CHAPTER I
INTRODUCTION

1.1 Background of the study

Kashmir is accounted one of the most likely places in India to witness major political conflicts from time to time. Kashmir valley is surrounded by beautiful Himalayan Mountains, and is also known as ‘heaven on earth’. The armed conflict in Kashmir was the result of the rebellion movement that started in 1989 after elections of 1987. The ruling party of that time i.e. National Conference conducted the unfair elections against MUF (Muslim United Front) candidate. And later the same candidate founded the militant outfit Hizbul Mujahideen to counter the national movement in Kashmir. In order to curb the rebellion movement Indian government set many counter agencies. Paramilitary forces while countering the conflict with rebellions put a high rise on human rights violation in Kashmir leading to the phenomenon of enforced disappearances and half widows.

The fateful consequences of a conflict situation cause multiple psychological, social, and environmental challenges to dignity of an individual (Pedersen, 2006). An individual’s sense of identity gets disrupted while living in such conditions of prolonged conflict and systematic violence (Das, 2007) it even stifles his or her psychological integrity (Punamaki, Kanninen, Qouta, & Sarraj, 2004; Baker & Shalhoub-Kevorkkian, 1999).

There are a large number of evidences that are testimony to the fact that traumatic events have the power to produce many negative physical and psychological outcomes. The recent studies have shown a shift in the paradigm from negative to positive. Posttraumatic growth (PTG) is the widely used tool to find out
the positive changes experienced as an outcome of the psychological and cognitive endeavours made in order to tackle the challenging circumstances (Calhoun & Tedeschi, 2001). Posttraumatic growth (PTG) has been identified in adult civilians exposed to war (Kimhi, Eshel, Zysberg, & Hantman, 2010; Maercker & Herrle, 2003), civilians exposed to terrorism (Hall, Hobfoll, Canetti, Johnson, Palmieri, & Galea, 2010; Hobfoll, Hall, Canetti, Galea, Johnson & Palmiera, 2007; Laufer & Solomon, 2006), veterans of war (Kaler, Erbes, Tedeschi, Arbisi, & Polusny, 2011; Pietrzak, Goldstein, Malley, Rivers, Johnson, Morgan III & Southwick, 2010), and former war prisoners (Dekel, Ein-Dor & Solomon, 2012, 2005, 2008; Solomon & Dekel, 2007). In one survey, Margoob, Khan, Mushtaq, and Shaukat (2006) found a lifetime extensiveness of traumatic events which were experienced by the people living in four major districts of Kashmir and among those traumatic events the firing and explosions were witnessed by majority of victims (81%) and exposure to combat zones (74%) (Bhat, 2015).

Dispositional hope, a positive psychology construct related to goal attainment, may be related to the development of PTG (Snyder, Harris, Anderson, Holleran, Irving & Sigmon, 1991). In comparison with optimism, the concept of hope appears to hold more emotional and motivational components (Ai, Peterson, Tice, Bolling, & Koenig, 2004). A study done by Ai, Cascio, Santangelo, and Campbell (2005) on 9/11 victims provided evidence for linkage between PTG and hope resulting in better adjustment.

Schaefer and Moos (1998) recommended a comprehensive model for life crises and personal growth to clarify the factors that contribute to the development of PTG. The model implies that both individual (e.g., socio-demographic variables, self-efficacy) and environmental resources (e.g., family, and social support, better quality
in relationship) combine to influence event related factors (e.g., severity, duration) during a life crisis or the transition period (Durak, 2010). Many studies revealed that individuals demonstrate better adjustment of traumatic episodes when perceived level of social support is high (Halcomb, Daly, Davidson, Elliott, & Griffiths, 2005; Keane, Marshall, & Taft, 2006; McIntosh, Silver, & Wortman, 1993).

Rayees (2015) studied the effect of exposure to the conflict and relation of social support with posttraumatic growth among people of Kashmir. The exposure to traumatic events and social support were found related to posttraumatic growth positively. Linley and Joseph (2004) claimed that social support and posttraumatic growth is suggesting weak relationship. Social support has been comprehensively studies and found as a protective factor of to help in minimising posttraumatic stress (Stephens & Long, 1999), however social support is less studied in the context of posttraumatic growth.

In addition to social support, this research focuses on the role of coping Strategies in determining posttraumatic growth among victims of Kashmir. Many people cope with potentially traumatic events by means of religion or spirituality (Pargament, Koenig & Perez, 2000. A large number of studies demonstrate the relationship between health and global religious indices, like prayer, church attendance, self rated religiousness and spirituality (Koenig, McCullough, & Larson, 2001; Pargament, 1997). Kashmir is the place also known as ‘Valley of Sufis’ or we can say mystics. People are very religious minded here and prefer to visit shrines for solace seeking to cope with the adversities by religious/spiritual coping. In the context of Kashmir, the religious domain remained an important aspect of growth. However, the existential domain does not predominate in the sample of persons studied in the United States (Tedeschi & Calhoun, 2004).
Recently more attention has been given to the approach oriented, active coping strategies and social support as antecedents to posttraumatic growth (PTG) in cancer survivors (Bellizzi & Blank, 2006; Sears, Stanton, & Danoff-Burg, 2003; Swickert & Hittner, 2009; Thornton & Perez, 2006; Widows, Jacobsen, Booth-Jones, & Fields, 2005). This has led to the promise that the role of hope, social support and coping strategies is effective in the Posttraumatic growth. A study conducted by Bhat and Rangaiah (2015) explored the effect of conflict exposure and social support on Posttraumatic growth among people of Kashmir. The study suggested that conflict exposure and social support are positively associated with PTG. This study was conducted on Northern population of Kashmir. Nisa and Rizvi (2016) assessed the relationship between social support, coping strategies and personality traits with posttraumatic growth in cancer patients of Kashmir. Results showed significant relationship between all the factors. This research will explore the coping strategies used by victims in Kashmir to cope with the conflict based traumas.

1.2 Statement of the problem

This research revolves around the enormous agony and apathy of Victims of Kashmir conflict, conducted on victims and we need to define whom this research has identified as victims. In addition there will be use of the term ‘secondary victim’ which will be utilised to include the immediate family or dependants of the direct victim. Two types of victims are taken for this research and both are secondary victim i) Parents of Disappeared (Fathers, as Secondary Victims). ii) Half Widows.

The present study will explore the role of social support and coping strategies among the conflict victims from all the regions of Kashmir. The present study is conducted to fill the gap in the role hope, social support and coping strategies in
posttraumatic growth among victims of Kashmir. Positive psychological states like hope, social support and coping strategies could be effective in minimizing the negative outcomes associated with stressful experiences emanating from conflict situations in people living in conflict zones. We expect that there is a methodological benefit in studying these variables together as it will lead to an intervention programme.

1.3 Posttraumatic Growth: Concept and Definitions

The idea that crisis and sufferings can lead to some changes in human life, many times in positive ways, is not a recent phenomenon or something discovered lately. Human sufferings are central to both ancient and contemporary religious thinking. If we see the origin of Buddhism, it is believed to lie in the sufferings of Prince Siddhartha Gautama to come to terms with human mortality. Christianity, on the other hand regards the suffering of Jesus as the important chapter that has saving consequences for humans. Islam views suffering in some circumstances a way towards ‘journey heavenward’. Even in Greek tragedy, the themes like cathartic or transformative consequences are of human sufferings (Calhoun & Tedeschi, 2006).

Posttraumatic growth refers to a change in people that goes beyond an ability to resist and not be damaged by highly stressful circumstances; it involves a movement beyond pre trauma levels of adaptation. Posttraumatic growth, then, has a quality of transformation, or a qualitative change in functioning, unlike the apparently similar concepts of resilience, sense of coherence, optimism, and hardiness (Tedeschi & Calhoun, 1995). People who have struggled with life crisis indicate that most of them have undergone positive changes in their lives.
O’Leary and Ivkovics (1995) used the term ‘thriving’ synonym to posttraumatic growth and defined it as a post event adaptation of any trauma that exceeds pre-event levels of functioning. The readjustment experience is transformative.

Calhoun (1996) defines posttraumatic growth as both a process and an outcome. It develops out of a cognitive process that is initiated to cope with traumatic events that extract an extreme cognitive and emotional toll. These events that initiate PTG have the quality of “seismic events” on a psychological level.

Calhoun and Tedeschi (2004) define Posttraumatic growth as a “positive psychological change experienced as a result of the struggle with highly challenging life circumstances”. The general paradox of this field is “out of loss there is a gain”. These gains are generally reported in the areas of heightened appreciation of life, more meaningful personal relationships, awareness of increased personal strength, changes in life priorities and recognition of new possibilities, and a deepening of engagement with spiritual or existential concerns and the enhancement of faith.

1.3.1 Theoretical Models of Posttraumatic Growth

The process of Posttraumatic growth

Calhoun and Tedeschi (1998) gave the model of Posttraumatic growth which provides a general view of what processing trauma into growth entails (figure1.). On the basis of empirical works in the area and on their own experiences as practicing psychologists, their model proposes that posttraumatic growth involves a variety of elements beginning by personality characteristics of a person and their styles of managing the distressing emotions that increase the chances that individuals will experience PTG.
Next important aspect for growth according to the model is the degree to which individuals engage in self disclosure about their emotions and their perspective on the crisis they have faced and the way their close ones respond to that self disclosure. This may also play a role in growth. The model also described how the cognitive processing of any traumatic event is related to growth like ‘ruminative thought’ i.e. rumination is thinking that (a) is conscious; (b) revolves around an instrumental theme; and (c) occurs without a direct cueing from the environment, but is easily and indirectly cued because it is connected with important goals, leading to recurrent thoughts (Martin & Tesser 1996).

Finally, the model suggests that posttraumatic growth can be connected to significant development of wisdom and of the individual’s life narrative.
Fig 1. The model of posttraumatic growth

Source: Calhoun and Tedeschi, 1998.
The Posttraumatic growth model with Sociocultural Considerations

Calhoun, Cann and Tedeschi (2010) developed a comprehensive model of the process of posttraumatic growth. Fig. 2 presents the current revised version of the posttraumatic growth on the basis of new findings. The schematic illustrations of the model starts with person pretrauma and ends with positive changes which can occur from struggle with life crisis. In previous model, the disruption of one’s assumptive beliefs, rather than characteristics of the event itself that initiates the process of growth. The latest version of the model recognize that the same event can challenge some people’s assumptive worlds.

The present model emphasizes that cultural influences play significant role in shaping the assumptive beliefs that determine the different possibilities of perceiving an event. Cann, Calhoun, Tedeschi and Gil-Rivas, (2007) developed a brief measure (Core Beliefs Inventory) to allow a better appreciation of the role of challenges to assumptive beliefs. They found that the extent to which an event leads people to examine their core beliefs is somewhat related to the stress reported (r’s around .20), but to a greater extent related to experienced growth (r’s over .50). (Calhoun, Cann, & Tedeschi, 2010). The important point here is that emotional distress is still likely to occur after exposure to stressful events, even if the events are consistent with one’s assumptive belief.
Fig. 2. Sociocultural Model of Posttraumatic Growth

Source: Calhoun, Cann, and Tedeschi, (2010).
Another important aspect highlighted in the current revised model is the nature of the relationship between PTG and indicators of well being or life satisfaction. According to the authors, it is important that people can experience growth and distress concurrently. The model states, ‘it is possible that growth facilitates development of new wisdom which consequently leads to well being’.

The revised model also adds clarification of the interaction between levels of distress and rumination. Soon after the traumatic event, rumination is positively associated both with emotional distress and disruption of beliefs. Present model is more comprehensive and provides more detailed description of earlier version of posttraumatic growth model (Calhoun & Tedeschi, 1998, 2004).

American Psychological Association (2005) in a Science Directorate conference on Positive Life Changes in the Context of Medical Illness, stated that “Posttraumatic growth and the mechanism associated with it suggest a radical reconstruction of a person’s life as a result of rebuilding assumptions that are shattered by trauma”. (p.13)

Joseph and Williams (2005) defined “Posttraumatic growth as a shift of focus to the relation between appraisal mechanisms and personality/assumptive world” (pp.423-441).

1.4 HOPE: Concept and Definitions

The psychiatric literature in 1950’s introduced the constructs of hope with a variety of conceptualizations. Many theorists have considered hope to be a factor in coping, multidimensional and future oriented. It helps people in adversities to cope with the uncertainties and traumatic experiences. Hope is an characteristic which
serves as a motivational factor that helps to start and sustain action towards goals and is linked to happiness, perseverance, achievement and health (Peterson, 2000).

Erikson (1964) defines hope as “the enduring belief in the attain ability of fervent wishes” and posed dialectics between hope and other motives, one of the strongest and most important being trust/hope vs. mistrust, which is the infants first task”. Another broad dialectic according to Erikson (1982) pertains to the generatively of hope vs. stagnation.

For Goltschalk (1974), hope involves positive expectancies about specific favourable outcomes and it implies a person to move through psychological problems. Staats (1989) defines hope as “the interaction between wishes and expectations.” (p.367).

Snyder (1994) proposes that hope has no hereditary contributions but rather it is completely a learned cognitive set about goal directed thinking. Pathway and agency goal directed thinking is inherent part of parenting and an important element of the hopeful thought.

Pathways thinking demonstrate basic cause and effect learning a child acquires from care givers and others. Such pathways thought is acquired before agency thinking with the latter being posited to begin around age 1. Agency thought reflects the baby’s increasing insight as to the fact that she is the causal force in many of the cause and effect sequences in her surrounding environment.

In general, Hope scale scores have predicted outcomes in academics, sports, physical health, adjustment and psychotherapy. Snyder (2000) listed some features of person with high hope as follows:

1. More likely to have fairly stable pattern of high hope thought across time
2. Mostly has had a major positive role model to look up to as adult.
3. Is assured of his or her goals and challenged by them.
4. Easily make friends in childhood and later.
5. Enjoys talking with people and listening to viewpoints of other.
6. Relaxed especially in evaluative test taking circumstances.
7. Better recovery from physical injuries.
8. Less likely to have suicidal thoughts.

Paul Pruyser considered hope to be an existential condition. That is the link between trauma and hope: hoping presupposes a tragic situation and serious suffering (Allen, 2015). Here we can conclude ‘to hope is to adopt an existential stance’. The basis of hoping is not in the reality but in the meaning we ascribe to reality. Hence hoping is an active process of making meaning (Allen, 2015).

1.4.1 Theoretical Models of Hope

*Stotland’s Model of Hope*

Through a review of literature, Stotland (1969) develop a theory that portrays hope as an expectation of future goals attainment that is mediated by the importance of goal are determinants of motivation. The greater the expectation and the importance of the goal to the individual, the greater will be the effort to achieve the goal. If goal is important and the individual perceive a low portability of attaining it, anxiety will be experienced. In difficult situations hope helps in adaptive mechanism and hopelessness results in maladaptive behaviour.

*Miller’s Model of Hope*

The model states that hope is a complex attribute. It is not only goal attainment; it includes a state of being. It includes a certain desire of a continuous decent condition of being. It includes a sure desire of a continuous decent state or freedom from troublesome circumstance. Hope exists at three levels. The main level
concentrates on shallow wishes that are portrayed by shallow positive thinking. It requires minimal psychic vitality to keep up and no depression when it is not completed. The second level concentrates on seeking after relationship, self-change, and achievements and includes more noteworthy psychic vitality than the principal level. In the event that these expectations are not completed, tension outcomes. The third level is identified with a yearning for help from anguish, individual trial, or capture and includes an aggregate commitment of psychic vitality. In the event that individual sees that alleviation is not approaching, profound misery or surrendering happens.

Mill operator and Powers (1988) distinguished 11 basic components of expectation from meetings of basically sick patients:

1. Commonality and alliance relate to relational relationship and experience of unrestricted love.
2. Feeling of conceivable includes a worldwide state of mind that there is potential in life.
3. Evasion of absolutizing involves permitting adaptability in one's desire and keeping away from a win or bust demeanour.
4. Suspicion grasps the certain desire of some future great joined with approval of the need to calmly hold up.
5. Building up and accomplishing objectives are the "question of one measurement of hope".
6. Mental prosperity and adapting are variables that enable the person to have the vital psychic vitality.
7. Reason and importance in life give the individual something to live for and to get a feeling of fulfilment with life.
8. Flexibility is capacity to perceive that the individual can affect a result and keep up an inspirational mentality.

9. Reality reconnaissance includes subjective assignments intended to acquire data that affirms the truth of hope.

10. Idealism is basic for hope.

11. Mental and physical wellbeing actuation incorporates vitality that is use to balance lack of care of gloom.

The Miller Hope Scale (MHS; Miller & Powers 1988) was extracted from Miller’s conceptualization of hope. Miller’s (1983, 1992) model of hope concentrates on idea identified with expectation with a couple proclamation of connections among the ideas. This decreases its capacity to clarify, foresee or control wonders. Miller’s model has demonstrated to have restricted handiness to examines that utilized the MHS however picked another reasonable structure. It is comprehensively generalizable to numerous populaces and circumstances and has been utilized with different gatherings including undergraduate students (Miller & Power, 1988), elderly (Beckerman and Northrup, 1996; Fehring, Miller & Shaw 1997) the incessantly sick (Herth and Stewart, 1994; Miller, 1992) the basically sick (Miller, 1989) and their life partners (Patel, 1996). It needs niggardliness in that it utilizes numerous idea and vague relationship.

1.5 Social Support: Concept and definitions

Social Support usually refers to the functions performed for the individual by significant others, such as family members, friends and co-workers. Significant others can provide instrumental, informational, and/or emotional support (House & Kahn, 1985). A substantial number of studies have demonstrated that people show better
change in accordance with traumatic occasions when seen levels of social support are high (Halcomb, Daly, Davidson, Elliott, and Griffiths, 2005; Keane, Marshall, and Taft, 2006; McIntosh, Silver, and Wortman, 1993). Along these lines, social support is an outstanding indicator of positive change after an injury or life emergency (McMillen, Smith, and Fisher, 1997; Schroevers, Helgeson, Sanderman, and Ranchor, 2010; Schulz and Mohamed, 2004; Tedeschi and Calhoun, 1996; 2004).

Furthermore, there is strong evidence that greater social support is related to resistance and resilience trajectories. Within the literature on PTG, both Schaefer and Moos’s and Tedeschi and Calhoun’s models consider social support as an important environmental resource for growth.

Hobfoll and Stokes (1988) define social support as ‘social interactions or relationships that provide individuals with actual assistance or with a feeling of attachment to a person or group that is perceived as loving or caring’. Aro, Hannimen, and Paronene (1989) viewed social support as a resource to offset or moderate the impact of stress caused by illness.

Schaefer and Moos (1998) social support may be a precursor of personal growth by influencing coping behavior and fostering successful adaptation to life crises. Dumont and Provost (1999) refers social support to support received (e.g. informative, emotional, or instrumental) or the sources of the support (e.g. family or friends) that enhance recipients’ self-esteem or provide stress-related interpersonal aid.

Catell (2001) viewed both formal and informal support networks as a central component of an individual’s ‘social capital’, a valuable resource that contributes to better health chances.
According to Holland and Holahan (2003) social support includes interpersonal interactions aimed at helping an individual achieve positive outcomes.

On the basis of individual’s perception of support and the actual support he/she receives following a stressful event, the important theoretical distinction in support literature has been made (Barrera, 1986; Dunkel-Schetter & Bennet, 1990). Usually these two types of support are weakly correlated and have different outcomes not only for support provided but for the psychological consequences of such support (Barrera, 1986; Schwarzer & Leppin, 1991).

1.5.1 Types of Social Support

Received Social Support

According to Barrera (1986) received support describes the actions actually performed by others when offering assistance. Indeed the received support is sometimes termed as the actual support. The role of receiving higher social and familial support (O’Leary, Alday, & Ickovics, 1998) and higher quality in marital relationship (Weiss, 2004) have been highlighted as important environmental resources in the prediction of PTG (Durak & Ayvasik, 2010). Supportive actions by significant others are thought to enhance the ways of coping. It is obvious that the absence of social ties or social isolation may be very stressful, producing chronic illness, lack of identity or lack of behavioural regulation (Hughes & Gove 1989; Rook, 1984, 1990). Received social support can be in terms of stopping a friend from drinking alcohol, smoking cigarettes, providing financial assistance etc. One form of received support is structural support which refers to the organization of people's ties to one another-in particular, to the number of relationships or social roles a person has, to the frequency of his/her contact with various network members, to the density and multiplicity of relationships among network members, and so forth. Network
measures often capture the individual's level or degree of social isolation/integration or social embeddedness (Thoits, 1995).

**Perceived social support**

The conviction that enthusiastic support is accessible seems, by all accounts, to be a substantially more grounded impact on psychological wellness than the real receipt of social support (Dunkel-Schetter & Bennett 1990; Wethington & Kessler 1986). Solberg (2006) emphasised the importance of social support, he stated that those who have a high perception of social support experienced less stress.

Researchers in behavioural medicine have conceptualized support in cognitive terms “as a perception that one is loved and esteemed by others” i.e. perceived Support (Turner, Frankel, & Levin 1983). The view presented here is that a perception of cared for can in itself promote health (Cobb 1976; Lynch, 1977) whether this perception is accurate or not. Yet perceived support availability has been constantly demonstrated to buffer the effects of stress on psychological outcomes (Kessler & McLeod, 1985). These results have led researchers to measure social support as the perception that support would be available if needed (Sarason, Levine, Basham & Sarason, 1983; Procidano & Heller, 1983; Cohen & Syme, 1985). The role of perceived social support is largely examined, especially the role of perceived emotional support i.e. beliefs that love, care, sympathy, understanding or esteem are available from significant others. As Norris and Kaniasty (1996) also stated, perceived support exerts the strongest effects on health and well-being in old age.

Fleming, Gisriel, and Gatchel (1982) showed that perceived social support exerted significant main effects on a variety of emotional and behavioural symptoms of distress. Perceived support exhibited several buffering effects, protecting both violent and property crime victims against various manifestations of distress.
(Kaniasty, 2005). Studies have identified approach-oriented, active, and social support coping strategies as antecedents to posttraumatic growth (PTG) in cancer survivors (Bellizzi & Blank, 2006; Sears, Stanton, & Danoff-Burg, 2003; Swickert & Hittner, 2009; Thornton & Perez, 2006; Widows, Jacobsen, Booth-Jones, & Fields, 2005).

1.6 Coping Strategies: Nature and Definitions

The idea of coping has been considered in different disciplines, sociologists, e.g. allude to the courses in which a social request changes with an emergency and scholars talk about the alteration of a tissue arrangement of the body the harmful occasion as in Syley's (1956) "General Adaptation Syndrome". In any case, coping is basically a mental idea. In mental utilization, there are numerous meanings of coping; however all share a focal topic, in particular, the battle with outer and interior requests, clashes and troubling emotions.

Adapting alludes to a man's dynamic endeavors to determine stress and to make better approaches for taking care of new circumstances at every life stages (Erickson, 1959). This thought underlines the significance of the individual asset and abilities that are utilized to manage new difficulties. Coping underlines dominance of the circumstance while safeguard stresses assurance of the self. This does not suggest that adapting jumps out at no respect for the self. The coping procedure requires as full of feeling individual who effectively draws in every life challenges.

White (1974) recognized three segments of coping. To start with, coping requires that the individual have the capacity to pick up and handle new information. New information is expected to comprehend a troublesome circumstance all the more completely or to build up another position despite risk. Second, coping requires that the individual have the capacity to keep up control over his or her enthusiastic
significance of effectively deciphering feelings, communicating them when vital, and restricting their look when fundamental. Third, coping requires that the individual have the capacity to move uninhibitedly in his or her condition.

The term coping has two meanings in literature. The term has been used to denote the way of dealing with stress, or the effort to master conditions of harm, threat or challenge when a routine or automatic response is not readily available (Lazarus, 1974). Coping refers to efforts to master conditions that tax or exceed adaptive resources (Monet & Lazarus, 1977). At a general level, coping has been broadly defined as “any effort at stress management” (Folkman & Lazarus, 1980). The term coping is viewed as a stabilizing factor that may help individuals maintain psychological adaptation during stressful period (Folkman & Lazarus, 1985).

The most commonly used definition of coping is put forward by Folkman and Lazarus. They see coping as psychological mechanism for managing psychological stress (Lazarus & Folkman, 1984). This mechanism may be both action oriented and intra psychic and is intended to avoid or mitigate the consequences of stressor (Cohen, 1987).

Dewe and others (1979) define coping as an individual’s attempted response to reduce feeling of discomfort. To Burke and Wier (1980) coping process refers to “any attempt to deal with stressful situations when a person feels he must do something about, but which tax or exceed his existing adaptation response patterns”. Maddi and Kobasa (1984) have discussed two forms of coping: 1) Transformational coping involves altering the events and by thinking about them optimistically and acting toward them decisively, change them in a less stressful direction. 2) Regressive approach to coping includes a strategy wherein one thinks about the events pessimistically and act evasively to avoid contact with them.
Definitions and conceptualization of coping have a spanned a wide range of views including: (a) coping as a personality trait or disposition versus coping as a situation-based or state-like effort; (b) coping strategies as inherently adaptive, reality based, conscious, and purposive approaches versus coping or defense strategies as global, primarily intrapsychic, reality-distorting, rigid and maladaptive processes; and (c) the nature of coping classification (e.g. approach versus avoidance coping, instrumental/ active versus affective/ passive coping; adaptive versus maladaptive coping (Billings & Moos, 1984; Holahan, Moos & Schaefer, 1996; Lazarus & Folkman, 1984).

1.6.1 Types of Coping

**Cognitive Coping Strategies**

We can cope with a stressor or our emotions by problem solving, self talk, and reappraisal. Problem solving involves analyzing the situation to generate possible courses of action to evaluate the efficacy of the actions, and to select an effective plan of action (Jannis & Mann, 1976). To continue with hidden anxiety (emotion-oriented, self as target), which classes to drop to reduce worry (emotion-oriented, environment as target), or on how to enlist the aid of fellow students to study, (problem-oriented, environment as target). Self talk refers to convert statements or thoughts that are used to direct our efforts at coping with the stressful event and its associated emotional arousal. This internal talk directs attention to relevant stimuli facilitates the formulation and implementation of coping strategies and provides corrective feedback (Meichenbaum, 1977). Reappraisal involves reducing the impact of a stressful event by altering how that event is interpreted. In other words, the event is given a different meaning.
**Behavioural Coping Strategies**

People also respond to stress behaviourally. There are four general classes of behavioural responses to stress: seeking information, direct action, inhibition action, and turning to others. Seeking information refers to gathering data on the nature of stressor and on possible coping strategies. An individual faced with a diagnoses of cancer, for example may seek information about prognosis from a health care provider (Hamm, 1977). Information thus provides useful instrumental coping strategies and enhances feelings of control and predictability. Direct action refers to overt verbal and motor responses that alter stressors or stress related emotional arousal. Avoidance of anxiety provoking situations would fit in this category, for example, a person frequently misses his appointments with health providers because of the pain and embarrassment associated with these visits. The last class of behavioural coping, turning to others, has been traditionally labelled social support.

**Avoidance Coping Strategies**

According to Holahan and Moos (1986), avoidance coping is a response to threatening situations when personal and contextual resources are scarce. Also when severe stressors persist, individuals may gradually lessen their use of problem solving coping and increase their reliance on avoidance strategies (Moos, 1992). In avoidance coping, a person reduces his tensions by drinking more (alcohol), eating more and take tranquilizing drugs.

Thus, individuals experiencing stress have to do something to deal with this and what is done to deal is referred to as coping. There can be several types of coping strategies such as cognitive, behavioural, avoidance or turning to others. There is no agreement as to who will use a particular type of coping strategy and who will use certain others. People use a mixture of several coping strategies.
1.7 Research objectives: The present research aimed at:

1. To examine the relationship of Posttraumatic growth (PTG) with hope, social support and coping strategies among male and female victims.

2. To examine the relationship between dimensions of hope (agency and pathways) and dimensions of posttraumatic growth (new possibilities, relating to others, personal strength, spiritual change and appreciation of life) among male and female victims.

3. To examine the relationship between dimensions perceived social support (family, friends, and significant others) and dimensions of posttraumatic growth (new possibilities, relating to others, personal strength, spiritual change and appreciation of life) among male and female victims.

4. To examine hope, social support and coping strategies as predictors of posttraumatic growth among male and female victims.

5. To examine the dimensions of hope (agency and pathways) as predictors of dimensions of posttraumatic growth (new possibilities, relating to others, personal strength, spiritual change and appreciation of life) among male and female victims.

6. To examine the dimensions of perceived social support (family, friends, and significant others) as predictors of dimensions of posttraumatic growth (new possibilities, relating to others, personal strength, spiritual change and appreciation of life) among male and female victims.
1.8 Hypotheses:

On the basis of the understanding gained through the review of literature, the following hypotheses are framed for the present research.

**H_A1**: There will be positive relationship of posttraumatic growth with hope, perceived social support and coping strategies among male and female victims.

**H_A2**: There will be positive relationship between dimensions of hope (agency, pathways) and dimensions of posttraumatic growth (new possibilities, relating to others, personal strength, spiritual change and appreciation of life) among male and female victims.

**H_A3**: There will be positive relationship between dimensions of perceived social support (family, friends and significant others) and dimensions of posttraumatic growth (new possibilities, relating to others, personal strength, spiritual change and appreciation of life) among male and female victims.

**H_A4**: Hope, social support and coping strategies will predict posttraumatic growth among male and female victims.

**H_A5**: Dimensions of hope (agency, pathway) will predict dimensions of posttraumatic growth (new possibilities, relating to others, personal strength, spiritual change and appreciation of life) among male and female victims.

**H_A6**: Dimensions of social support (family, friends and significant others) will predict dimensions of posttraumatic growth (new possibilities, relating to others, personal strength, spiritual change and appreciation of life) among male and female victims.

1.9 Significance of the Study

Recent studies have shown the signs of posttraumatic growth among the conflict affected people of Kashmir. (Anjum & Maqbool, 2015; Bhat & Rangaiah, 2015). The
present investigation intends to explore the role of positive psychological states like hope in victims of Kashmir. No such study has been conducted so far on victims of Kashmir i.e. Half Widows and Parents of disappeared assessing their posttraumatic growth considering hope, social support and coping strategies as predicting factors. No research has been done so far assessing the role of hope in Posttraumatic growth among victims in Kashmir. Present research expects to predict PTG as an outcome of hope. The present study has taken precedence in highlighting the literature that forms the foundation in identifying the role of the hope, social support and coping strategies in posttraumatic growth of victims in Kashmir.

1.10 Operational Definitions of Variables

Posttraumatic Growth

Calhoun and Tedeschi (2004) defines posttraumatic growth as a “positive psychological change experienced as a result of the struggle with highly challenging life circumstances”.

Hope

Snyder’s cognitive theory (Snyder et al., 1991) present hope as a dispositional construct that examines the degree to which individual believe that they can achieve their goals for the future.

Perceived Social Support

Zimet, Dahlem, Zimet, and Farley (1988) define perceived social support as an individual’s perception of how resources can act as a buffer between stressful events and symptoms. According to Zimet, Dahlem, Zimet, and Farley (1988), perceived social support consists of three dimensions, namely, family, friends and significant other. Whereas family and friends are self-explanatory, a significant other could be a
supervisor, peer, co-worker or any other person not explicitly defined, but with whom the individual has contact on a daily basis.

**Coping Strategies**

Carver, Scheier, and Weintraub (1989), Zeidner and Endler (1996) “A coping strategy can be either to approach or to avoid the particular stressor. Some strategies may be more useful than others”. It springs partly from the mental sets brought by an individual to a stressful event, and serves as an option one chooses in accordance with its perceived usefulness to respond to a stressor, or potential stressor.

**Victim**

A victim is one who is arrested, detained or abducted against their will or otherwise deprived of their liberty [or life] by officials of different branches of Government, acting on behalf of, or with the support, direct or indirect, consent or acquiescence of the Government (UN Declaration on the Protection of All Persons from Enforced Disappearance, 1992) (Crew, 2008).