Kashmiri Hindu migrants (75 males and 75 females) in the age range from 30 to 50 years who had migrated following the 1988 insurgency in Jammu and Kashmir State. The data was collected from the urban areas of Jammu city using the purposive sampling technique. The variables of age, education, socio economic status and marital status were controlled in the present study. The subjects taken were at least graduates, from middle socioeconomic status, employed and married.
the world. The present study forms part of an exercise to understand the emerging pattern of resilience as developed by migrant segment of population displaced from their original habitat due to politico-ethnic compulsions. It highlighted significant correlations between resilience and perceived stress, coping strategies and health symptoms. Also significant correlations between resilience and its correlates. Relief and rehabilitation measures provided should take gender differences in account. The results of the current study may also shed light for counseling theory and practice while discovering the human strengths. The results may contribute to positive psychology at the pragmatic level accounting for the research methodologies and practical applications used by positive psychologists. The implications of the present study might be observed in the efforts striving for what makes people especially migrants more resilient.

References


Lazarus, R. S. (2005). Does the positive psychology movement have legs? *Psychological Inquiry*, 16(2), 93-109.


fatigue, change in appetite, and sleep difficulty. Reliability of AHC was established (r = .78) by Forgays, Bonaitu, Wrzesniowski and Forgays (1994). Concurrent validity of AHC was established by Forgays et al. (1994) as illness measured by AHC was significantly correlated with stress (r = .29) and dysfunctionality (r = .27). Internal consistency (r = .79) has been reported for the present study.

Results and discussion

Table I showing correlations between resilience, perceived stress, coping strategies and health

<table>
<thead>
<tr>
<th>Variables</th>
<th>Males (n= 154)</th>
<th>Females (n= 189)</th>
<th>Total (n= 343)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived Stress</td>
<td>-24**</td>
<td>-25**</td>
<td>-24**</td>
</tr>
<tr>
<td>Health Symptoms</td>
<td>-24**</td>
<td>-31**</td>
<td>-16**</td>
</tr>
<tr>
<td>Problem solving coping</td>
<td>-26**</td>
<td>-34**</td>
<td>-21**</td>
</tr>
<tr>
<td>Cognitive Restructuring coping</td>
<td>-19.8</td>
<td>18.8</td>
<td>0.09</td>
</tr>
<tr>
<td>Emotional coping</td>
<td>31**</td>
<td>.24**</td>
<td>.24**</td>
</tr>
<tr>
<td>Social Contact coping</td>
<td>.29**</td>
<td>.31**</td>
<td>.30**</td>
</tr>
<tr>
<td>Problem Avoidance coping</td>
<td>-.29**</td>
<td>.35**</td>
<td>-.22</td>
</tr>
<tr>
<td>Wishful Thinking coping</td>
<td>-.17</td>
<td>-.21</td>
<td>-.12</td>
</tr>
<tr>
<td>Social Withdrawal coping</td>
<td>-.20</td>
<td>-.21</td>
<td>-.11</td>
</tr>
<tr>
<td>*p &lt; .05, **p &lt; .01, ns-non significant value</td>
<td></td>
<td></td>
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</tbody>
</table>

Table II showing gender differences on resilience and its correlates

<table>
<thead>
<tr>
<th>Variables</th>
<th>MALES</th>
<th>FEMALES</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resilience</td>
<td>145.0</td>
<td>211.1</td>
<td>194.5</td>
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<tr>
<td>Perceived Stress</td>
<td>30.9</td>
<td>9.3</td>
<td>12.2</td>
</tr>
<tr>
<td>Health Symptoms</td>
<td>72.0</td>
<td>18.7</td>
<td>23.5</td>
</tr>
<tr>
<td>Problem Solving coping</td>
<td>39.0</td>
<td>10.1</td>
<td>9.5</td>
</tr>
<tr>
<td>Cognitive Restructuring coping</td>
<td>25.4</td>
<td>12.5</td>
<td>22.4</td>
</tr>
<tr>
<td>Emotional coping</td>
<td>28.0</td>
<td>11.9</td>
<td>13.2</td>
</tr>
<tr>
<td>Social Contact coping</td>
<td>35.0</td>
<td>12.1</td>
<td>13.8</td>
</tr>
<tr>
<td>Problem Avoidance coping</td>
<td>24.0</td>
<td>12.3</td>
<td>12.1</td>
</tr>
<tr>
<td>Wishful Thinking coping</td>
<td>28.0</td>
<td>9.8</td>
<td>18.3</td>
</tr>
<tr>
<td>Self-criticism coping</td>
<td>19.0</td>
<td>16.7</td>
<td>13.4</td>
</tr>
<tr>
<td>Social Withdrawal coping</td>
<td>38.0</td>
<td>23.9</td>
<td>29.3</td>
</tr>
<tr>
<td>*p &lt; .05, **p &lt; .01, ns-non significant value</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Results are tabulated in the form of table I and II. It was found that there was significant negative correlation between resilience and perceived stress (r = -.24, p < .01). Resilience was positively correlated with problem solving (r = .21, p < .01), social contact (r = .30, p < .01) and express emotion coping (r = .14, p < .05) and negatively correlated with problem avoidance (r = -.22, p < .01) and social withdrawal (r = -.35, p < .01) coping. Hence, the hypotheses were not rejected for these dimensions. Research to date suggests that those who typify psychological resilience do not discount the existence of stress in their lives; instead, stressful conditions are appraised as opportunities for growth and development as opposed to threats to well being. Given this mindset, psychologically resilient persons make use of more proactive coping strategies and thus respond to stressful life circumstances more effectively (Kobasa et al., 1982, 1985). A host of studies tend to provide direction to the association between stress, coping and resilience (Kelly, 1998; Ong, Bergemen & Bisconi, 2004; Wagnild & Young, 1993).

Significant correlations were found between resilience and health complaints among both males (r = -.24, p < .05) and females (r = -.31, p < .01). Researchers have provided numerous explanations for the underlying relationship of psychological, physiological, and mental health. It is stated that one's self-perception of resilience may be reflected in one's bodily responses to stressful stimuli. For trait resilient individuals, the experience of positive emotions is related to accelerated speed in rebounding from cardiovascular activation generated by negative emotions (Tugade & Fredrickson, 2004). It is possible that this quick recovery provides the body with restoration time to toughen it up in preparation for additional stressor should they arise (Dienstbier, 1989) and provide the opportunity to resilient people to explore other coping possibilities (Fredrickson, 2000; Tugade, Fredrickson & Barrett, 2004).

Results also revealed significant gender differences on resilience (t = 5.75, p < .01), perceived stress (t = 6.22, p < .01), problem solving (t = 6.52, p < .01), express emotion (t = 2.29, p < .05), social contact (t = 2.81, p < .01), self-criticism (t = 2.02, p < .05) and social withdrawal (t = 2.83, p < .01) coping strategies as well as health symptoms (t = 2.13, p < .05). Feminist scholars and resiliency researchers have highlighted significant gender differences in susceptibility to, and protection from situations of risks (Turner, Norman & Zuss, 1995). Several studies suggest that among men and women experiencing the same traumatic events, there are more psychological sequelae of the traumatic experiences among women (Breslau et al., 1999; Brewin et al., 2000; Kessler et al., 1995). Gender differences first in the psychological reaction to the same events and second in the severity of events experienced, may account for the high prevalence of mental health problems and low resilience after traumatic event experiences among women (Kessler et al., 1995; Breslau et al., 1999; Stein, 2000, Stein et al., 2002).

In interpreting the results, several limitations should be taken into consideration. First, self-report instruments were used in the study. If other data collection methods could have been used the present results would have confirmed. Additionally, since the sample size of this study is relatively small, the study might be replicated with a larger number. The results gathered from the present research are based on quantitative methods. It would be inspiring to replicate the study with qualitative methods in order to explore the core elements in resilience.

Limitations and future directions

This study does not provide exact prescriptions for resilience. It only proposes possible correlates to psychological resilience within its limitations. It would be feasible if the interrelations of the variables could be replicated in future. More research is required to confirm the interrelation pattern obtained in the present research.

Conclusion

Resilience theory provides a useful framework for the study of the dynamic process of adaptation as it occurs during various types of migration. Although the experiences of migration can be as diverse as the peoples of the world, the study of migration is a valuable endeavor because new knowledge from these migration studies can benefit hundreds of millions of migrants and refugees throughout
the world. The present study forms part of an exercise to understand the emerging pattern of resilience as developed by migrant segment of population displaced from their original habitat due to politico-ethnic compulsions. It highlighted significant correlations between resilience and perceived stress, coping strategies and health symptoms. Also significant correlation was observed between emotional health and resilience. Relief and rehabilitation measures provided should take gender differences in account. The results of the current study may also shed light for counseling theory and practice while discovering the human strengths. The results may contribute to positive psychology at the pragmatic level accounting for the research methodologies and practical applications used by positive psychologists. The implications of the present study might be observed in the efforts striving for what makes people especially migrants more resilient.

References


